EXTERNAL FACTORS INFLUENCING THE WORK OF FAMILY PHYSICIANS IN ARMENIA. A QUALITATIVE RESEARCH STUDY.

Master of Public Health Thesis Project Utilizing Professional Publication Framework

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ABSTRACT

The National Health policy of the Republic of Armenia for 2004-2015 stresses the importance of Primary Health Care (PHC) development and emphasizes the institution of Family Medicine (FM) as a main PHC provider. FM is the medical specialty that provides continuing, comprehensive health care for an individual and a family.
Physicians were retrained and started to work in such settings of Armenia as rural ambulatories, Family Care Center (FCC) in Gyumri, etc. Within the framework of the Armenia Social Transition Program (ASTP) FM departments were established in urban polyclinics of pilot sites. Doctors who completed the training in FM started to work in these departments.

The purpose of the present study was to reveal the knowledge of Family Physicians (FP) about the legislative field of FM in the RA, and reimbursement mechanisms; their perceptions of relationships between FP and narrow specialists (NS) and patient attitudes towards family medicine and FP; and suggestions of FP concerning ways of improvement and changes in abovementioned areas. In-depth interview guide was used. Study was carried out among certified FPs occupying the position of FP. Thirty-one FPs from Ararat, Shirak, Lori marzes and the city of Yerevan participated in the study.

Respondents answered that the current legislative field of FM is imperfect; reimbursement of the labor of FP is insufficient; NS – FP relationships are problematic; and patients' attitude towards FP and institution of FM (by perceptions of FP) in general is positive with some exceptions. Respondents also made such suggestions for changes as: improvement of legislative field of FM – clearer definition of FP scope of work; increase of per capita payments; provision of trainings in narrow specialties; improvement of laboratory – diagnostic capacity of FP practices etc. Results of the study go in line with other studies

that were carried out in several countries of FSU. However there are certain differences that are connected with concrete historical situation in the country.

Recommendations: educational campaign among FP to improve their knowledge of legislation; define clearly the scope of work of FP by the law with provision of wide participation of FP in decision-making process, branding and image building to improve the status of family physicians; establish monitoring and evaluation mechanisms that will allow enough flexibility for policy makers to reflect adequately shortcomings in the process of family medicine establishment.

Key words: Family Medicine, Family Physicians, External factors, Legislative field, Reimbursement practices, Narrow specialists.

LIST OF ABBREVIATIONS

GOA – Government of Armenia

MOH– Ministry of Health

USAID – United States Agency for International Development

ASTP – Armenia Social Transition Program

UNICEF - United Nations Children's Fund

WHO – World Health Organization

UNICEF – United Nations Children's Fund

PHC- Primary Health Care

FM – Family Medicine

FP – Family Physician

NS – Narrow Specialist

FCC – Family Care Center

SMU- State Medical University

NIH- National Institute of Health

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INTRODUCTION / LITERATURE REVIEW

In the mid 1970s the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at the international conference on Primary Health Care (PHC) introduced the idea of "health for all" (L.Magnussen, J.Ehiri, & P.Jolly, 2003). This had significant sociopolitical implications. It was estimated that the overwhelming majority of patients seeking health care are of the focus of PHC (S.Andreopoulos, 1974). "Primary care has an equity-producing effect on health…" (Starfield, 2001). The purpose of PHC is to detect, diagnose and prevent sicknesses as early as possible. In Armenia, 80 % of illnesses could be treated on primary care level(Susanna Hayrapetyan, 2004). Based on research data from 10 countries, in 7 of them the poorest quintile benefited proportionately from primary health care more than from hospital care (Susanna Hayrapetyan, 2004). That is why promotion of PHC, especially in low-income countries in transition, is very important.

The National Health Policy of the Republic of Armenia for 2004-2015 stresses the importance of PHC development and as a main PHC provider the institution of Family Medicine (FM).(Hakobyan & et Al, 2004; Hakobyan et al., 2004; 2005c; MOH, 2005). As a part of the Armenia health reform, the Government of Armenia (GOA) initiated and prioritized strengthening and developing Family Medicine as the foundation for PHC. The MOH decided that FM was the country's recognized route for achieving effectiveness, efficiency, and accessibility for the population and would be the foundation for strengthened PHC (ASTP, 2004b; MOH, 2005).

During the soviet era, population was attached to certain physician under the territorial-district principle. Today, by law, every resident of the Republic of Armenia has a right to choose his or her health care provider. In particular the possibility is provided for citizens to choose their own primary health care physician. (ASTP, 2005a; MOH, 2005)

Critical steps have been taken at a national-level effort to establish Family Medicine as the basis for PHC in Armenia. The MOH of Armenia has formally approved the specialty of Family Medicine (ASTP, 2005c).

