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Jørn Holm-Hansen

# Family Medicine in Russia

Swedish reform support evaluated



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# Preface

This Evaluation has been carried out for the The East Europe Committee of the Swedish Health Care Community (SEEC) with the aim of facilitating a learning process. The Report documents the project activities on primary health care and family medicine. In accordance with the Terms-of-Reference the Review has aimed at identifying results, and it presents a set of recommendations.

The preparations, field studies and writing up have taken place within the framework of 225 man hours. In addition to interviews in St. Petersburg, Vólogda, Stockholm, Gävle and Östersund, interviews have been made in several city districts of St. Petersburg (Krasnogvardéiskii, Petrográdkii, Kalíninskii), districts and settlements of the Leningrad region (Gáchina, Vsévolozhsk, Vólosovo, Sel'stó, Bergardóvka, Shcheglóvo), as well as semi-rural settlements of Vólogda town (Molóchnoe, Prilúki), and districts and settlements of Vólogda region (Skeksná, Chëbsara, Nífantovo). The Norwegian Institute for Urban and Regional Research would like to thank all those having shared their time, information and insights with the Evaluator. Everybody has been very helpful.

The Evaluator is particularly grateful to Annica Larsson and Birgitta Jansson at SEEC, who provided all necessary documents, neatly organised chronologically in binders. This saved much time for the Evaluator.

The Evaluator has drawn on NIBR senior researcher PhD Aadne Aasland's insights into the Russian health care system. Inger Balberg at NIBR deserves thanks for her technical finish on the final version of the report.

Oslo, March 2009

Marit Haug  
Research Director

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# Summary

*Jørn Holm-Hansen*

## **Family Medicine in Russia**

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Primary health care used to be one of the Russian health system's strong sides. During the Soviet period basic health services were made accessible to the population at large, including rural dwellers. Easy access to specialists was a particular feature of the system as it developed. Correspondingly, the gate-keeping functions of the generalists were weakly developed.

Not treating patients at the "lowest possible" level proved to be cost-inefficient. Therefore, during the perestroika period in the second half of the 1980's, economic incentives were introduced to reduce over-referrals to specialists. General medicine was made a recognised specialisation in 1992, but the practical follow-up has been lengthy. Still today, the number of general practitioners in Russia is under 5000.

Since 1998, the The East Europe Committee of the Swedish Health Care Community (SEEC) has been supporting the ongoing Russian reforms of primary health care and family medicine in the regions of North West Russia. SEEC is a non-profit NGO representing almost the entire Swedish health sector. SEEC aims at promoting public health in adjoining parts of East and Central Europe.

The Evaluation Report goes in-depth on three Swedish-Russian projects aiming at promoting family medicine in Russia. With the aid of the concept of "programme theory", the Report identifies the assumed mechanisms leading to the desired goal of stronger general and family medicine services in Russia.

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The projects are carried out in co-operation between the regions of Jämtland and Vologda, Gävleborg and Leningrad and Stockholm and St. Petersburg. Vologda and Leningrad are pilot regions for primary health care reform, and St. Petersburg used to be forerunner in the field at the time the project co-operation with Stockholm started up.

The belief in making regional authorities in the two countries co-operate on health reform is one of the characteristic features of the operation's programme theory. The second pillar of the programme theory is the belief in training. The bulk of the project activities consists in training and education. Thirdly, there is the emphasis on model units. Equipping model units in order to show the merits of the GP system by the power of example has formed an important element all three projects.

The Report concludes that the projects have been well-thought out with a logical programme theory. In general, the projects follow sequences in which one activity is followed up by an activity that makes use of the achievements from earlier phases.

The project leaders on Swedish side are all experienced medical personnel and health managers. The projects have drawn extensively of Swedish personnel currently working in the primary health care which allows their Russian colleagues to get acquainted with fresh inputs from the field. On the Russian side the day-to-day project leaders have been experience health care personnel with a strong will for reform.

The knowledge-intensity of working in Russia has been underestimated, and very little has been done to systematically compensate for this lack. Although SEEC has been useful as an advisory and structuring element, the projects seem to have been less well prepared to cope with obstacles. Although having an intention of being system-oriented the Swedish project owners have lacked the necessary insight in Russian realities to cope with them. Sadly, the Russian side has not done enough to explain – or sort out – the problems. Concrete knowledge about and understanding of each others specificities and realities is probably the single variable that could have raised project efficiency most effectively.

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Russia is a country where reform support is welcome, but where “donor-driven” policy transfer is of little relevance.

Project activities having their origins in the 1990’s, when Russia was a quite chaotic place with representatives of the health sector open to almost any suggestion to co-operate, have had to adapt quickly to a situation of more efficient streamlining from above and more selective approaches on the part of relevant Russian authorities. This latter factor has to do with the considerable improvement of public finances since the early 2000’s.

Immediate project results, or *outputs*, are the strong side of the projects. Outputs, like the establishment of model units, seminars and study trips, are produced efficiently, and they are carefully and pedagogically reported.

The next step – *outcomes* – however, is clearly more problematic. Since the projects’ main intervention consist in training, looking for outcomes equals investigating how the newly acquired knowledge is being put into practice. Really to account for changes on outcome level requires insight in the Russian system that the Swedish side does not possess, and the Russian side does not share. Nonetheless, it is evident that family medicine is being practiced in model units established by the project and/or by medical personnel trained through the project.

When it comes to *impacts*, more has been achieved on the personnel side than on institutional change. Where family medicine is being practiced as a result of the project, there are fewer referrals to specialists. The model units have attracted some attention from health authorities in neighbouring districts. Large-scale impacts are contingent upon factors beyond project level, most importantly the degree to which Russian regional health authorities push the reform.

The projects have been expensive, not least because man-hours spent are considerable. Project leaders and assistants on the Swedish side have part-time positions to run the projects. On the Russian side the project leaders also have part or full time positions.

Cost-efficiency is likely to increase if the co-operating partners are the most suitable implementers. In order to assist Russian reforms

in the field of primary health care, the Russian authorities in charge are at regional (federation subject) level as well as municipal level. Health care is the one policy field that dominates among the responsibilities of Swedish county councils. Therefore, basing the co-operation on regional authorities enhances the chances of cost-efficiency.

The Report presents four basic recommendations for use in ongoing or future projects, in Russia or elsewhere:

1. Projects established in chaotic periods of a county's history should take care not to misinterpret the lack of initial resistance to the project idea as a sign the project is well thought out.
2. All projects should be carefully linked up to domestic reform agendas.
3. The knowledge-intensity of carrying out projects in a foreign country should not be underestimated. All projects should be preceded by a consequence analysis carried out by external experts.
4. Project holders are advised to restrict the number and complexity of activities going on simultaneously. Keeping project activities simple (yet challenging) and few in numbers makes it possible to make sure results are verified before moving on.

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## Краткое резюме отчета

*Jørn Holm-Hansen*

### **Family Medicine in Russia**

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Первичная медицинская помощь всегда была одной из сильных сторон российской системы здравоохранения. Во время советского периода основные услуги здравоохранения были в целом доступны населению, включая и сельских жителей. Особенностью системы, по мере того, как она развивалась, был легкий доступ к специалистам. Следовательно, функция отбора и сортировки, которую выполняют врачи общего профиля, получила слабое развитие.

Отсутствие лечения пациентов на «возможно более низком уровне» оказалось экономически неэффективным. Поэтому, в период «перестройки» во второй половине 80-х годов были введены экономические стимулы для ограничения числа направлений к специалистам. Общая медицина стала признанной специализацией в 1992 году, однако путь к ее практическому применению был долгим. На сегодняшний день число врачей общей практики в России все еще не превышает 5000.

Шведский Восточно-Европейский комитет по медицине и здравоохранению (ВЕК) оказывает поддержку российским реформам первичной медицинской помощи и семейной медицины в регионах Северо-запада России, начиная с 1998 года. ВЕК является некоммерческой неправительственной

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организацией и представляет практически весь сектор шведского здравоохранения. Цель ВЕК – способствовать развитию общественного здравоохранения в близлежащих регионах Восточной и Центральной Европы.

Отчет об оценке проектов содержит детальный анализ трех шведско-российских проектов, направленных на содействие развитию семейной медицины в России. С помощью концепции «теории программ» Отчет идентифицирует механизмы, которые, предположительно, ведут к достижению поставленной цели, а именно, к усилению служб общей и семейной медицины в России.

Проекты выполняются в сотрудничестве между регионами Йемтланд и Вологда, Явлеборг и Ленинградская область, Стокгольм и Санкт-Петербург. Вологда и Ленинградская область являются федеральными пилотными регионами, где ведется реформа первичной медицинской помощи, а Санкт-Петербург стал первым партнером в этой сфере, когда сотрудничество со Стокгольмом только начиналось.

Одной из характерных особенностей концепции программы всего мероприятия является вера в то, что необходимо побудить региональные власти к сотрудничеству в области реформы здравоохранения. Второй основной принцип концепции программы - вера в обучение. Основная часть мероприятий, включенных в проект, посвящена обучению и повышению квалификации. И, в - третьих, программа уделяет особое внимание показательным офисам. Важным элементом всех трех проектов стало оборудование показательных офисов для того, чтобы продемонстрировать на их примере преимущества системы семейной медицины.

В Отчете делается вывод, что проекты были хорошо продуманы, и что в них наличествовало логическое теоретическое обоснование. В целом, проекты основываются на принципе последовательных действий, а именно, когда каждое последующее действие логически опирается на достижения действия предшествующего.

Все руководители проектов со шведской стороны являются опытными медиками и руководителями здравоохранения. Проекты широко использовали опыт шведских медиков,

работающих в первичной медицинской помощи в настоящее время, что дало возможность их российским коллегам ознакомиться с последними достижениями в этой области. Оперативные руководители проектов с российской стороны были опытными работниками здравоохранения, стремящимися к реформам.

Значимость конкретных знаний о том, как работать в России недооценивалась, и мало что делалось для того, чтобы систематически компенсировать этот недостаток. Хотя ВЕК был полезен в качестве консультирующего и структурирующего элемента, проекты производят впечатление недостаточно хорошо подготовленных для преодоления трудностей. Несмотря на то, что шведские держатели проектов намеревались работать, ориентируясь на систему, им не хватало необходимого понимания сложностей российской реальности для того, чтобы успешно с ними справиться. К сожалению, российская сторона не предпринимала достаточных усилий к тому, чтобы объяснить – или решить – имеющиеся проблемы.

Россия – страна, где приветствуется поддержка, оказываемая реформам, но где, однако, простой перенос методик и концепций «под руководством донора» мало уместен.

Работа над проектом началась в 90-х годах, когда Россия была в весьма хаотическом состоянии, и представители здравоохранения были открыты практически любому предложению о сотрудничестве. А позже нужно было быстро адаптироваться к более эффективному упорядочению процесса сверху и к более селективному подходу со стороны соответствующих российских руководящих органов. Этот последний фактор повлиял на значительное улучшение государственного финансирования с начала 2000-х годов.

Непосредственные результаты, или *реальная отдача* проекта, являются сильной стороной проектов. Такие мероприятия, как открытие показательных офисов, организация семинаров и ознакомительных поездок, проводились эффективно, отчетность по ним носит детальный и обучающий характер.

Следующий шаг, или *подведение итогов*, однако, явно более проблематичен. Поскольку основное содержание проектов



заклучалось в обучении, попытка подвести итоги равноценна попытке выяснить, как вновь приобретенные знания применяются на практике. Чтобы получить реальную картину изменений на уровне подведения итогов, необходим взгляд на российскую систему как бы изнутри. Шведская сторона такой возможности не имеет, а российская сторона не делится информацией. И тем не менее, очевидным остается тот факт, что семейная медицина функционирует в показательных офисах, созданных либо в рамках проектов, либо медицинскими работниками, обученными в рамках проектов.

Когда же речь идет о *влиянии* проектов на дальнейшее развитие, результаты, достигнутые в работе с персоналом, производят большее впечатление, нежели результаты, достигнутые в институциональных изменениях. Там, где в результате проектов, уже работает семейная медицина, стало меньше обращений к специалистам. Показательные офисы привлекли определенное внимание руководства соседних районов. Крупномасштабное же воздействие зависит от факторов, находящихся за рамками проектов, а именно, от степени приверженности российского регионального руководства здравоохранения к реформам.