"The implementation of FM in Armenia is one of the pivotal provisions of the health care reform strategy adopted by the GOA. It will provide Armenian citizens with an effective and accessible health care system that focuses on early diagnosis and treatment and disease prevention, which is in the best interest of the population and the state in general" (ASTP, 2005a).

PHC reforms are a key component of the overall GOA strategy for reforming the health sector. Within the framework of the reforms, Armenia Social Transition Program (ASTP) has supported health program pilots in several locations, both inside the city of Yerevan and in the outlying marzes, or governorates. Health pilot sites include two policlinics in the city of Yerevan, thus Polyclinic 17 and Erebuni Medical Center Polyclinic, Polyclinic 4 in Vanadzor, and, as of May 4, 2004, three new rural health pilot sites in the Health Centers of Dsegh, Vahagni and Tumanyan communities in Lori Marz.(ASTP, 2005a) Reforms have tended to center on the development of a concept of family medicine, with all that implies to continuity of care, capitation payments and physician responsibility.(Figueras, McKee, Cain, & Lessof, 2005)

A Unified Curriculum for Family Medicine, comprising of 33 modules developed in 2002 by the Armenian Association of Family Physicians with support of the ASTP was adopted in July 2003. The Unified FM Curriculum was fully adopted by the NIH, but was also utilized by the SMU (2005f). Around 350 FPs are currently graduated from NIH and SMU, and this covers about 30% of the need of FPs in the Republic(2005e) . However, a number of weaknesses and challenges were identified, including: a large number of

unemployed professionals; a poorly paid workforce with a lack of incentives; and uncertainty regarding the future of PHC.(2005d)

Family medicine is the medical specialty that provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, sexes, each organ system and every disease entity (ASTP, 2005d). Family Medicine is an expert medical specialty that involves all-round, comprehensive medical care to people of all ages regardless the gender for common medical conditions (ASTP, 2004a).

Family Medicine core values are (ASTP, 2005b):

1. Evidence-based cost-effective health promotion and disease prevention interventions, such as certain screening activities, immunization and behavior change counseling.
2. Needed first contact skills, such as recognition and stabilization of emergency conditions, and broad symptom-based diagnostic, evaluation and management skills.
3. Needed knowledge ands skills for effective communication and relationship building for patients throughout the life span.
4. Early recognition and outpatient treatment of acute and chronic common conditions that are not life threatening and do not require specialty in-patient diagnostic and treatment resources.
5. Familiarity with Narrow Specialty expertise to effectively refer and coordination when indicated by widely accepted clinical standards of care, rather than automatic referral based upon nosology.
6. Holistic care concerns, relating to the whole patient within a family and community that community that cut across narrow specialties, such as mental health disorders.

In Former Soviet Union (FSU) countries, the process of PHC development was also launched: “The changes were aimed at facilitating the introduction of family medicine as a

specialty and strengthening primary care, although measures to incorporate rural practice in the reform proved difficult to achieve… Reform in medical education can only be justified if it will contribute to the improvement of the health of the population. In order to achieve this goal, the production of better physicians must be assured in Kyrgyzstan". (Alkan, Akylbekov, & Oztek, 2002)

Payment systems must be balanced, combining preferably the salary or the other form of fixed payment with per capita payment and fee for service. Its aim is to stimulate provision of the full spectrum of services in the general practice area and promotion of a high quality PHC via introduction of different incentives.(Boerma & Fleming, 2001)

In 1997–2000, the GOA issued four government decrees on the subject of priority services specified in the Basic Benefit Package (BBP). In 1998 the first Basic Benefit Package (BBP) was introduced with the support from a World Bank While current specialists were retrained in general practice or as family practitioners, after retraining they returned to their previous positions. Retraining was supported by the World Bank's loan. (Hovhannisyan, Tragakes, Lessof, Aslanian, & Mkrtchyan, 2001)

During the sixth assembly of Armenian Association of Family Physicians that took place on October 22-23 (year) with participation of Association members, representatives of interested state structures, NGOs, international organizations and pharmaceutical companies, issues related to the introduction of family medicine were discussed. The problem of an imperfect relevant legislative framework was particularly emphasized; it was especially noted that despite the fact that there are 250 physicians with certificates of family physicians, not everyone works as a family physician in Armenia. (NGO-center, 2005)

Within the framework of the ASTP (funded by USAID) implemented by PADCO Inc, supported by Abt Associates Inc. FM departments were established in urban polyclinics. Doctors who completed the training in FM became eligible to work in these departments.

Semi-yearly patient satisfaction surveys were carried out within the framework of this program. But there were no surveys on provider perceptions of their work conditions, knowledge of legislative field in Family Medicine, their perception of reimbursement mechanisms, relationship between family physicians (FP) and narrow specialists (NS) in these pilot sites. Also FPs were never asked what would they change in abovementioned areas and how.

The purpose of the present study is to reveal the knowledge of Family Physicians about the legislative field of FM in the RA, and reimbursement mechanisms; their perceptions of relationships between FPs and narrow specialists and patient attitudes towards family medicine and family physicians; and suggestions of family physicians of ways of improvement and changes in abovementioned areas.

The information obtained will be used for presenting it to the governing bodies to "make voice of family physicians sound".

METHODS AND MATERIALS

A formative research study was conducted in the Republic of Armenia within the framework of AUA MPH program from May to July 2005. The goal of the study was to reveal perceptions by Family Physicians of such external factors as legislative, reimbursement mechanisms, patient attitude towards FP, relationships with narrow specialists that have impact on their work. For that purpose an instrument was developed (see Appendix #1). It consists of two sections: first is demographic part, which contains questions about age, background education, experience and place of study of FM. Second section of the instrument is an interview guide that contains five main open-ended questions with probe questions. The first question-domain explored knowledge of FP of legislative field

of FM; second domain aimed to reveal knowledge and perceptions by FP of existing reimbursement mechanisms; third domain aimed to reveal the attitude of FP towards narrow specialist-family physician relationship, fourth domain tried to reveal FP understanding of how population perceives FP and FM concept. Separate domain in the instrument was about suggestions of FP about possible changes in areas explored during the in-depth interviews. The instrument was pre-tested on two certified family physicians who worked in urban setting.

Inclusion criteria were the following: respondent had to be certified Family Physician, working at the position of Family Physician and be willing to participate in the study. Respondents were from Yerevan polyclinics #17 and "Erebuni", Vanadzor polyclinic # 4 (these polyclinics are PADCO Abt pilot sites, and there are established Family Medicine departments), Gyumri Family Care Center (FCC), and Ararat Marz rural medical ambulatories (rural family physician group or solo practices). Researcher used convenience sampling to select respondents. Semi-structured in-depth interviews were performed among 31 Family Physicians (one male and thirty female). Thirty-two FPs were asked to participate in the study, but one of them refused to participate.

Interviewer made hand-written notes, which were entered into the computer MS Word program immediately after the interview. During entering the interview data were coded, i.e. similar responses were entered by same words in order to facilitate data analysis. To increase the reliability of data they were translated from Armenian and Russian into English and translated back into Armenian and compared with original transcripts. Qualitative part of data analysis was done by hand. Demographic data were entered into SPSS 11 software and case summary was made. (See Tables and figures section)

Ethical approval was obtained from AUA IRB (see appendix #2). An oral informed consent form was developed (see appendix #3) for interviews. This form contains the

information for interviewees concerning the goal of the project, their role, their volunteer participation, and confidentiality. Interviews lasted about 18-20 minutes on average.

RESULTS

Thirty-one family physicians participated in the study that was carried out during the period of March to July 2005. Demographic results are summarized in the following table.

Table. Summarized demographic data of study participants

Mean Age of participants	35-45 years
Mean Experience as FP	2.06 years
Mean general experience	14.39 years
Pediatricians by background	41.90%
Doctor of General Practice by background	58.10%

Qualitative part of study results can be divided into several subgroups according to major questions of the interview guide

Knowledge about legislative field of Family Medicine.

The majority of respondents mentioned that the legislative field in Armenia concerning FM, which is fairly new and is in the stage of establishment, is yet imperfect, that it needs development.

"In general the legislative field of Family Medicine is very imprecise and not clearly defined"

"Yes, there are certainly laws … But they are imperfect."

"The legislative field of family medicine in Armenia is immature."

"The legislative field of Family Medicine is not clear. As in any new specialties there are lots of gaps, and shortcomings."

"Laws are not fully reinforced."

"There is the law – family physician regulations."

Family physicians also mentioned that they only know their obligations but they do not know their rights:

"Everywhere there are laws about rights of patients, but I never heard about rights of FPs."

"I am not aware of what are my rights as a family doctor."

Many of respondents mentioned that they do not feel safe and secure with current legislation.

"We are not secured because in those cases when we have to refer the patient to the hospital and on the other hand they do not go to the hospital, and it becomes our fault if they refuse to go to the hospital. The whole responsibility lies on our shoulders."

"The physician is defended neither by government nor by the head physician."

"Legally FP is not defended."

Some of them said that they do not know any laws accepted in Armenia about Family Medicine.

"We do not know the legislation. We only know what we have to do."

All of them mentioned "Family Physician Regulations" as a document that defines scope of work. But many of respondents were not sure if "Family Physician Regulations" have legislative power. Many respondents still mentioned that they did not have a feeling that FP Regulations give clear definition of their working protocols.

"There are laws that define the extent of responsibilities of FP."