Проекты были дорогими, что в значительной степени объясняется большим количеством затраченных человеко-часов. Руководители проектов и их ассистенты со шведской стороны были заняты неполное рабочее время. Руководители проектов с российской стороны также уделяли работе над проектами часть полного рабочего дня.

Вероятно, возможно увеличить экономическую эффективность, если в качестве партнеров выбирать кандидатуры, наиболее подходящие для реализации проектов. Для того, чтобы помочь российским реформам в области первичной медицинской помощи, нужно иметь дело с властями, ответственными за это на региональном уровне (в субъектах федерации) и на муниципальном уровне. Здравоохранение является доминирующей политической сферой в ряду прочих зон ответственности шведских окружных советов. Следовательно, опора партнерских отношений на контакты с региональными властями

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увеличивает шансы на улучшение экономической эффективности.

Отчет представляет четыре основных рекомендации для использования в будущих проектах в России, либо в какой-нибудь другой стране:

1. Если проекты начинаются в такой исторический период, когда в стране царит хаос, нужно следить за тем, чтобы отсутствие первоначального сопротивления идее проекта не принималось ошибочно за признак того, что проект хорошо продуман.
2. Все проекты должны быть тщательнейшим образом увязаны с программой проведения реформы внутри страны.
3. Не следует недооценивать важность знаний о том, как осуществлять проекты в зарубежной стране. Всем проектам должна предшествовать стадия анализа последствий. Такой анализ должны выполнять внешние эксперты.
4. Держателям проектов рекомендуется ограничивать количество и сложность действий, выполняемых одновременно. Если количество мероприятий в рамках проекта ограничено, они достаточно просты (и в то же время интересны и перспективны), тогда можно быть уверенным в том, что результаты будут проверены и проконтролированы, прежде чем проект будет двигаться дальше.

# 1 Introduction

## 1.1 Brief information on the project activities evaluated

### **Purpose of the evaluation**

The main purpose of the evaluation, as described in the Terms-of-Reference, has been to enable *a learning process*. The groups targeted by the evaluation is a variety of actors, among them Russian and Swedish project owners and managers, students and graduated health staff in North-West Russia, staff in the Russian training system, politicians, managers of social services, NGO's and patients themselves. Also Sida and the Board and Secretariat of SEEC are target groups. Learning is important to avoid duplicating mistakes within the project itself, and to provide a better starting point for future project activities, notably the future project staff of similar projects in Belarus and elsewhere.

### **History**

The first Swedish – Russian projects on “Development of Primary Health Care and Family Medicine in Regions of North West Russia” were initiated in 1998. Promoting primary health care and family medicine in Russia is among the priorities of the The East Europe Committee of the Swedish Health Care Community (SEEC) and the Russian authorities alike.

SEEC is a non-profit NGO representing almost the entire Swedish health sector broadly speaking. SEEC was established in 1992 by the Swedish Medical Association, the Swedish Society of Medicine, the Swedish Association of Health Professionals and the National Board of Health and Welfare. Later, regional councils, government agencies, organisations and state-owned and private companies

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have joined as members. SEEC aims at promoting public health in adjoining parts of East and Central Europe. Today, most of the activities take place in Russia and Belarus.

### **Objectives**

The *objectives* of the projects on primary health care and family medicine have been to support the ongoing reform of the Russian health system by strengthening primary medicine among others by introducing General Physicians (GP's).

### **Relevance**

The projects have been considered relevant on the background of a set of unfavourable aspects of the Russian primary health care system. Although having enjoyed the reputation of having one of the world's best primary health systems (the WHO-UNICEF International Conference on primary health care in Alma Ata 1978) when Russia formed the core republic of the Soviet Union, today a host of problems have been identified. First of all, resources are being used inefficiently due to a high hospitalisation rate and an excessive use of first aid ambulances. Moreover, the polyclinical system in Russia is based on excessive use of specialists. Patients are sorted by doctors with basic education, the so-called therapists and referred to a specialist with very little efforts to solve the problem by the therapists themselves. Preventive work has been neglected.

The Russian health authorities have set in motion a host of measures to improve primary health, among them introducing day hospitalisation, "schools" for patients with certain diseases, as well as the introduction of GP and FM. These measures are followed up by economic incentives to those who choose to direct or re-direct their medical practice into efficient primary care. Also, there are incentives to health institutions that have good scores on e.g. day hospitalisation or visits to GP's.

In other words, the three primary health projects evaluated in this report all are co-current with official Russian strategies. Since Russia's constituent entities, the federation subjects, like St. Petersburg, Leningrad and Vologda, have a certain leeway as to how and to what degree they push central reforms, the three projects have been working under different conditions/in contexts that differ.

## **Geographical scope**

The projects are carried out several places in North-West Russia, among them St. Petersburg and the surrounding Leningrad region as well as Murmansk, Arkhangelsk, Vologda, Pskov and Kaliningrad. These regions co-operate and twin with regions in Sweden, among them the Stockholm region, Jämtland and Gävleborg.

## **Actors**

The partners in the project are the authorities of three Swedish regions and the authorities in three Russian regions. Also municipalities on the Russian side are involved. The projects are co-ordinated by the East European Committee of the The East Europe Committee of the Swedish Health Care Community (SEEC), and financed mainly by Sida, the Swedish International Development Cooperation Agency.

The primary target group is the medical doctors and nurses working in primary health care.

## 1.2 Methodology

### 1.2.1 Programme theory

The following questions are helpful in structuring the analysis of the effects and impacts of the projects on primary health care:

1) What is it that makes the intervention, measure or project lead to the anticipated output? Outputs are the direct results of the activity (the “input”), like for instance the number of people trained through seminars.

*In the case of primary health care and family medicine, one question would be to what degree the activities (among them the primary health care centres and the staff exchange) create capable primary health care staff.*

2) What is it that makes the output lead to the desired outcome?

*Will the trained GP doctors and nurses use their recently acquired skills for the purposes sought by the programme? What will make them work as primary health care medical staff?*

3) Is there reason to believe that the outcome will lead to the wanted impact? To follow up the example: Will the activities carried out as a result of training lead to – or contribute to – the impacts identified.

*In what ways will the fact that a certain number of people have been trained in primary health care and family medicine contribute to the establishment and survival of primary health care and family medicine in Russia?*

In other words, what mechanisms leading to the desired goal will the project bring into play? What makes A (the input) lead to B (the output)? What makes B lead to C (the outcome), and what is the link from C to D (the impact)?

There are three elements that are common to all three primary care projects evaluated in this report. Firstly, there is the belief in linking *regional authorities* in the two countries involved, and make them co-operate. Secondly, there is a strong belief in *training*. The bulk of the project activities consists in training and education. Thirdly, there is the emphasis on *model units*. Equipping model units in order to show the merits of the GP system by the power of example has formed an important element all three projects.

### 1.2.2 Case study approach

Much of the methodological approach is outlined above. The use of programme theory to clarify the expected links between interventions and results, outcomes and impacts has been combined with an open attitude to real-life complexities that will be accounted for in the report. In real life, of course, processes of change are less linear than envisaged in programme theory. Therefore, in order to account for change in an efficient way, the analysis is based on attention to *actors* in the processes of change as well as their *activities*, and not least seeing these activities in their *institutional context*.

At times Russian legislation appears vague and even contradictory, and institutional practices may lack transparency. However, on a whole Russia is a well-structured country, with an elaborate legal framework, strong and self-confident administrative institutions, financial mechanisms and professional traditions. The National Priority Project on Health, among them on health, shows that

Russia has great administrative capacities to carry out reforms from above, among them in the field of primary health care and family medicine. The institutional context has been accounted for in the investigation and the analysis made in this Evaluation. This requires going in-depth analysing the primary health care and family medicine projects in their real-life context. Doing this, we will draw on case study approaches.

Having chosen three cases (the “twinning” between Stockholm County Council and St. Petersburg City; Gävleborg County Council and Leningrad Region; and Jämtland County Council and Vologda Region respectively) allows for an additional methodological manoeuvre – *contrasting cases*. By contrasting (comparing) elements within the cases new light can be thrown on the preconditions for success and reasons for suboptimal results.

### 1.2.3 Interviews

In evaluations the interview constitutes a major source of information. Good interviews, therefore, is of great importance. The interviews have been semi-structured, meaning that they proceed according to a plan common for all interviews with similar interviewees. Being semi-structured the interviews allows the interviewees to bring in aspects or issues other than those planned by the consultant.

Listening carefully to what the interviewee is actually saying and what he/she tells between the lines is fundamental for all research interviews because it is the source of follow-up questions that may lead the research further, and throw light on what other interviewees have told or what has been written in project or programme documents.

Several interviews made a part of the evaluation of the primary care projects have been group interviews, which has allowed for a certain dynamic not often experienced in individual interviews. Going in-depth however, is easier in individual interviews.

The large majority of interviews have taken place at the interviewee’s work place.

#### 1.2.4 Documents

The evaluators have had access to all relevant documentation (among them applications and reports) on the Swedish as well as Russian side. The fact that the SEEC provided all documents in neat order placed in three binders, one for each project was of great help for the evaluator, who was saved from a considerable amount of practical work.

Document studies are the first step in the investigation and allow the evaluator to get a picture of the programme theory as well as achieved outputs. If reports are of good quality, they also provide analyses of the challenges met throughout the project period.

#### 1.2.5 Ethics

The evaluation has followed the standards of the Joint Committee on Standards for Educational Evaluation as well as the AEA Guiding Principles. Among others this implies making sure individuals and organisations evaluated as well as those directly involved in the evaluation are treated with due respect during the work as well as in the report. Critical assessments and comments have been based on fairness and justification, and no uncalled for harm has been done.



## 2 Primary health care and family medicine in the Russian context

### 2.1 A short guide to Russian terms

The heads of the health sectors at municipal level have the title of *chief physician*, and have their office in the central district hospital (the *TsRB – tsentral'naia raionnaia bol'nitsa*). One of their deputies heads the out-patient (ambulatory-policlinical) work. (The deputy heads referred to in the interview list belong to this category).

General practitioners are termed VOP (*vrach obshchei praktiki – doctor of general practice*). Similarly, nurses in general practice are called MOP (*medestra obshchei praktiki*). VOP's (and MOP's) often work in small medical centres/group practices called "*ofis semeinogo vracha*" (family doctor's office) or "*ofis vracha obshchei praktiki*" (GP office). These may be located within the polyclinic, or in separate office in dwelling areas. Unlike the terminology many other European countries, the Russian GP (VOP) does not cover all specialities, paediatrics and gynaecology not being included. For doctors covering even these latter specialities, the term is family doctor (*semeinyi vrach*).

Unlike the case for e.g. Sweden primary health care in Russia traditionally does not cover children and women with gynaecological diseases. Widening the scope of the primary health services to cover the "entire family", has been an aim of the Swedish project holders and their Russian partners. The federal Russian health authorities are positively inclined to this idea, and there are no legal or regulatory obstacles to introducing it in the

federation subjects (regions) or at municipal level. In the period 2002 – 2007 several legal documents were issued. At the same time, there are no strong directives from above to introduce all-encompassing FM. Therefore, there is leeway for those opposing the idea and a certain reserve among those in charge at regional level to push the issue. This varies between regions, however.

Despite the gradual introduction of GP into Russian primary health care, the bulk of the patients go to the traditional polyclinical system. Here, they are examined by a doctor without specialisation and with only one year of house office training. This is the so-called “*terapevt*” (“therapist”) or “*uchastkovyi vrach*” (“district doctor”). The district doctor, which is the term used also in the cities, refers the patient to a specialist in the polyclinic. These specialists are called “narrow specialist” (“*uzkiy spetsialist*”). In other words, unlike the GP whose task is to solve basic medical problems, the district doctor mainly separates the patients into different queues to the specialist.

The Russian health system has several professions at middle level education-wise. These are the nurses (3 years of education, but with a possibility to enter higher education and become “nurse with a higher education”). Education-wise the so-called “*fel'dsber*” finds himself somewhere “between” the nurses and the medical doctors, and is currently often referred to as “*doctor assistant*”.

In the country-side the primary health services are offered through local medical centre called “*ambulatoriia*”. These are manned by basic medical staff, and the medical doctors very often are all-round doctors, resembling GP’s.

### **Financing system**

Much is up to the regions and municipalities on whose payrolls the medical personnel are. Most medical units are financed through the Fund of the Compulsory Health Insurance, by the region and the municipality. In some cases health institutions are paid per patient according to a certain scheme in which a home visit by a GP is remunerated with a certain sum, and a visit to surgeon in a polyclinic by another sum. In case, say, consultations with a trained medical nurse are not remunerated, GP/FM suffers.