"There are FP regulations, but laws are in the future"

"There are FP regulations according to which people have to be served. We have guidelines where our scope of work is defined."

Few respondents were content with current legislative field of Family Medicine:

"There are good laws, for example free of charge services"

"Many things have been done to give field of action to Family Physician. Family Physicians have pretty good security by the law."

"I think that we already almost have the legislative field."

Reimbursement mechanisms

The entire group of respondents was dissatisfied with reimbursement size. Everybody mentioned that if compared with the level of responsibility and the burden of work of the Family Physician, the reimbursement is insufficient and unfair. Nevertheless they confessed that their salary is higher than therapeutists or pediatricians ones'.

"…our salary – per capita payment is higher by 5 AMD, but our responsibilities are larger by 200-300 AMD."

"Our reimbursement differs from other specialists' reimbursement, but it is just nominal difference. In reality if compare our work and their work is compared, definitely we receive much less reimbursement than therapeutists do."

"Our salary is just 5,000 AMD higher than therapeutists'. These 5,000 AMD are not covering the difference in the workload."

"The responsibility is very high, but it is not adequately reimbursed."

"The reimbursement is too low yet. It is on per capita basis. For one patient registered we receive 25 AMD. And we need to have 2,000 patients to receive full wage. This number of patients is too high."

"The reimbursement mechanism is also imperfect. It does not consider the burden of work of FP."

All of respondents mentioned that one part of their salary is calculated on per capita basis, but there were discrepancies about minimum and maximum number of adult and children population served for one wage. The number ranged from 500 to 2,500.

"We can have 800 children and 1,500 adults."

"Minimal number of patients registered has to be 500-600 children or 1,200 adults"

Capitation payment size also varied among respondents' answers from 23 to 50 AMD. Respondents' answers also differed when they described other parts of salary: some of them mentioned that they are paid for providing narrow specialist consultations such as neurological, endocrinology, otolaryngology, and cardiology; others mentioned that they were not paid for this.

"Per capita is 50 AMD for children and 25 for adults."

"Per capita payment 18-20 AMD is too low."

Many of them mentioned the presence of ceiling top limit after which all services delivered were not reimbursed. For example doctors from rural ambulatories complained that they couldn't avoid making emergency calls, but after certain number they were not paid for this.

"But there is a ceiling. If there are more than 15 calls we are not reimbursed for it. "

An opinion was expressed that per capita payment is decreasing if the physician has enrolled more than 2,500 patients – so the physician is discouraged to enroll more patients than recommended maximum.

Many doctors complained because of the necessity to go from door to door knocking and explaining to people what the Family Physician is in order to enroll them.

"It is so humiliating to go and knock doors to collect signatures and passports, to register patients in order to reach required number of patients."

Most of family physicians agree that having more than 2,000 patients is a too big number to perform duties on an appropriate quality level.

"If we have 25 AMD per capita, then 2000 it is too big number. It is not realistic to perform fully all tasks of FP on the high quality level."

Respondents also reported that besides capitation payments, as a part of their salary, they have mentioned payments for performing narrow specialist consultations, payments for emergency calls, and payments for organizing so-called "home hospitals".

"We also get payments for "home hospital"; we are not paid for narrow specialist consultations, only neurological."

These payments differ depending on the workplace of the respondent and rural/urban setting.

"We are paid separately for narrow specialist consultations."

There were more extra payments in salaries of rural physicians, but respondents' answers differed in a large variety of narrow specialist consultations. In rural ambulatories physicians mentioned that they receive now the budget for whole ambulatory and can manage it independently.

"We have our budget and we can manage it ourselves. The state reimburses us better than physicians of other specialties. We are paid in per capita basis and it is feasible mechanism."

Generally in rural ambulatories physicians are more content with reimbursement practices and find that mechanisms are fair. They see improvement tendencies. There are physicians who had the opportunity to participate to the National Assembly session where they were able to express their opinion.

"I have participated to the National Assembly session and could express my opinion, which is very valid valuable experience for me."

In one point doctors agreed, that there was a ceiling. If physician performed more than certain number of consultations they were not reimbursed for extra consultations.

"We also have some payments for home calls about 400-500 AMD per each. But there is a ceiling. If there are more than 15 calls we are not reimbursed for it."

Relationships between family physicians and narrow specialists

Concerning to relationships with narrow specialists respondents' answers can be divided into two groups. First larger group finds that there is a big conflict with narrow specialists with the reason lying in mercantile sphere. But respondents mentioned that conflict comes from misunderstanding by narrow specialists of role of family physicians.

"Finances are in the basis of FP and NS relationship."

"Narrow specialists see potential enemies in us. The source is of course finances. They think that they loose clients and consequently earnings. But this is not so."

"Narrow specialists might think that we can take over their patients."