In Leningrad region five municipalities are pilots for “result-oriented budgeting” in their health care system. Gatchina was the

first municipality to try this, and its background from the project made is easier.

## 2.2 Ongoing reforms to strengthen primary health care and family medicine

Reforms along very similar lines as those of the three projects evaluated below, were introduced during the perestroika period in the second half of the 1980's. Economic incentives were introduced to reduce over-referrals to specialists, and pilot projects were carried out, among others in St. Petersburg and Samara. Group practices, or GP offices, were introduced (Tragakes and Lessof 2003: 69).

In fact, GP was made a recognised specialisation as early as 1992 (Law no. 249), but the practical follow-up has been lengthy. As of today, the number of FM doctors in Russia is under 5000.

The main reason why primary health care and family medicine has been put on the Russian reform agenda is that fragmentation is being perceived as a problem. Specialists over focus their own specialities and loose sight of the big picture. This leads to sub-optimal treatment of the patients. The GP system is considered more cost-efficient by treating illness at a lowest possible level. GP's are considered to be "gate-keepers".

The Russian government wants a thorough reform of its health care system consisting in the following main elements:

- New structures for the organisation of hospitals
- Reduction in number of hospital beds
- Shorter waiting lists/time
- More efficient co-operation with the sector
- More efficient administration
- Modern management of the health care sector

### **The National Priority Project Health**

In 2005, President Vladimir V. Putin met with the legislators and the regional authorities to announce that the budgetary fund would

be concentrated in specific National Priority projects “to invest in human resources”. National Priority Projects were established for health, education and housing.

The National Priority Project Health (Prioriteteniy Natsional’nyy Proekt “Zdorov’e”) aims to increase the accessibility and quality of medical aid in Russia. A considerable amount of money follows the Programme, an equivalent of 3.7 billion euro each year for two years. The Programme has three main fields of priority:

- Primary health care
- Prevention (including vaccination)
- High tech medicine

In order to strengthen primary health care, the job descriptions of public medical doctors and nurses were amended (with the National Health Insurance Agency), and salaries tripled. This has stopped the brain drain of medical personnel from public primary health care. Among others, some of the medical personnel that were trained through the projects with the Swedish regions left for private medical services. Some of them might not have left if the wage hike had arrived some years earlier.

Various projects with foreign institutions have aimed at strengthening FM in a, for instance a huge EU project in the mid-1990’s. Also the Helsinki-based STAKES and the University of Tromsø have had projects on FM in Russia.

### **Incentives for GP**

In Russia over the last few years primary health care in a broad sense has increased its status considerably. The huge National Project on Health identifies primary health care as one of its priorities, and as a result in 2006 salaries for those working in the primary health care was raised drastically. In 2004 the average salary in the health sector was 58 pct of the average salary of people working in the industry.

Interestingly, now GPs earn twice as much as specialists. It should be noticed that the hike applies to all professions within primary health, therapists, fel’dshers, and GP’s alike. GP’s, however, gets one additional step on the wage scale.

The health institution gets paid per patient treated. Payments come from the Compulsory Voluntary Insurance System. Also here there are incentives to go for GP. For instance, in St. Petersburg the institution (policlinic) gets around 100 RUR extra per visit to a GP. For a home visit by a GP the Insurance System pays 304 RUR, for a visit to a surgeon in a polyclinic it pays 240 RUR and for a visit to an otolaryngologist it pays only 150 RUR. On the other hand GP have two days more off a year.

### 2.3 Opposition to the introduction of primary health care and family medicine

Russia has a long tradition for primary health care, and much of it used to be offered as company (and kolkhoz) health service. About 20 different branches, including defence, security, railways, river and marine transportation, mining, heavy industry, offer health services to their employees in parallel to the public health service. Still, the company health service plays an important role. By the early 2000's, 15 percent of out-patient facilities belonged to this parallel system (Tragakes and Lessof 2003: 36). In big cities, like St. Petersburg, where there are a huge concentration of strong government services and industrial branches ("vedomstva"), a large percentage of the population are offered primary health care.

#### **FM as a rural phenomenon**

By tradition, the "family doctor" has been considered a "virtue of necessity" in remote, rural areas where there is at best one doctor, and no specialists, to serve the population. There is a surprisingly strong tendency in Russia, even among health managers, to confuse "family doctor" (semeinyi vrach) with "rural doctor" (sel'skii vrach).

#### **The resistance from the gynaecologists**

The gynaecologists – having a six year specialised education - fear that FM doctors with only a small module of gynaecology in their education will be incapable of treating even basic gynaecological problems.

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### **The resistance from the paediatricians**

In Russia, paediatricians receive their education in separate universities/academies. Likewise, children (age group 0-15 years) are treated in separate clinics whereas the adults go to the ordinary polyclinics.

The resistance to FM from the paediatricians resembles that of the gynaecologists: The FM doctors will not be able to identify medical problems specific for children. They criticise FM for looking upon children as “small adults”.

In the Russian health system until 2004 children up to 14 years of age, were considered children and were to be treated by paediatricians. Those between 16 and 18 years were considered adolescents. In 2004, a redefinition subsumed as children all patients under 18 years.

Also in the Nordic countries there used to be strong rivalries on this issue, and the solutions chosen has been to have a strong mother-child apparatus around FM.

### **Other types of scepticism**

It should also be noticed that not only the paediatricians, but the parents as well may object to taking children to a GP. In the case this entails going to a polyclinic the dislike might be particularly strong as it is not considered correct to take a sick child out, in particular not to a place where the child may be exposed to unpleasant scenes. A GP on home visit, however, might be more acceptable.

Interestingly, even GP have objections to including children in their workload. They feel unprepared for the task. Another reason is unwillingness to carry out home visits. The fear of high-rise blocks with elevators out of order is prevailing.

The idea, at times put forward, by the Swedish side to reduce the role of the polyclinics and rather concentrate of FM offices with a few doctors and nurses in each, has been met with some scepticism on the ground that the pathological picture in Russia is considerably more serious than in Sweden. According to this argument public health, personal care for the health and social services in Russia make for a large number of difficult cases that require a fully-fledged polyclinic to deal with them.

## 3 The project activities: Stockholm – St. Petersburg

### 3.1 The project in brief

#### **Objective**

The project has aimed at contributing to the development of sustainable Family medicine in St. Petersburg.

#### **Partners**

The project partners are the Stockholm County Council (Beställarkontoret – Vård) and the St. Petersburg Health Committee.

#### **Methods**

Development of model units for Family Medicine. Training.

#### **Scope**

In the period 2001 – 2007 13-15 million SEK have been granted for the project. The project started in 1997.

### 3.2 Background

The project cooperation between Stockholm County Council and the authorities and the city of St. Petersburg started up in 1997. At the time Sida would like to see larger projects, and the East European Committee of the The East Europe Committee of the Swedish Health Care Community (SEEC) asked Stockholm country council if it was willing to contribute with a project on Family Medicine. In the Swedish division of tasks between the

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different levels of government, the county councils are basically managing health care (health care constitutes 75 percent of the Stockholm County Council's annual budget). The county council was of the opinion that it would not suffice to train doctors in family medicine. One also had to change elements of the health care system. Therefore, the project included training in financing systems, model care centres and patient flows (the relation between the different levels of care, i.e. between hospital, policlinics and FM).

The fact that the project started up in 1997, in the midst of post-Soviet Russia's chaotic epoch, caused some problem for the project implementation since plans and legal regulations made in St. Petersburg not always have been in phase with those at federal level.

The project has consisted of a multiplicity of sub-projects and sub-activities. The project has been the clearly most costly among the three primary health projects evaluated here (which does not mean that it necessarily is not cost-efficient) because of the use of consultants rather than health workers themselves. The project has had a firm foundation in Stockholm County Council.

As of November 2008 there were altogether 215 registered (federal register) GP's in the city. In addition there are around 150 GP's working in company health care (like the railways, police, big enterprises) and in private practice. In order to cover the city of St. Petersburg with GP's a total number of 3500 is needed (based on 1200 patients per doctor).

The St. Petersburg Health Committee is in favour of general practice in line with the federal policies. This, however, should take place within the existing policlinics. There is no question of replacing the policlinics. In remote, semi-rural areas of the city with a lack of a population base to uphold a multi-faceted policlinic, there is a long tradition for not having policlinics. More interestingly, however, is the fact that the committee is in favour of GP offices in newly built dwelling areas, of which there are quite a few in St. Petersburg. An estimated 50 percent of them have GP offices. In round number it costs 4 ½ million RUR to set up a GP office, with furniture and the necessary medical equipment (like electrocardiography).



On the ground floor in several newly built blocks of flats GP offices have been installed. They have between 2 and 6 doctors in each and between 4 and 8 nurses. These offices are not legal persons, and form part of a polyclinic. Three GP offices in the city (i.e. in the outskirts) receive both adults and children. The St. Petersburg Health Committee is cautious on this point, but applies a policy of supporting the inclusion of children where conditions are favourable.

Doctors and nurses are being retrained to become GP's and GP nurses. The so-called therapist doctors and district doctors (both with a 7 year education) attend a 7 ½ month course at MAPO (St. Petersburg Medical Academy of Post-Graduate Studies) and receive a certificate as FM doctors.

Similar 7 ½ month courses were held by MAPO in the mid-1990 financed by the EU. At the time, however, there were no positions for the doctors having gone through the course, and they went back to their previous positions. Fear of repetition created a certain suspicion toward the Stockholm/St.Petersburg project in the beginning.

The first phases of the project concentrated on Polyclinic 34 (P34), but after 5-6 years time had come for dissemination and general capacity-building of the Public Health Committee. Then the project started to work mainly with the St. Petersburg Health Committee. The function of project director was transferred from the P34 to the St. Petersburg Public Health Committee. Later the project was somewhat decentralised again by concentrating dissemination work in three city districts, Kalininskii, Petrogradskii and Krasnogvardeiskii although retaining the cooperation with the Public Health Committee.

### 3.3 The project design

#### 3.3.1 The project objectives

The project objective should be summed up as contributing to the health reform in St Petersburg through development of sustainable Family Medicine.

### 3.3.2 Programme theory

The approach chosen was “system-based” in the sense that the project was aware of the danger of training medical personnel that would have nowhere in the system to apply their new skills and knowledge. A system-based approach in St. Petersburg would imply paying due attention to the ongoing reforms.

The project made use of three basic project methods, one of them being the establishment of a model unit (Policlinic no. 34) in one of the 18 city districts of St. Petersburg. This was followed up by dissemination through new model units to other city districts. In the Russian system city districts and municipalities are sufficiently self-governed to formulate their own profiles within e.g. health care, and they have their own money to allocate. Therefore, in municipalities or city districts with an administration, and not least head of administration, positively inclined to FM, substantial reforms may take place.

The second basic method of bringing about change consisted in training. In addition to seminars, staff exchange took place between Stockholm and St. Petersburg.

The third major method within the programme theory in the cluster of projects run by Stockholm county council and St. Petersburg may be summed up in “change through system thinking”.

## 3.4 The project implementation

### 3.4.1 The actors

Organisation. The project partners are the Stockholm County Council (Beställarkontoret – Vård) and the St. Petersburg Health Committee. The Swedish side has delegated the project level responsibility to a project group with three members. The operative implementation of the project on the Swedish side has been carried out by a consultant paid by the project.

On the Russian side the project group initially consisted of representatives from the immediate beneficiary of the project, the

Policlinic No. 34 in the Petrograd city district of St. Petersburg. In the second phase of the project, the chairman of the Health Committee formally was project director on the St. Petersburg side. This formed part of the project's endeavours to build capacities for family medicine also at central city level in addition to the city districts. However, since late 2005 much of the work has been decentralised and carried out in the original pilot district of Petrogradskii (P34), and in the two new pilot districts of Krasnogvardeiskii (P10; P17) and Kalininskii (P54).

Also the medical academies play an important role contributing to providing retraining and education of health staff, institutional development as well as management training and development.

### **Target groups**

The immediate target groups were technical/administrative staff at the Public Health Committee of St. Petersburg, heads of Policlinics and GP units, other relevant administrative staff at district level, staff at the GP centres at policlinics 34, 54 and 112, medical staff at District level and staff at two medical universities. The target group in the management development project included all heads of the 18 district health care departments.