Other smaller group of answers was that there is no conflict with narrow specialists. They are communicating with each other very well and full of mutual understanding.

"I think that there must be tight connections between narrow specialists. There is no conflict between FP and narrow specialists."

Some respondents mentioned that narrow specialists were very tensed and sarcastic about family physicians doing minor narrow specialty interventions.

"NS are ironic, they simply do not understand."

"NS were very skeptical at the very beginning, but now they are gradually getting used to it. We are not narrow specialists and will never be."

Patients' attitude in perspective of respondents

Almost all respondents agree that the population is not well familiar with the institution of Family Medicine. They do not understand what the difference is between family physician and district physician (therapeutist or pediatrician).

"The idea of FM is gradually making its place in the minds of population. Now the situation has improved. People began realizing that I am a family physician, but anyway people appeal to me more with children problems rather than with adult ones, and to my colleague – therapeutist – adult patients go more."

"Patients do not understand what family medicine is."

Several respondents said that patient attitude though generally positive but there are some layers of population (not necessarily people who are in better financial state) who avoid attending primary care physicians preferring to go directly to hospitals.

"There is a certain layer of population who by-passing the primary care chain goes directly to the hospitals."

Another thread was that at the very beginning patients were mistrustful and were scared that they would be charged for FP services. Once they became convinced that it is not so they began to trust and attend more.

"At the very beginning when the program started its implementation patients attitude was negative, they thought that they would be charged for those new services. But now their attitude switched to positive."

Respondents also said that patients' trust relies primarily on the knowledge and skills of physician rather then on the label of family physician.

"The trust of patients did increase but is mostly depends on the level of expertise of each particular doctor."

About FP trainings respondents said that there were different opinions among patients. Some respondents said that their patients value their work on self-improvement, while the others were discontent that they often come and do not see their physician because they are off for training.

«Patients do not realize that the doctor needs to study continuously. They always ask, "Doctor jan, are you again going to study?"»

Many physicians mentioned increase in trust and attendance of patients connecting it with change of their own style of work.

«Patients' attitude is positive because we are now able to fix lots of problems. There are many psychological problems that we often help to resolve. »

Many patient families started to perceive according to respondents their family physician as the person who will not only deliver health services, but also will help in everyday situation, like a priest.

"Very often simple conversation helps the patient more than any medicine."

"We often play the role of psychotherapist: people share with us their family problems."

Suggestions for changes.

Among suggestions made the vast majority of them were dedicated to increase of reimbursement in various ways: increase per capita payments;

"First of all the reimbursement has to be increased because the burden of work is too big and inadequate to reimbursement. But I do not know how to do it."

Establishment co-payment system;

"I suggest establishing a small fee which would be charged from each family. The fee can be symbolic and affordable (e.g. 1000 AMD). And this fee could go to the fund of FP, another part of payment to be paid by the State. This would create the incentive for FP."

Legalization of under table payments, and establishment of insurance system.

"But in Lithuania it is now generally accepted practice that the patient pays something to the doctor and no one thinks that it is something criminal."

"I would suggest defining clearly the framework of FP activities in legislation."

"Our permissions have to be defined clearer."

"I would like to have legally approved the right to treat gynecological, ophthalmologic, surgical patients."

The other major point that was raised was clear definition of FP extent of permissions and provision of safety and defense by the law for FP.

«I would set out more clear boundaries as it is in Russia permissions of FP. »

All of respondents although there was no specific question about it mentioned the necessity of continuous education and all of them stressed that this need to have more practical nature particularly in narrow specialties area.

"First of all for development of FP skills training is needed. And this training has to be sustainable and continuous."

"Also there is a big need of continuous education particularly in narrow specialties, because, we have to be realistic, it is impossible to learn every nuance in 11 months."

Many of respondents - rural physicians in particular mentioned that equipment and laboratory diagnostic capacity of their practices should be improved.

"I would like to expand the laboratory diagnostic capacity. To establish day-treatment unit in the ambulatory."

"To improve the laboratory capacity, different equipment upgraded."

Only few respondents were willing to have opportunity to work separately in their practices.

"I would like to have an opportunity to work independently and calmly. I wish no one to touch me. I would distribute finances in a way where rich patient would pay for the poor patient"

Several respondents mentioned that they would like to have an access to the treatment process of their patients while they are hospitalized.

"And when the patient is in the hospital to have connection with the treatment process."

Half of respondents were happy with volume of work (number of population served), and another half considered the burden of work too high to perform their duties on the appropriate quality level.

"I would change the minimum required number of patients for one wage. Let it be 80 patients but they will receive high quality services."

"The volume of work is satisfactory."

In summary, physicians provided a large variety of answers that varied according to positions (managerial and non-managerial) that they held. Little differences were noticed between rural and urban physicians occupying same types of positions, between physicians of different ages.