### **3.4.2 The activities**

The project has been complex in the sense that it has been composed of a relatively large number of sub-projects and activities. Some sub-projects, however, have been more conspicuous than others because they have been conceived as model projects. The Policlinic #34 (P34) in the Petrogradskii city district is the most prominent example. Between 4 and 6 million SEK have been spent on refurbishing and equipping P34.

The project was divided into two phases. The first phase lasted from 1998 to 2003 (with a prolongation into 2004), and consisted in developing Policlinic 34 (P34) in the Petrogradskii city district into a model unit for FM. The second phase lasted from 2004 to 2008, and consisted in disseminating the experiences from P34 to more city districts.

The number of sub-activities has varied between 15 and 21 per year. Some of the activities in the early phases of the programme

could be questioned, like the inclusion of English lessons. Even more questionable, however, was the inclusion of activities like “the creation of regulation and law documents which are necessary for the work in general practice” and “to improve the health care financing and remuneration system” (Plan of Action 2001). These are crucial, systemic factors for the GP and FM to strike roots. However, neither of them could be solved at project level. Project activities at city district levels could have led to valuable experiences that could be analysed and made use of in a larger context. To a certain extent this happened in the Kalininskii city district.

The great majority of sub-activities have been to the point. For instance the introduction of a systematised tutorship system for young doctors was considered an innovation in St. Petersburg.

Likewise, management training courses modelled after the ones carried out in the Swedish county councils were chosen as a tool to strengthen capacities for change.

In order to secure FM as an integrated part of higher medical education in St. Petersburg, the project aimed at establishing a Faculty of FM at the Mechnikov Academy.

In order to strengthen the pro-GP advocacy coalition, one of the activities chosen was to establish a St. Petersburg chapter of the Association of Family Medicine.

## 3.5 The results so far of the projects

### 3.5.1 Outputs

*Tutoring.* The introduction of a tutorship system for young doctors was considered an innovation in St. Petersburg. There are GP training centres in the polyclinics taking part in the project as model units, P10, P34 and P54.

*Higher education in GP.* An “under-faculty” of FM has been established at the Mechnikov Academy, but is still not a fully-fledged faculty. The sub-faculty forms part of the Basic Medical (Lechebnyi) Faculty. In late 2008 the sub-faculty was in its second year. Each year it trained 50 students. In order to set up the under-

faculty without going the long way through an official approval of a new line of study, less than 25 percent of the curriculum was changed.

*The St. Petersburg Association of Family Medicine.* The association was established in 2000. By late 2008 it has 150 members, medical doctors, nurses and teachers.

*A Resource Centre for GP in the Health Committee.* A Resource Centre for FM in the St. Petersburg Health Committee's Outpatient Department was equipped with, among other a xerox machine and a fax.

*Model unit P34.* The polyclinic #34 on the Petrograd side used to have 120 therapists and specialists, but as a result of the project they were replaced by 25 GP's. There are 16 GP's working in two shifts in P34, of whom ten were among those trained through the project. Six trained GP doctors now work in private firms.

P34 was reconstructed, financed by the project, which is one reason why costs were high during parts of the projects. Now the polyclinic has been totally converted to a family centre, and is the only polyclinic without "therapists", only GP's and specialists. After some years without specialists P34 decided to re-introduce the positions as oncologist, urologist, neurologist, a surgeon, and a gynaecologist.

According to Russian legislation several diseases have to be treated by a specialist, e.g. in the case of diabetes, the patient must address an endocrinologist (to get medicines, which are free of charge) or in the case of glaucoma, the patient must seek out an ophthalmologist. For a period children were included as patients at the P34. A separate entrance was made for children to spare them from bad impressions. The reception of children, however, was halted due to "administrative, not legal obstacles".

P34 applies core elements of the project ideas on the role between the medical professions. In the polyclinic medical nurses has got an active role, and relieves the doctors from some tasks, like taking the temperature and the blood pressure in case a patient shows up without a prior agreement. Likewise, the medical nurses reportedly at times save the doctor from patients who primarily come to

unburden themselves. Also, the medical nurses relieve the doctors from much of the paper work.

*Scientific work.* Initially, including scientific aspects was a wish from the Swedish side, and a novelty to the medical doctors involved from the St. Petersburg side. The processes as well as the results are generally summed up as interesting by those involved.

*Model unit P10.* This unit is located in the Krasnogvardeiskii city district, which is a pro-GP district. All medical units in the city district have a room (kabinet) for GP. In the district 48 GP's work with 1500 patients each, which means that one third of the adult population, has a GP. The GP unit in P10 has ten general practitioners.

The material support to P10 consisted in refurbishing and equipping two rooms for training purposes in the Centre of Re-training, located in P10. According to its head P10 is ready to become a GP Centre, but lacks GP personnel. In 2008 five GP doctors left for private medical care or the health insurance company.

*Model unit P54.* Polyclinic 54 belongs to Kalininskii district, which is actively pursuing pro-GP policies. P54 has a strong training centre for GP. P54 has the only GP unit in St. Petersburg that is applying GP not only for adults, but also for children.

### 3.5.2 Outcomes

Through the tutorial activities at the model units, FM is continuously being disseminated to new groups of students. Students stay at the units for three weeks. After having finished their studies they will come for house office training (*ordinatura*) in the model unit where they received tutorship. This secures continuity.

The model unit at P34 has been visited by most of the 18 city district level heads of health care departments.

People in St. Petersburg health committee, who were taking part in the project, were involved in the work on federal level developing legal regulations that underpin the GP reform. Here, they made

use of what they had been exposed to through the project with Stockholm.

In 2001, St. Petersburg launched its “City programme on FM” (gorodskaya tselevaya programma po razvitiyu SM”, in which P34 was one of the models. An equivalent to 1 million USD was allocated through this programme over a few years.

The project activities clearly have given the participants stronger confidence in the “cause” of FM. The project has brought people interested in strengthening FM together into a loose network of contact. Contacts between the doctors are tighter than those between nurses.

Networking activities are further strengthened through the Association of FM in St. Petersburg. Professionals in the sector have the opportunity to meet and exchange experiences and to be trained. The association gives advice to the institutions that have included GP, and when needed the association assists doctors in their communication with the authorities.

### 3.5.3 Impacts

Despite the official objective of the authorities and the support rendered through the project with the Stockholm region, the GP profession has not struck roots in St. Petersburg. The number of GP doctors and nurses is still ignorable, and there is a drain of GP professionals out of public primary health care. This is a result of the slowdown of the reform in the city (among other lack of incentive structures to make medical students and personnel choose, and remain in, GP) rather than the project itself. The project has not been able to counteract these tendencies.

To a certain extent, however, the project has struck roots in the Mechnikov Academy, MAPO and the three pilot city districts. Today, 16 out of a total 18 St. Petersburg city districts have family medical centres. In city districts where GP centres have been operating fewer patients are referred to specialists. In newly built areas of St. Petersburg’s outskirts, family medicine is integrated into the primary health system.

### 3.6 Cost effectiveness

Table 3.1 *Grants 2001 -2007*

| Year | Amount granted<br>(in mill SEK) |
|------|---------------------------------|
| 1998 | 0,31                            |
| 1999 | 4,1                             |
| 2000 | 4,0                             |
| 2001 | 3,75                            |
| 2002 | 3,5                             |
| 2003 | 2,6                             |
| 2004 | 2,0                             |
| 2005 | 1,9                             |
| 2006 | 1,9                             |
| 2007 | 1,0                             |
| SUM: | 25,06                           |

The Swedish project manager has been employed 35 percent of full time in average throughout the project period paid by the project. Other consultants have been employed 50 percent of full-time in average, paid by the county council.

2.25 persons have been employed in average, i.e. one local project coordinator and one local project manager and 0.25 other local consultants paid by the project.

The project has paid due attention to policy issues and has had an ambition of applying a system-oriented approach. Nevertheless, considerable time could probably have been saved if the Swedish side had made more use of expertise on Russian administrative systems in addition to the contacts they had in St. Petersburg's universities.

Unlike the two other primary care projects, the Stockholm – St. Petersburg project has been making use of an external consultant. This has been costly, but according to the project leaders it would have been impossible to set aside one employee in the regional administration to do the job. The consultant has specific competence in working abroad, in project planning as well as report writing. The project reports clearly reflect this fact.



### 3.7 Sustainability

The FM centres will continue to work in the same vein. The training centre in MAPO will remain, and probably also the sub-faculty in the Mechnikov Academy.

An exit phase for one and a half year (final conference in October 2008). During the exit phase the Swedish and Russian partners have been working on developing skills in applying for grants (among other a conference in March 2008 on this subject). Still, there has been certain unwillingness on the Russian side to realise that the project period actually is going to be over.

The project contributed to the establishment of a GP Association covering St. Petersburg. This is a mixture of a professional and scientific association. Also, the fact that FM is well established in the educational institutions training doctors bode well for the survival of central aspects of the project cooperation. The sub-faculty for GP in the Mechnikov Academy (established in September 2007 as a result of the project) and the FM units in MAPO both contribute to the survival of the project ideas. In all three to four universities in St. Petersburg offer education in FM.

### 3.8 The relevance of the project

The project conforms well to the on-going endeavours to strengthen primary health in Russia. With its insistence on family medicine (FM), the Stockholm – St. Petersburg project contributes to the more innovative sides of the reforms. Whereas practices resembling FM already takes place in the countryside (one medical doctor covering a village), FM is far less widespread in big cities. Moreover, in big cities FM may expect to be met with more scepticism than in rural areas due to the fact that the number of specialist is bigger there, and also the number of patients expecting to get specialist care is higher. Moreover, St. Petersburg has a very well developed paediatric health care. Given the fact that paediatricians constitute one of the strongholds of resistance to FM, the project has ventured into the lion's den. The fact that the project takes place in a place where it is challenged, contributes to its relevance.

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### 3.9 Conclusions on Stockholm – St. Petersburg

There are several structural factors that coincide to make the Stockholm –St. Petersburg project less easy to carry out than the two other projects evaluated in this report. Unlike the projects in the regions of Leningrad and Vologda the Stockholm – St. Petersburg project has not taken place in a GP pilot region. Furthermore, the St. Petersburg project naturally has taken place in a purely urban context where FM meets far more resistance than in the countryside.

In line with federal policies, the St. Petersburg Health Committee has been in favour of strengthening primary health care and the multiplication of GP's, but is more reluctant to support FM and explicitly against closing down policlinics. In fact the enthusiasm for FM on the part of St. Petersburg regional health authorities has cooled down over the last years, although the governor reputedly is clearly in favour.

The model units have all developed into strongholds of GP, whereas only one is practicing FM. The model units from the second round have all been able to reach the level of their “mentor” (P34) and have developed their own profiles. P54, for instance, is strong on training activities.

The tutor programme is worth a special mention. Its functions are to secure continuous training in the future, linked to non-project normal educational activities. The tutor programme secures continuation of the project and sustainability. By having FM specialists as a “stable” of tutors a core group of FM people is preserved.

The project reports are strong on their analysis of the policy context of St. Petersburg's health care sector and the Russian health care system as a whole.

## 4 The project activities: Gävleborgs län – Leningrad oblast

### 4.1 The project in brief

#### **Objective**

The project has aimed at supporting the development of Primary Health Care and Family Medicine in the region.

#### **Partners**

Gävleborg county council and Gatchina municipal health authorities and the Health Committee of Leningrad region.

#### **Methods**

Model unit. Training. Systematic dissemination to municipalities in Leningrad region.

#### **Scope**

The project lasted from 1998 to 2008. The total cost amounted to 11,9 million SEK.

### 4.2 Background

The project between the region of Gävleborg and the Leningrad region, started out in 1998 with some preliminary study trips in Sweden and Russia. This was in the midst of the great Russian crisis, characterised by economic and administrative collapse.

Later, Leningrad like Vologda, entered into the presidential pilot programme on GP. In all, 15 Russian regions were singled out as pilot regions. Among others, being a pilot region implied trying out new financial mechanisms within the health care system based on volume and quality and no longer “just pay for buildings and doctors”, as one interviewee described the former system.

The Gävleborg – Leningrad project had a firm foundation locally at district level, whereas the foundation at regional level has been weaker.

Gatchina is one among several small towns of the Leningrad oblast. In 1991 – 2003 Gátchina district (municipality) was singled out as a pilot. Thus, the first three years of the project co-operation between the two regions aimed at establishing a model centre in the district of Gatchina. Leadership training formed part of the activities, and a centre for youth health was established, based on experiences from Gävle.

Gatchina started out developing elements of FM in the early 1990's. The sturdy elements of FM in Gatchina were one of the reasons the initiative for co-operation was made. Today, GP in Gatchina town has struck roots in one half of the town's area whereas traditional primary health dominated in the other half. The fact that GP has been introduced in the town, and not merely in the countryside, is important.

Dissemination of experience from Gatchina formed part of the previous project period, and was developed into a separate three year project lasting from 2002 to 2004. Within this project “replication” of the Gatchina project was carried out in three more districts of the Leningrad region, Lúga, Vólosovo, and Vsévolozhsk. Unlike Gatchina, these districts did not have much in terms of FM at the outset of the project. During the second period much of the focus was on municipal organisation of primary health care.

The Leningrad region authorities' management training made a request that the co-operation focus on top health managers at district/municipality (rayon) level.

The Leningrad region authorities also wanted the centre in Gatchina to become an educational centre for various health professions.

In 2005 – 2006 the project activities had two main foci. Partly, the activities consisted in a training programme in management for heads of the municipal health care system. Partly, the project focused on the establishment of an Education Centre for personnel involved in FM, i.e. medical doctors, nurses and “medical secretaries”. In 2007 and 2008 finalising activities were carried out.

## 4.3 The project design

### 4.3.1 The project objectives

The objective has been to support the development of Primary Health Care and Family Medicine in the region.

Target groups have been doctors, nurses, medical secretaries as well as people in leading positions within municipal health care.

### 4.3.2 Programme theory

“Replication” is a key element in the programme theory of the Gävleborg – Leningrad co-operation. From Gatchina experiences have spread to three more Leningrad towns/districts through replication. Gatchina drew on its previous experiences with FM as well as its experiences from the first project period to assist the development of FM in the other districts. This way, much of Gävleborg’s unfamiliarity with Russian realities and specificities has been compensated for.

## 4.4 The project implementation

### 4.4.1 The actors

The first project (1999 – 2001) was carried out between the county council of Gävleborg and the municipal authorities of Gatchina.

Also, in 2002-2004 during the replication phase, the project to a large extent was going on between the Swedish region and the Russian municipalities. The Swedish side has made efforts to make sure the project activities are anchored with the heads of administration (mayors) and heads of the municipal health care systems.

The Committee of Health of the Leningrad region, however, has played an important role since 2001, among others taking the initiative to the management training project.

The two model units have been matched with the health centre of the village of Hofors, the “Centrum” health centre of Sandviken and Valbo and Sättra health centres of Gävle town. The Youth Centre in Gatchina has been matched with the Ungdomsmottagningen (Youth Reception) of Gävle. About 15 people were actively involved in these Swedish institutions, sharing their competence and experience.

The roles of the target groups are particularly important within the Gävleborg – Leningrad project due to its emphasis on patterns of co-operation externally between “care levels” as well as internally within each institution offering primary care.

On an operational level there has been a project leader and a project assistant on the Swedish side and a project leader and an assistant project leader on the Russian side. This core group has been unchanged since the beginning (with the exception of the assistant project leader in Gatchina).

#### 4.4.2 The activities

##### *Primary Care in Gatchina*

In order to reach the objective of strengthening primary health care in Gatchina, the project concretised some core issues to be addressed through project activities. Thus the project aimed at improving capacities to co-operate across professional dividing lines. Moreover, the project has aimed at improving the mechanisms of cooperation between different “care levels” (i.e. the levels of hospitals, polyclinics, family doctors respectively). Also routines within the care units were addressed. Support to management was another issue in focus. Last, but not least training

in specific problems within medical care was offered, among others in diabetes nursing.

Although there was a wide range of foci within the project, there were only two main *types* of project activities. The first type was the direct, material support to the two model units of primary care and the one model unit on teenage care (advice on abortion, drugs, sexual diseases and other). The second element consisted in training the leaders of the local health sector as well as the employees in selected institutions (the units of primary care and the employees in the youth centre). Training was carried out in seminars and during study tours to Gävleborg.

The activities were spread on a relatively large number of themes, training managers, such as training personnel in teenage care, training internal cooperation within units of primary health care, co-operation between primary care units/ polyclinics and hospitals, and disseminating experiences to the district of Luga.

Also a less clearly defined project component on a rehabilitation centre for children should be mentioned. This component had some starting problems due to difficulties defining the group of patients to be included and what organisation in Gatchina to take on the task. Also, some rivalries of competence between the two sectors of health and social protection respectively may have played a role. It seems as if the initiative was on the Swedish side without much local support. In stead of knocking their heads against the wall on this issue, the Swedish side dropped the idea.

The training of managers has covered issues like conflict solution, team work, activity planning, quality development, and lecturing techniques. Also issues like the encounters between the doctors and patients with a difficult diagnosis have been singled out for further project activities.

Material support to the health centres in Gatchina formed part of the project. A total 400,000 SEK was granted for this purpose. The Youth Centre received 310,000 SEK for repair and equipment. In addition, some training equipment (overhead projector, slide projector, video camera) were handed over as part of the project. The development of a laboratory for use in primary medicine was supported by a 10,000 SEK grant.

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*Extension to Luga, Volosovo and Vsevolozhsk*

This project mainly was a replication in three more districts of the project with Gatchina. Considerable parts of the training took place in Gatchina, where medical doctors went for three month training in FM.

Also the project element on youth centres was replicated. In Gatchina, Luga and Volosovo the youth centres were under the health authorities whereas in Vsevolozhsk it was under the policy sector of social protection.

Gatchina district has contributed significantly to the project by arranging the practical training for medical doctors from the other three districts for three months and medical nurses for one month.

The material support consisted in support to the purchase of FM equipment. Each doctor trained in Gatchina under the project received 2,500 USD. The equipment was bought by the management of the hospital according to a list approved by the project managers.

Also each of the new youth units received material support amounting to 14,000 USD according to an approved list of equipment needed.

*FM Education Centre in Gatchina*

The Gatchina Polyclinic was a training unit for MAPO also before the project on an FM training unit. In order to secure dissemination of the experiences from Gatchina a project on the establishing of an education centre for FM was initiated. As a part of this project so-called “medical secretaries” modelled on Swedish experiences have been trained. The purpose of this was to show one way of reducing the administrative workload of the medical doctors. The activities are closely co-ordinated with MAPO. Training is followed by practices in Gatchina’s own FM system.

The Education Centre was to offer education and re-training of medical doctors, medical nurses and “medical secretaries”, the latter being an innovation the Russian context.



### *The management training*

The Russian government wants a general increase of the health care sector's efficiency (see chapter 2.1), and the Health Committee of the Leningrad region took the initiative to a management training project. The Committee would like the training to concentrate on state-of-the-art in Sweden, and the Swedish project leaders chose to adapt some of the management training methods and principles used by the MIL Institute in Lund, Sweden.

In all 24 managers were selected by the Health Committee of Leningrad. Among these, 12 were experienced (most of them heads of municipal health care departments) and 12 were selected because they were considered up-and-coming. In practice this meant deputy heads of municipal health care departments.

The training has consisted of 2-3 days of training approximately ten times each of the two years of the project period.

Based on the fact that the Russian system of health care is under reform, the training was focused on how to manage changes. In line with practices in Sweden one of the foci was on managers' self-understanding, on the difference between the roles of a "boss" and that of a "leader", on team-work and how to solve conflicts. The trainers presented the development of Sweden's health care system in a historical and sector-wise perspective. One seminar was on quality assurance, one on planning. Also the practice of performance interviews – or individual co-operation talks – was addressed.

## 4.5 The results so far of the projects

### 4.5.1 Outputs

#### The Gatchina project

Table 4.1 *Number and types of activities*

| Number of/Year         | 1999 | 2000 | 2001 |
|------------------------|------|------|------|
| Study visits in Sweden | 1    | 3    | 4    |
| Study visits in Russia | 2    | 1    | -    |
| Seminars in Sweden     | 2    | 2    | 1    |
| Seminars in Russia     | -    | 4    | 5    |

The care centres #1 and #4 in Gatchina are now considered “model units” that can be used as FM training centres for personnel within the primary care sector.

A major output was the opening in May 2001 of the Youth Centre. The centre has an inter-professional staff, including a narcologist, gynaecologist, venerologist, midwife, nurse, lawyer, social workers, urologist, and two psychologists (one for girls and one for boys). The Youth Centre in Gatchina is more multi-disciplinary in its inclusion of legal and welfare specialists than its partner in Gävle.

In the autumn of 2001 a conference was arranged on the initiative of the health administration and the project organisation in Gatchina. The conference was supported by SEEC and the project. Altogether 200 participants from all over the North-West Russia took part, and a representative of the presidential administration was present.

Four medical nurses from Gatchina with specialised training in diabetes have been trained through the project.

Ten health managers from health care units in Gatchina have undergone training in altogether 14 seminars, half of them in Sweden.

A “White Book” presenting the principles for co-operation between the “care levels” – hospital, polyclinic, family doctors – has been written in Gatchina. This book was inspired by a similar in-house publication in Gävleborg’s health sector (“Samvårkanspärm för läkare i primärvården och Länssjukhuset Gävle”).

The material support has resulted in the acquisition of a large number of equipment according to a list approved by the SEEC.

### The extension to Lúga, Vólosovo and Vsévolozhsk

Under the project altogether 13 Russian/Swedish seminars for medical doctors were arranged.

Training in Gatchina was provided for 16 medical doctors (3 months) and 6 medical nurses for one month).

One conference for nurses in FM was arranged in 2003 attracting 60 participants from all over North-West Russia.

Eleven leaders participated in the management training, of which seven were heads of FM units.

Table 4.2 *Number and types of activities*

| Number of/Year         | 2002 | 2003 | 2004 |
|------------------------|------|------|------|
| Study visits in Sweden | 5    | 3    | 1    |
| Seminars in Sweden     | 3    | 2    | 2    |
| Seminars in Russia     | 4    | 5    | 5    |

#### *Luga*

In Luga after the project there were two FM units in operation, covering 4,500 and 5,000 inhabitants respectively. One of them had three FM doctors and three FM nurses, all trained in Gatchina. Prior to the project Luga only had "FM" in the countryside.

Four medical doctors went for three month training in Gatchina. Two doctors went for training in FM. Two medical doctors took part in the leader training. A youth unit based on experiences from Gatchina and Gävle resulted from the project.

#### *Volosovo*

In Volosovo after the project three former rural medical points or health posts (ambulatoria) staffed with basic doctors (terapevty) were transformed into FM units. Three medical doctors went for three month training in Gatchina. In addition, some doctors went for training in FM. Prior to the project Volosovo had three FM doctors in one-doctor units in the countryside.

Being a rural municipality, FM is not very controversial in Volosovo. The problems in the ambulatoria with GP doctors and

GP nurses consist in motivating more staff to switch to GP, and hereby take on more personal responsibility.

Three medical doctors took part in the leader training. A youth unit based on experiences from Gatchina and Gävle resulted from the project.

#### *Vsevolozhsk*

In Vsevolozhsk the number of FM doctors increased from two to 15 during the project period, and at the end of the project an additional eight doctors were under re-training to FM doctors. As of late 2008, only ten GP's are left. There has been a tendency that GP's move to St. Petersburg, go to the pharmaceutical industry of the health insurance sector. The two latter tendencies, however, certainly do not only apply to Vsevolozhsk. Prior to the project Vsevolozhsk had "FM" in the shape of two one-doctor units in the countryside.

Three doctors from Vsevolozhsk participated in the leadership training. A youth unit based on experiences from Gatchina and Gävle resulted from the project.

#### FM Education Centre in Gatchina

The project equipped two lecture and meeting rooms ("konferents-zal" for 10-15 and 50-60 people respectively) and provided necessary equipment for the "medical secretaries".

Table 4.3 *Number and types of activities*

|                                  | 2005 | 2006 |
|----------------------------------|------|------|
| Seminars for doctors and nurses  | 4    | 4    |
| Seminars for medical secretaries | 5    | 2    |

Also two study visits to Sweden were arranged, one for the vice-rector at MAPO and one for the future "medical secretaries". The project spent somewhat less money than expected (and granted), and for the "surplus" an additional study visit to Gävleborg was made in 2007.

The training was provided at seminars by Russian lecturers as well as lecturers from Gävleborg. In between the seminars, training was

organised by MAPO and the Health Care Department of Gatchina organised training.

Altogether six “medical secretaries” were trained.

#### The management training

The training was carried out.