DISCUSSION

Results of the study described above indicate that there are many points of agreement between study participants. Answers can be grouped in answers of respondents who occupied managerial position and respondents in non-managerial position.

Urban physicians who were at managerial positions were better informed about legislation issues and were more interested in it. Respondents from rural ambulatories were much more aware of current legislation in FM area and were very active in participation in activities of the Association of Family Physicians of Armenia. Being managers themselves

rural physicians quite naturally were much more aware of current legislation and payment mechanisms. This point can be supported by the fact that rural physicians who worked in non-managerial positions, there was 5 of them in the study were, same as urban physicians, unaware of issues described above. The role also could play the fact that there are 1 or two physicians in rural practices, who were involved in the study, both manager and supervisee are in tight relationships with each other and are much more aware of each other's business. In the one practice where there were 4 FP who were managed by non-FP were very much discontent with the current situation and were unaware neither of legislative field of FM nor of the payment mechanisms. Other physicians who were working in the rural area were more content with reimbursement practices. This happened because most of respondents from rural ambulatories were chief physicians and they had an opportunity to immediately manage their finances. Also a big role for physicians played the fact that they had opportunity to have their representative in the parliament. But the role could also play the fact that was reflected in the study recently carried out in Armenia: «The new regulations were in conflict with existing regulations. This created uncertainty and confusion. »(2005g)

As stated by the Chairman of the Association of FP S. Hovhannissyan, with the assistance of the Association members, the relevant legislative framework is being gradually developed, which will contribute to the widespread and optimum introduction of family medicine in Armenia." (NGO-center, 2005)

"We have made the suggestion in the National Assembly to provide lonely people with free of charge medicines and medical examinations." (Verbatim answer of the current study respondent)

The same pattern was noticed while exploring knowledge of reimbursement practices among physicians in managerial and non-managerial positions. Those who occupied managerial positions as it was expected had much clearer understanding of how salary was

calculated, while the others had unclear understanding of that matter. They came up with a big diversity of answers. Also the fact played the role that in rural and urban settings wages of doctors were calculated in different ways. The problem of low reimbursement calls up with similar problem in other FSU countries where the PHC reform is taking place (2005g; 2005h; 2005a; 2005b). FP in such countries as Moldova, Kyrgyz Republic, Bosnia and Herzegovina are also complaining for having low incentives to work.

Relationships between narrow specialists and family physicians according to their reports were much more harmonious in pilot sites of PADCO program, than in other settings where the study was carried out. This can be explained by the fact that the PADCO program staff paid special attention to this problem and took appropriate measures to manage this. In Bosnia, Kyrgyz Republic, the problem of relationships between NS and FP is also quite acute. There is also direct access to narrow specialist care, which creates inefficiency. "When we joined adult and pediatric clinics with women consultation centers, the MOH came under strong pressure from politicians and narrow specialists in the Kyrgyz Republic and neighboring countries." (2005g; 2005a) But Moldova achieved «branding and image building to improve the status of FM specialists, as compared with narrow-specialists».(2005g; 2005b)

Most of respondents mentioned that the idea of FM is fairly new and not yet well understood among population. Physicians felt that there is a need to promote the idea of FM. *«We need to promote the idea of FM, to advertise it in the media»* (Verbatim answer of the current study respondent).

«The benefits of an FM-centered PHC system are not adequately communicated to citizens and health professionals. There is, hence, a limited understanding of FM and modern PHC among health professionals, citizens and politicians. In particular, the awareness of health reforms and role of the family physician among the general population in Armenia is low». (2005g) Like any new specialty, FM needs promotion and advertisement. Common opinion

of physicians about patients valuing the knowledge, experience and skills of physicians more than the label of FP is also quite logical because the knowledge experience and skills of physician treats the patient rather than the name of FP. Many physicians nevertheless mentioned that trust increased among patients because of change of their style of work, such as visiting patients being more attentive, performing more procedures. This of course makes services of FP more attractive for population. (2005g)

Unified Family Medicine Curriculum should be modified to include increased practical elements and should be delivered in FM training centers.(2005i) A review o f the empirical evidence, derived from both developing and developed countries, demonstrates that health systems with strong FM-centered PHC are able to effectively discharge first contact, comprehensiveness, continuity and coordination functions, and perform well in relation to health system goals and objectives of improved health outcomes, equity, efficiency, effectiveness and responsiveness. (Peleg, Biderman, Polaceck, Tandeter, & Scvartzman, 2005)

Almost all physicians felt the need to be continuous. Physicians felt the lack of practical skills. This seems to be not only the feature of the group that was questioned. “Most medical teaching takes place in the academic hospital setting and students continue to have little exposure to community-based medicine.”(Peleg et al., 2005)

The main limitation of the study is the lack of generalizability because opinions collected from FP cannot be generalized to other physicians who were not questioned. The other limitation was that no physician from private practice was included in the study because they were not found. Another limitation of the study could become the fact that interviewer knew some of study participants. These could create unequal circumstances for those interviewing people who were familiar with study participants and could be more willing to participate in the study. But being aware of that fact the interviewer was able to establish

rapport in all cases and did not see the difference in the willingness to participate among those who were familiar to the interviewer and those who were not.