### 4.5.2 Outcomes

Gatchina has five departments of GP/FM with 5-6 GP doctors in each and twice as many GP nurses. One half of the town (geographically speaking) is served by these GP departments. This is a significant outcome of Gatchina’s long-term reform efforts, to which the project contributed.

The medical personnel trained in the Educational Centre apply the new skills in their regular GP work. Medical students have their two-year house office training (ordinatura) in Gatchina. In all, 75 medical doctors have gone through Gatchina, most of them before the Educational Centre was opened. In addition, Gatchina was a training base also before the project was established. These facts contribute to the likelihood that there will be outcomes of the project.

As a result of the training of “medical secretaries”, the medical nurses in the registering office (registratura) apply new methods. During home visits doctors register information on a dictaphone and leaves it to the nurses who have been trained in the functions of “medical secretaries”. This outcome is in line with the overall objective of making the primary health care more efficient by unloading the doctors of some of the technical-administrative tasks. On the other hand, since it is nurses that are trained it goes contrary to the objective of relieving the nurses of some of their secretary functions in order to allow them to make use of their medical skills as professional assistants working in team with the doctors.

The aim of reducing the work load on medical doctors by preparing nurses to take over some of the tasks not requiring deep medical specialisation has been hampered by Russian legislation, but also lack of prior competence among Russian nurses.

The management training was received well by the participants, who found the training and seminar techniques interesting. The initiative to the management training came from the Leningrad regional health authorities themselves, and was motivated by their need for more knowledgeable “cadres” in the large-scale restructuring of the health sector that was going on.

In fact, the initiative was made in order to improve the “cadre reserves” as the Russian expression goes. In fact, among those 12 coming leaders participating, six have experienced a promotion (two have been promoted to the regional health care committee, two deputy heads of the municipal health care system/central municipal hospital have become municipal head doctors, and two were promoted to bigger hospitals.

Some of the seminar contents, like the role of leaders, communication with the staff and individual development conversations between leaders and employees have not been introduced system-wise. Reportedly, the leaders who took part in the training try to apply elements of the core ideas from the seminar in their daily work.

### 4.5.3 Impacts

Since outcomes are somewhat unclear, it is not possible to give a very substantiated account of the impacts. It is, however, quite clear that the very fact that the personnel within primary health care have been involved in an international project, enhances their professional self-esteem, which is important for the FM advocacy coalition’s impact. Even more important is the fact that the programme offered by the Swedish side has been concrete and has aimed at everyday practices. This has enabled the beneficiaries of the educational and training activities do a better job, which again enhances the position of GP/FM within primary health care. The impacts so far are more on the personnel side than on the institutional one. Since Leningrad is a pilot region with an administration positively inclined to FM, this is not a problem.

The Gatchina project has had an external impact. Due to its forerunner status, it has had an impact on other districts in the process of developing FM.

## 4.6 Cost effectiveness

The project leaders working hours have been between 20 and 25 percent of full-time. Until 2005 the fees were covered by the county council. Later the salaries were covered by the project.

The working hours of the project assistant has been 55 -65 percent of full-time employment and has been paid by the project.

All other personnel from the country council who have taken part have been covered by their ordinary salaries. Travel, accommodation and meals, however, are covered by the project.

Private doctors invited in have been remunerated.

Table 4.4 *Project costs (in mill. SEK)*

|                     |             |
|---------------------|-------------|
| Gatchina 1999-2001  | 5,9         |
| Extension 2002-2004 | 4,6         |
| FM Education Centre | 4,7         |
| Management training | 2,4         |
| <i>SUM</i>          | <i>17,6</i> |

The project's cost-efficiency is enhanced by the fact that the Swedish project leader has long experience with reform of the health care sector. It could have been further enhanced if the Swedish side had made more use of expertise on Russian administrative systems.

## 4.7 Sustainability

The project has been carried out in one of Russia's pilot regions on GP, and to a large extent the project activities have been integrated into everyday use.

## 4.8 The relevance of the project

The projects that have been run between the two regions of Gävleborg and Leningrad have been highly relevant, and in line both with priorities of the SEEC and more importantly, the

Russian government. Strengthening primary health care, among others through the introduction of state-of-the-art FM, is in line with overall priorities.

Training Russian managers in Swedish management principles and practices is highly relevant since the Russian health care system is under revision towards state-of-the-art internationally (through reduction of beds, shorter waiting lists, intra-sectoral co-ordination etc).

Also the other projects in Leningrad region have shown ways to make the health care system more efficient, among other by making as much use as possible out of the professional competence of medical nurses, and by introducing the function of medical secretaries. The latter element is highly relevant since medical doctors in Russia have a heavy administrative workload, and the health care sector has entered a period of computerising patient data, which is a huge operation.

One of the project elements has consisted in training medical nurses in tasks carried out by medical secretaries in Sweden. The profession of medical secretary is not acknowledged in Russia, but the third all-Russian Congress of GP doctors in November 2008 suggested that it become an official profession. There is an acknowledged need to relieve the GP's of some of the simpler tasks. Besides, Russia has begun the huge task of computerising health data, and the nurses working in the "registratura", keeping the patient files, will need training. Although the project component might have run the risk of becoming irrelevant by training people who not have the opportunity to apply what they learnt, there is reason to believe that GP offices are going in the direction of having nurses do some medical secretary tasks.

#### 4.9 Conclusions on Gävleborg –Leningrad

Interviews and conversations with medical doctors and nurses directly involved in the project activities show that they are convinced of the need for a stronger position of GP within primary health care, i.e. in practice the ambulatory-policlinical system. Among those involved in the Gävleborg – Leningrad projects many also go all the way to support FM, not only as a



suboptimal solution for the countryside, but even as a practice in urban and semi-urban areas.

Those medical doctors and nurses directly involved in the projects clearly are of the opinion that it has been useful. For most of the participants, taking part in an international project has given self-esteem in addition to a strengthened professional self-confidence on behalf of FM. Moreover, the seminars and travels have made people getting in touch with each other on a professional and also personal basis. Reportedly, the project participants call each other when there is a need for information or advice. In this sense, the project has contributed to the development of an “advocacy coalition” for GP and FM in the Leningrad region.

The project reports are well written in the sense that they are concise on inputs and outputs. However, the reports do not go far in explaining the outcomes. The reader is not invited to look into how the curriculum of the seminars and contents of the study tours are being used in practice. Neither do the reports go in depth analytically regarding the challenges of supporting the introduction of primary medicine in Leningrad region. For instance, the problems introducing child rehabilitation are merely mentioned, not analysed. Given the fact that outcome is so vaguely described it is difficult to account for impacts. Nevertheless, the medical personnel involved in the project seem to have gained self-esteem on behalf of their general practices as a result of having acquired useful and practical skills and knowledge.

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## 5 Jämtlands län – Vologda oblast

### 5.1 The project in brief

#### **Objective**

The project has aimed at contributing to a strong GP and FM within the primary health care system of the Vologda region.

#### **Partners**

Jämtland county council and Vologda regional health committee.

#### **Methods**

Model units. Making use of the Russian system of regular updating of medical personnel every five years.

#### **Scope**

The project lasted from 2003 to 2008 and has received grants amounting to 7, 48 mill SEK.

### 5.2 Background

The co-operation on primary health care has taken place on the background of a general agreement that was signed in 1999 on co-operation between the two regions of Vologda and Jämtland. The project started in 2003, after a pre-study consisting of five conferences/seminars was made in 2001 and 2002. Originally, being a three year project to be ended in 2005, the project continued into a second phase lasting from 2006 to 2008.

The starting point is important because at that time the Russian crisis was over and the country had entered a period of administrative and legal consolidation. On federal and regional level the health care system was targeted as one of the prioritised fields of reform, among others aiming at strengthening primary health care. The Russian reforms in the field of GP speeded up in 2005, with the Order (Prikaz) on GP. Vologda was chosen as one of 15 pilot federation subjects the same year as it entered into the second phase in its co-operation with Jämtland.

The Jämtland side could draw on its experiences from similar project cooperation with the Estonian region of Valga. Moreover, the co-operation could build on a systematic overview of the health care sector of Vologda resulting from a joint Russian-EU TACIS project under which several reports were published (<http://www.vologda.ru/~health/indexf.html>).

At the time of the project start-up, the Vologda region was implementing its long-term regional programme “Vologda Region – Health 21 Regional Long-Term Health Policy” for health promotion and disease prevention, in which primary health care was singled out as one of the main priorities. Altogether 23 medical doctors had been retrained as general practitioners within the programme. The programme was followed up by a more specific strategic plan “Protection and Strengthening of the Population’s Health”, which was followed by a “Target Programme” (“tselevaia programma”). In the Russian system Target Programmes are linked to concrete funding of activities.

Vologda region was planning to establish a special training centre for GP’s in co-operation with the Russian Medical Academy of Postgraduate Training (MAPO). Training courses for GP nurses were also being planned in co-operation with the Vologda Medical College. A health centre for primary health care had been established centrally in Vologda city (under Polyclinic no. 3).

The regional authorities of Vologda have been determined in their objectives of reforming the primary health care system. At the same time the reform has been carried out with due consideration to institutional realities, like the presence of paediatricians (without the GP additional re-training) in the polyclinics and ambulatories. Also, cultural aspects, like the parents’ wish to take their children to a specialist, i.e. a paediatrician, have been respected. The

element in “pure” GP that children and adults are treated by the same doctors has not been pushed.

In other words, Jämtland entered into co-operation with Vologda on issues that were given priority in the regional (and federal) health policies, and for which there were on-going activities at the time when the Swedish-Russian cooperation was set up.

In fact, Vologda should be considered a region that pushed for GP. For instance, it has introduced a regional pay rise (“nadbavka”) for GP doctors and GP nurses in addition to the general rise of the salaries in primary health care from the National Project on Health.

Being a pilot region, Vologda took the request in the Order (Prikaz) No. 84 from 2005 that the regions raise the salaries of GP doctors and nurses seriously. In Vologda salaries jumped from 10,000 RUR to 28,000 RUR for family doctors and from 5,000 RUR to 14,000 RUR for family nurses. This makes wages for the GP medical workers 1.5 times higher than for other professional categories in the sector.

Moreover, the region has introduced a financing system of health institutions that compensates the primary health institutions on the basis of the size of the population they serve, i.e. not based on the number of patients treated. This way, there are no incentives not to take the necessary time with each patient.

## 5.3 The project design

### 5.3.1 The project objectives

The overall goal is a strong GP and FM within the primary health care system of the Vologda region.

### 5.3.2 Programme theory

The projects have based themselves on the assumption that training and exposure to real-life practices will lead to change. Therefore, seminars and practical training have been preferred activities. Interestingly, the projects have had a relatively strong

emphasis on practice. Therefore, the idea of model units formed a core element of the projects. Likewise, the project activities to a very large extent consisted in seminars, study tours and auscultations in places where GP and FM were being practiced widely, like Jämtland and Valga.

## 5.4 The project implementation

How were the projects implemented? What were the working methods applied? Have the partners involved been able to learn lessons during the project period?

### 5.4.1 The actors

The project has strong links with the respective regional authorities on a political as well as a managerial level. On the Russian side the local level is involved together with the regional health committee, which is Jämtland's direct partner. A leadership group for each of the two partner regions has been set up. There have been no changes in the set up of project leaders during the project period. The technical co-ordinator on Russian side stayed all the way through the project.

The project has involved people in top positions, both leading politicians and managers. On the operative level the project has been run by the primary health care department of the Jämtland region and the regional health authorities of Vologda. There have been few changes in the composition of the core project group.

The head of the Department of Health Care in Vologda region is directly involved in the project, among others as lecturer at the regional branch of MAPO. This has been useful because it has brought in a strong analytical capacity on the politico-administrative context, and no less important the inclusion of the Health Director has made it possible to make decisions. Also direct dissemination of insights from the project to Moscow through the Health Director.

#### **The role of the target group**

There are four target groups in the project. The primary target group is the existing family doctors and nurses and the family doctors

and nurses who are educated during the project. The second group is the heads of the Health Care Departments in the districts where family units already have been started and will start. The third group is the doctors and nurses who will be educated and responsible for the 24-hours-call units in Vologda and Cherepovéts. The fourth group is the doctors who participate in the audits.

#### 5.4.2 The activities

The activities have consisted in a quantitative increase of the number of GP doctors and nurses and a qualitative emphasis on their skills and knowledge. As a part of the qualitative emphasis GP and FM units with trained GP's have received necessary equipment to carry out all-round medical services.