CONCLUSIONS

Basing on the qualitative data obtained during the study following conclusions were made.

Family Physicians questioned occupying non-managerial positions have imprecise and incomplete knowledge on current legislation in the field of Family Medicine.

The overwhelming majority of respondents are dissatisfied with current reimbursement mechanisms particularly with the size of it. Many of them think that it is unfair. And this goes in line with the situation described in the study carried out in some FSU countries and in Bosnia and Herzegovina, which are undergoing similar process of reforms as Armenia.

Problems in relationships between narrow specialists and family physicians do exist. Study participants find that its roots lie in the financial sphere. However in the ASTP PADCO Abt pilot sites this problem is less actual, this is probably connected with special actions that they have done to solve this problem.

Most of respondents finds patients attitude towards themselves as Family Physicians positive, though they think that it is mostly because of their knowledge experience and skills rather than because of the label of FP.

Suggestions of study participants mostly concern to changes in reimbursement system, thus increase of per capita payments, etc; organization of continuous practical trainings, especially in narrow specialties; defining of Family Physician permissions clearly; have more protection and security for family physicians; promotion of the idea of Family Medicine both among population and physician of other specialties.

The situation in Armenia is not very much differing from the situation in other FSU countries, which are undergoing the similar process of changes. And this is connected with similar historical processes that happened in these countries.

RECOMMENDATIONS

Based on the analysis of data obtained during the study following recommendations are made for the possible implications of present study:

1. Carrying out the educational campaign among Family Physicians to improve their knowledge of legislation and their rights.
2. Defining clearly the scope of work of Family Physicians by the law with provision of wide participation of FP in decision-making process.
3. Branding and image building to improve the status of family physicians as it is done in Moldova to lessen conflicts between narrow specialists and family physicians.
4. Provide FPs with continuous trainings for improvement of their practical skills.
5. Establish monitoring and evaluation mechanisms that will allow enough flexibility for policy makers to reflect adequately shortcomings in the process of family medicine establishment.

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TABLES AND FIGURES

Table 1 Summary of demographic data

	Age of resp.	**Place of work**	**Background education**	**Position**	**Exp as family physician**	**Years of exp**	**Time of completion of FM**	**Place of FM study**
1	**35-45**	Pol #17	Doctor of general practice	Managerial position	over 3 years	4	2003	State Medical University
2	**45-55**	Pol #17	Doctor of general practice	Family Physician	1-3 years	4	2002	State Medical University
3	**55+**	Pol #17	Doctor of general practice	Family Physician	over 3 years	6	2001	NIH
4	**25-35**	Pol #17	Doctor of general practice	Family Physician	1-3 years	1	2002	State Medical University
5	**35-45**	Pol #17	Pediatrics	Managerial	0-1 years	4	2002	NIH

				position				
6	**25-35**	Pol #17	Pediatrics	Family Physician	1-3 years	2	2004	State Medical University
7	**25-35**	Pol #17	Pediatrics	Family Physician	0-1 years	2	2004	State Medical University
8	**45-55**	Pol #17	Doctor of general practice	Family Physician	0-1 years	6	2004	State Medical University
9	**45-55**	Pol #17	Doctor of general practice	Family Physician	1-3 years	5	2004	State Medical University
10	**55+**	Pol #17	Doctor of general practice	Family Physician	1-3 years	7	2004	NIH
11	**35-45**	Rural MA	Doctor of general practice	Managerial position	over 3 years	4	2000	NIH
12	**45-55**	Rural MA	Pediatrics	Family Physician	1-3 years	5	2002	NIH
13	**25-35**	5	Pediatrics	Family Physician	0-1 years	1	2002	State Medical University
14	**45-55**	Rural MA	Doctor of general practice	Managerial position	over 3 years	6	2001	NIH
15	**35-45**	Rural MA	Pediatrics	Family Physician	over 3 years	4	2000	NIH