Thus the concrete project elements have been

- Equipping two model units
- Arranging study tours, seminars and auscultations in Sweden, Estonia and Russia
- Assisting in the establishment of a branch of the St. Petersburg MAPO in order to provide formal training of GP doctors and nurses
- Assisting in the establishment of telephone consultation in GP units and casualty clinics
- Management training

##### *Equipping two model units*

The project aimed at starting a family unit in all districts of the Vologda region. In order to show the benefits of GP and FM, two FM units, so-called “GP doctor offices” (ofis vracha obshchei praktiki) were established in the settlements (posëlki) of Molóchnoe and Chëbsara Their function is was to serve the local population as well as students of GP, most of whom are medical doctors retraining in GP.

*Arranging seminars, study tours and auscultations*

Here the idea was to draw on a wide variety of sources, including Danish and Norwegian experiences, but also the experiences from Estonia. One week auscultations in Estonia were among the activities, and trainers from Estonia came to Vologda as trainers and lecturers.

*A branch of the St. Petersburg MAPO*

By the end of the project period in 2008, the concrete objectives for the project were to have trained altogether 110 family doctors, 170 family nurses. It is, however, not clear whether this was the objective of Vologda's reforms or whether the goals were those of the project.

In order to get the formal retraining to become a GP, one had to go to St. Petersburg MAPO, which due to distances was expensive and time-consuming. Furthermore, it excluded potential participants with intensive family commitments. A branch of MAPO in Vologda would allow for more efficient training. In order to achieve this, premises were needed as well as local lecturers and trainers. The project aimed at contributing to both.

*Telephone consultation*

A 24-hours-call unit each for the cities of Vologda and Cherepovets appeared on the list of concrete project objectives. In order to reduce the number of visits to the FM units and home visits, telephone consultation were seen as a useful tool. Not least the costly practice of calling the casualty clinic for an ambulance could be reduced by professional telephone consultations.

*Small scientific studies (audits)*

In order to keep the scientific and professional level of the GP doctors up, one of the activities consisted in carrying out small scientific studies based on their own data.

*Management training*

The project decided to train 12 heads of central district hospitals and polyclinics as a support in their work to develop guiding lines (kontseptsiia) for the development of the primary health care.

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*Other*

While summing up 2005, the project suggested that it support the establishment of a family doctor association in Vologda region. Also, information leaflets against the use of tobacco were introduced.

## 5.5 The results so far of the projects

### 5.5.1 Outputs

#### Pilot units

During the first project, called “Development of Family Medicine in Vologda Oblast”, two models of family units (one in Molochnoe and one in Chëbsara) were repaired and equipped.

The equipment handed over to the offices allows the doctors to carry out all-round GP. Among others, the equipment is used for glucometry, electro-radiography, otoscopy, ophthalmoscopy, checking of visual power, as well as carrying out small surgical operations.

#### MAPO branch

In May the rector of St. Petersburg MAPO issued a decree (prikaz 2004 no. 126) on the establishment of a section for post-diploma training of medical doctors in Vologda, and in September 2004 the Vologda section of St. Petersburg Medical Academy for Post-Graduate Education (MAPO) was opened. In December that year 12 health specialists of the Department for Health Protection were trained in St. Petersburg MAPO and received certificates that allow them to teach in the Vologda section of MAPO, which all of them still do (part-time) in December 2008. In February 2005 the government of Vologda region passed a resolution to finance the training at the MAPO section. In the period 2004 to 2008, the regional government has granted 6.5 million RUR to the section in addition to the 15 million spent on reconstruction of the premises.

As a result of the opening of the Vologda section of MAPO, re-training costs were reduced to one third, and the scope of participants could be widened to include medical personnel who



could not stay away from home for longer periods of time. The result of the opening of the Vologda branch was an increase in the number of trained family doctors from 2 in 2003 to 18 in 2004. Regular re-qualification into general practice of medical nurses as well as district doctors and paediatricians followed each of the remaining years of the project (phase I and II).

Jämtland contributed to the establishment of the MAPO section by financing the training of two GP teachers in St. Petersburg MAPO prior to the section's establishment and ten afterwards. Moreover, in the project equipped the lecture rooms, provided equipment and dummies for training in reanimation.

#### Qualification of doctors and nurses in GP

In all 141 family doctors have been trained in MAPO. In addition, 266 family nurses were trained in the VBMU (Vologda Basic Medical College) in the course of lectures called "Primary medical-preventive assistance to the adult population" under the specialisation of "general medical practice".

Table 5.1 *Number of trained medical doctors and nurses*

|      | Number of doctors trained/<br>planned | Numbers of nurses trained/<br>planned |
|------|---------------------------------------|---------------------------------------|
| 2003 | 2/8                                   | 28/12                                 |
| 2004 | 18/8                                  | 20/12                                 |
| 2005 | 16/8                                  | 38/12                                 |
| 2006 | 19/8                                  | 54/12                                 |
| 2007 | 22/8                                  | 59/12                                 |
| 2008 | 22/8<br>+ 44*                         | 67/12                                 |
| Sum  | 141/48                                | 266/72                                |

*\*In addition 44 medical doctors re-educated at Iaroslavl' State Medical Academy under the National Project on Health*

*(Sources: Annual reports as well as the project report by N.A. Kolin'ko "Predstviaem informatsiiu o khode proiekta 'Razvitie sistemy semeinoi meditsiny v Vologodskoi oblasti' za 2003-2008 gody")*

The project contributed to the qualification of doctors and nurses by financing the fees for the lecturers as well as travel, food and accommodation for the students.

#### Other training

In addition to the regular re-training in the MAPO branch in Vologda, the project has consisted of a large number of training activities. An extensive as well as intensive study programme has been carried out, as shown in the table below.

Table 5.2 *Number and types of activities*

|  | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|--|------|------|------|------|------|------|
| Study tours to Sweden  | 2    | 0    | 1    | 2    | 2    | -    |
| Seminars in Russia   | 2    | 2    | 2    | 2    | 2    | 4    |
| Seminars/auscultations in Estonia  | 1    | 3    | 2    | 2    | 1    |      |
| Working group meetings   | 5    | 6    | 2    | 9    | 7    | 2    |
| Other Swedish participation in Russian conferences, seminars or examinations | 4    | -    | -    | -    | -    | 1    |
| Other trips and meetings   | -    | -    | -    | 6    | 4    | -    |

#### *The overview*

*(Sources: Annual reports with addenda, as well as the project report by N.A. Kolin'ko "Predstviaem informatsiun o khode proiekta 'Razvitiie sistemy semeinoi meditsiny v Vologodskoi oblasti' za 2003-2008 gody")*

#### The "Group of 12"

The group of twelve heads of central municipal hospitals (TsRB's) and polyclinics in Vologda were trained through study visits to Sweden, Estonia, Norway, and Denmark.

#### Telephone consultation

Telephone consultation services were set up in 2008 as pilot projects in the two large urban centres of the region, Vologda city

and Cherepovets city. The services are based on the switchboards of the stations of the casualty clinics. These switchboards are manned by qualified doctor assistants (*fel'dshera po priemu vyzovov*). Three study tours to Sweden were carried out to prepare the staff. It turned out that the *fel'dshers* working on the switchboard were clearly qualified also according to Swedish requirements. The trips were followed by one seminar in Vologda and Cherepovets respectively.

#### Scientific studies

In all four, small scientific studies (clinical audits) were made. The subjects were respiratory infections, arterial hypertony, prophylaxis, and respiratory diseases. In all, 39 medical doctors took part in the scientific studies together with their Swedish counterparts. The results were presented in Vologda, Estonia, Sweden, Iceland and Norway. In addition, they were presented at the third congress of the All-Russian Association of GP (October 2008).

#### 5.5.2 Outcomes

Those having been trained make use of their skills in their everyday work as GP/FM nurses and doctors. The “pre-doctoral reception” (*dovrachébnyyi priëm*, as the Russian expression goes) is being carried out in a new way. Medical nurses and *fel'dshers* (doctor assistants as they are often called in Vologda) now have acquired skills that, combined with new legal regulations, enable them to receive and classify patients in a far more independent and competent way than before. This leaves more time for the doctors to do pure medical work.

The equipment provided through the projects is being used in GP practices. The equipment enables doctors to do all-round GP work.

The pilot units – GP offices – in Chëbsara and Molochnoe – are being used for work experience placement of students at the Vologda section of MAPO.

The large number of district doctors, paediatricians and nurses trained is partly due to the project. The increased number of GP doctors and nurses has allowed for the opening of GP units in 23

out of Vologda region's 26 districts (municipalities). In 2003, there were GP doctors working only in two of the districts (Vologda, Sheksná). No less than 60 offices/departments of general practice have been opened. They all work within the order (prikaz) no. 486 (2006) of the regional Department of Health Care. Appendix no. 3 to the prikaz establishes the criteria for evaluation the work of the GP's.

The casualty clinics in Cherepovets and Vologda have reduced the number of call-outs and are approaching the federal goal of 310 per 1000 inhabitants annually. The telephone consultation is considered a major reason why there are fewer call-outs. However, according to federal legislation the casualty clinic is not allowed to refuse to go to someone who calls and requires a visit.

### 5.5.3 Impacts

Given the fact that the projects have taken place in a region in which GP is being given priority by the regional authorities, and the regional health authorities are highly supportive, impacts are likely to follow.

In fact, in the areas directly served by offices of GP, figures show that there are results. The number of home visits decreases from year to year. Also the use of casualty clinics decreases.

The pilot GP office in the settlement of Molochnoe experienced a decrease in the percentage of patients referred to a specialist from 18 percent in 2003 to below two percent in 2007 and 2008. There is a steady increase in the number of patients that turn to a GP office or department with ophthalmological, neurological or problems that requires surgery.

Figures from Polyclinic no. 2, which is situated in the town and has two GP departments, shows that the visits to GP doctors has risen from 77,366 in 2005, and 87,586 in 2006 to 103,722 in 2007. The number of visits to specialists in the polyclinic decreased slightly from 2005 to 2006. The figures were 91,368 visits in 2005; 93,854 in 2006 and 89,150 in 2007. The number of visits for preventive reasons rose from 29,150 in 2005 to 48,242 in 2006 and 76,131 in 2007. The number of home visits shows a decline from 17,853 in 2005 to 13,117 in 2007.

The Swedish efforts have contributed to the fact that the regional authorities' strategies to strengthen GP – and to a certain extent FM – has led to impacts. It is however, impossible to isolate the share of the impacts that can be attributed to the Swedish efforts.

## 5.6 Cost-efficiency

The costs for the activities undertaken have been moderate as well as very well presented and documented in the reports.

The fact that Estonia was included in the project contributed positively to the cost-efficiency because Jämtland could draw on earlier experiences, which probably saved time. Moreover, the medical personnel from Vologda could go for seminars and auscultations in a country with the same background and where interpreters were not needed.

Table 5.3 *Grants received*

|               | 2003-2004 | 2005  | 2006  | 2007  | 2008 | Total |
|---------------|-----------|-------|-------|-------|------|-------|
| (in 1000 SEK) | 2,380     | 1,195 | 1,400 | 1,600 | 950  | 7,48  |

## 5.7 Sustainability

The project activities have been fully harmonised with the ongoing reform at regional level aiming at strengthening GP as an element within primary care. The people who have been trained are in full swing applying the newly acquired skills in their regular jobs. The equipment handed over through the project is being used in everyday GP work, which is forming part of the regular health system in Vologda. In other words, the fact that the project is co-current with real regional priorities makes it sustainable.

## 5.8 The relevance of the project

Vologda's health care system underwent a thorough revision during the period of co-operation with Jämtland, and what Jämtland offered was in line with federal and regional priorities.

The fact that medical doctors from other regions in North-West Russia are sent to Vologda to take part in seminars organised by the project – and the participation is being paid by their own regional health authorities – is an indicator of relevance.

## 5.9 Conclusions on Jämtland – Vologda

The project activities have consisted in showing that FM is possible on a large scale. Through seminars, study visits and auscultations it has conveyed insights in the practical details of FM administratively and medically. The project activities have strengthened the confidence in FM among the participants through building their competence. The links between the activities and the objectives are clear.

The project fully coincides with priorities made by the regional authorities of Vologda as well as the municipal authorities in the places the project is being carried out. Regional and local authorities have an “ownership” attitude to the project and make use of it strategically to strengthen FM.

The fact that the head of the regional Department of Health Care is directly involved in the project has been an asset because it has brought in a strong analytical capacity on the politico-administrative context, and no less important the inclusion of the Vologda Regional Department of Health Care has made it possible to make decisions. Also, insights from the project have been conveyed to federal health authorities through the head of the Health Department.

The project has added strength to an already ongoing process of reform towards GP, and to a certain extent FM, in the Vologda region. The fact that the Swedish efforts clearly are co-current with regional policies has made it possible to reach results in a relatively short period of time. Not only project outputs have been

produced on time, but they have contributed to outcomes and even impacts.

The fact that the project is a joint venture to a degree which is rare, unfortunately is not fully reflected in the Swedish reports from the project. In the reports some of the results, like the establishment of the Vologda section of MAPO, and the large number of certified GP doctors and nurses, appear as results of the project whereas in fact they are results of the reform carried out by municipalities and regional authorities. The final report signed by the head of Vologda Regional Department of Health Care gives a concise overview of contributions from both sides.

Some of the ease with which the project has been carried out could be attributed to the fact that most of the activities have been carried out in rural and semi-urban areas where going to a specialist never was a real alternative. Here, the activities have consisted in refurbishing the premises and equipping them, in addition to up-grading the personnel in their professions. This is relatively uncontroversial. The proof of the pudding is in the success introducing GP in the urban areas.

The project is excellent in its ability to keep focus on a relatively small number of activities, and wait until they are carried out before including new activities into the project. The partners have not yielded to the temptation of including new project elements as soon as good ideas pop up, which unfortunately often is the case in project co-operation.

The merit of the project between the regions of Jämtland and Vologda is that it has been giving an ongoing reform a push in addition to the pushes from the regional health authorities. The project has consisted in reform support rather than policy export.

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## 6 Conclusions and recommendations

All three projects have contributed to the ongoing reform of Russia's primary health care system through professional capacity-building. In general the projects have been well-through out with a logical programme theory. The activities have consisted in establishing model units and providing training. These activities have been logically well linked to the objectives pursued.

However, the project owners have been poorly prepared to handle interfering disturbances. Although having an intention of being system-oriented the Swedish project owners have lacked the necessary insight in Russian realities really to cope with them. Two of the projects have taken place in Russian regions with a status of pilot in the field of primary health (Leningrad and Vologda), and the third one, St. Petersburg, earlier had a reputation for being of forerunner in the field. Projects that started out after the re-stabilisation of Russia in the early 2000's have had to adapt to the Russian region's ongoing reforms and strategies from the outset, and encounter fewer obstacles than projects established at an earlier stage.

The project leaders on Swedish side are all experienced medical personnel and health managers. In fact they are experienced to the extent of being retired. Their experience is a strong side of the project cooperation because their long standing in the field makes them more able to see things in perspective. The projects have drawn extensively of Swedish personnel currently working in the primary health care which allows their Russian colleagues to get acquainted with fresh inputs from the field.

Although some reforms and some resistance to the reforms may resemble Sweden some decades ago, there is reason not to over-



state the similarities. The surroundings of the current Russian reforms differ among others because they are set in the 21 century technologically. Moreover, Russian health authorities today have several foreign models of primary health care to emulate elements from if they so wish.

The projects are costly. Not least the use of man-hours is considerable. Project leaders and assistants on the Swedish side have part-time positions to run the projects. On the Russian side the project leaders also have part or full time positions.

The projects are good on *outputs*. Outputs are produced efficiently, and they are carefully and pedagogically reported. When it comes to the next step – *outcomes* – reporting gets less clear. Since the projects' main intervention consist in training (seminars, study tours), looking for outcomes equals investigating how the newly acquired knowledge is being put into practice.

Reporting on outcomes is a by far more demanding task than counting outputs. It requires a close relationship with the partners in order to get the information. Moreover, it requires insight in the ways the Russian health system functions in order to assess to what extent allegedly new practices really are new practices. Also, really to understand and appreciate the importance and significance of apparently small changes requires insight in the Russian system. What from the outside may look like a small, technical change may at a closer look appear as an almost insurmountable, systemic change.

When it comes to *impacts*, more has been achieved on the personnel side than on institutional change. Where family medicine is being practiced as a result of the project, there are fewer referrals to specialists. The model units have attracted some attention from health authorities in neighbouring districts. Large-scale impacts, however, are contingent upon factors beyond project level, most importantly the degree to which Russian regional health authorities push the reform.

It should be borne in mind that family medicine is far less controversial when applied in Russia's rural areas than in the cities. In the countryside doctors always had to be all-round by pure necessity whereas in urban areas people expect to have almost direct access to "the best", which is commonly understood as a

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specialist. Also, in cities the institutional and epistemological strength of specialised physicians create obstacles to the introduction of FM.

The knowledge-intensity of working in Russia has been underestimated, which is somewhat paradoxical given the strong emphasis on learning in the projects. Project leaders on the Swedish side have learned by doing. It is fully understandable that the Swedish health sector lacks knowledge on Russian specificities and realities. However, very little has been done to systematically compensate for this lack, but the project leaders have drawn on the experienced staff in the SEEC and on locally employed personnel in Russia.

SEEC has been useful as an advisory and structuring element for the project holders in all phases of the projects. The conferences arranged by SEEC for those involved in the projects, both Swedish and Russian, have been highly appreciated. Unfortunately, for most of the time SEEC has lacked Russian speakers in its headquarters. The job description of the Russia-based personnel tends to focus on technical facilitation and does not emphasise the function of knowing and communicating the specificities of Russia (and Sweden). Concrete knowledge about and understanding of each others specificities and realities is probably the single variable that could have raised cost-efficiency most effectively.

The projects have found themselves in the point of intersection between *reform support* and *“policy transfer”* (exporting one’s own methods). Russia is a country where reform support is welcome, but where “donor-driven” policy transfer is of little relevance. The more closely and explicitly linked to ongoing processes of reform the more results there are. Russian health authorities are more and more selective as to what foreign projects they find interesting.

The idea of establishing an association of GP’s to promote the profession may be good. It is less obvious, however, that setting up associations in foreign countries is something that should be initiated on project level.

The underlying programme theory of the FM projects is characterised by a striking belief in *training* (seminars, study tours) and *model units*. These are the two main methods applied to bring about change. Training on a very large scale has been carried out

and a non-negligible number of model units have been established. We have identified a large number of training events and also model units. In other words, outputs have been produced *en masse*. The crucial question, then, is to what degree outcomes follow from the outputs. What effects do the trainings and model units have on the position of FM in Russia?

In general, the projects follow logical sequences in which one activity is followed up by an activity that makes use of the achievement from earlier phases, e.g. the dissemination project in the Leningrad region and the establishment of an Education Centre in Gatchina.

Nevertheless, there are also tendencies to bite over more than project holders can chew. This seems to be a problem primarily in the Stockholm – St. Petersburg project. Therefore, project holders are advised to keep the number and complexity of simultaneous activities down. In project cooperation there might be a tendency between project partners continuously to come up with good ideas for new activities. The number of good potential projects is almost infinite. Keeping project activities simple (yet challenging) and few in numbers makes it possible to make sure results are verified before moving on.

Cost-efficiency is likely to increase if the co-operating partners are the most suitable implementers. In order to assist Russian reforms in the field of primary health care, the Russian authorities in charge are at regional (federation subject) level as well as municipal level. Health care is the single policy field that dominates among the responsibilities of Swedish county councils. Therefore, basing the co-operation on regional authorities enhances the chances of cost-efficiency. Likewise, Sweden is strong on municipal health care. The fact that the project in St. Petersburg and to a certain extent also Leningrad has been carried out with the municipal authorities as direct counterparts, therefore, also is in line with the principle of finding the most suitable counterpart.

### **Recommendations**

Since the project has come to an end, the recommendations below are of a general character for use in ongoing or future projects. Based on the conclusions above, the evaluator recommends:

1. Projects established in chaotic periods of a county's history should take care not to misinterpret the lack of initial resistance to the project idea as a sign the project is well thought out.
2. All projects should be carefully linked up to domestic reform agendas.
3. The knowledge-intensity of carrying out projects in a foreign country should not be underestimated. All projects should be preceded by a consequence analysis carried out by external experts.
4. Project holders are advised to restrict the number and complexity of activities going on simultaneously.

## References

Project applications

Final Activity Reports

Other project documentation

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Tragakes, Ellie and Suszy Lessof (2003): Health Care Systems in Transitions, European Observatory on Health Systems and Policies, WHO, Bruxelles

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# Appendix 1

## List of interviewees

*Some of the persons were interviewed in the field as well as in their offices. In the list below, they are mentioned once (upon the first meeting with the evaluator).*

Göran Carlsson, head of office, SEEC

Ernst Michaeli, senior advisor, SEEC

Staffan Engblom, project leader Stockholm/St.Petersburg, Senior Consultant InDevelop-IPM

Lars Bertil Arvidsson, project director

Göran Sedin, deputy project director

Gunnar Wennström, professor, SEEC's first head of office

### Östersund

Olge Gääv, project leader

Hans-Olof Nylén, medical consultant of the project

### Gävle

Rolf Marksrom, project leader

Ann-Christine Wiberg, project assistant

### St. Petersburg

Marina Shapoválova, project assistant Stockholm – St. Petersburg project

Natalia Nakaznuk, local informational manager SEEC

Valentina Velest, Polyclinic 34 Petrogradskii district

Mariia S. Pugachëva, GP doctor, Polyclinic 34 Petrogradskii district

Antonina V. Matiusheva, head of Polyclinic 17, Krasnogvardeiskii district

Dmitryi Gromov, head of Polyclinic 10, Krasnogvardeiskii district

Jurii A. Petrov, head of the department for cooperation with domestic and international medical institutions of the Health Committee of St. Petersburg

Mikhail Y. Kasatkin, specialist department for cooperation with domestic and international medical institutions, Health Committee of St. Petersburg

Elena R. Pfau, responsible for co-operation with Sweden in the department for cooperation with domestic and international medical institutions, Health Committee of St. Petersburg

Irina Larina, head of the out-patient unit in the Health Committee of St. Petersburg

Mikhail S. Dotsenko, Head of the FM faculty, Mechnikov Academy

Irina Iubrina, head of the GP unit at the Polyclinic 54

Tat'iana N. Zasukhina, deputy executive director, Territorial Fund for Compulsory Medical Insurance St. Petersburg

Yurii A. Zerniuk, head of the St. Petersburg chapter of the General Practitioners Association

Iurii Korotkóv, head of the health care department of Kalininskii district

Pavel N. Riazanov, acting deputy chairman of the Leningrad region health care committee

Konstantin A. Kharitonenko, Leningrad region health care committee

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Olga Iu. Kuznetsova, vice-rector for science and international affairs, head of family medicine department, St. Petersburg Medical Academy of Post-Graduate Studies (MAPO)

Gáтчina

Mikhail M. Fomín, deputy head of town administration

Vladimir A. Ivanov, head of municipal health care department

Nataliia Baranova, deputy head of municipal health care department

Vólosovo, settlement Sel'tsó

Stanislav V. Serafimov, deputy head of Volosovo department of health care

Ol'ga B. Saprikina, GP doctor, head of the ambulatoria

Vsévolozhsk, mikroraion Bergardóvka

Liudmila G. Vasileva, deputy head of the municipal health department

Nataliia I. Gaevskaia, head of the GP office

Vsévolozhsk, settlement of Shcheglóvo

Nadezhda F. Vasina, head of the ambulatoria

Vólogda town

Ivan A. Pozdniakov, first vice governor of Vologda region

Aleksandr A. Kolin'kó, head of the Vologda regional Department of Health Care

Aleksandr Popugaev, first deputy head of the Vologda regional Department of Health Care

Nataliia A. Korolenko, deputy head of the Vologda regional Department of Health Care

Ivan V. Vorob'ëv, former technical assistant to the project

S. N. Zelentsov, the Vologda section of MAPO

Tat'iana V. Popugaeva, head of GP department in Polyclinic 2



Iurii N. Markevich, head of the Vologda casualty clinic (stantsiia skoroi meditsinskoi pomoshchi)

Aleksandra M. Martianova, fel'dsher (doctor assistant), Vologda casualty clinic

Vologda town, settlement Molóchnoe

Sergei A. Miaskov, head of Vologda municipal health department

Aleksandr V. Kosanin, head doctor, Polyclinic No. 5 (Molochnoe)

Svetlana A. Shirokova, head doctor, Molochnoe GP office

Vologda town, settlement Prilúki

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