16	**25-35**	5	Doctor of general practice	Managerial position	1-3 years	3	2005	NIH
17	**35-45**	5	Pediatrics	Family Physician	0-1 years	3	2005	NIH
18	**35-45**	Gyumri FCC	Pediatrics	Managerial position	over 3 years	3	2000	NIH
19	**less than 25**	Gyumri FCC	Doctor of general practice	Family Physician	0-1 years	1	2005	State Medical University
20	**25-35**	Gyumri FCC	Pediatrics	Family Physician	over 3 years	2	2001	NIH
21	**25-35**	Gyumri FCC	Doctor of general practice	Family Physician	1-3 years	2	2002	NIH
22	**45-55**	Gyumri FCC	Doctor of general practice	Family Physician	0-1 years	6	2004	NIH
23	**35-45**	Gyumri FCC	Doctor of general practice	Family Physician	1-3 years	4	2004	NIH
24	**45-55**	Gyumri	Pediatrics	Family Physician	over 3 years	3	2001	NIH

		FCC						
25	**45-55**	Gyumri FCC	Doctor of general practice	Family Physician	0-1 years	4	2004	NIH
26	**35-45**	Rural MA	Doctor of general practice	Managerial position	over 3 years	2	2000	NIH
27	**35-45**	Rural MA	Doctor of general practice	Family Physician	over 3 years	2	2000	NIH
28	**25-35**	Rural MA	Doctor of general practice	Family Physician	1-3 years	2	2002	NIH
29	**35-45**	Rural MA	Pediatrics	Family Physician	1-3 years	3	2004	NIH
30	**25-35**	"Erebuni" pol	Pediatrics	Family Physician	1-3 years	1	2003	State Medical University
31	**25-35**	"Erebuni" pol	Pediatrics	Family Physician	1-3 years	1	2002	State Medical University
Total	**31**	31	31	31	31	31	31	31

Figure1. Age distribution of Family Physicians participated in the study.

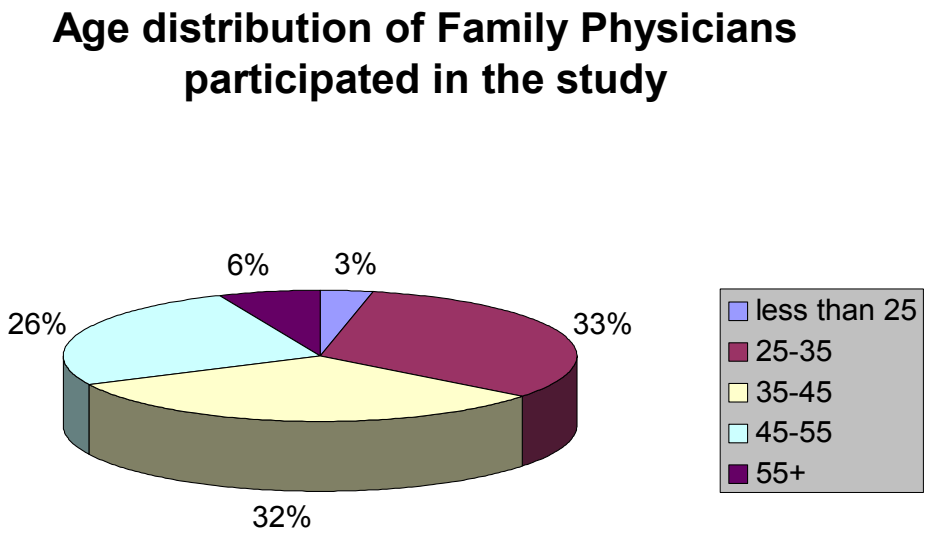
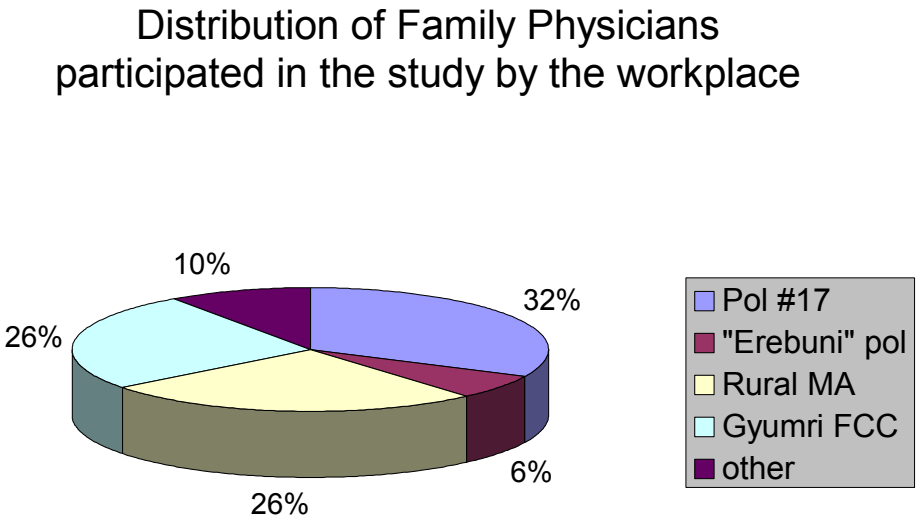


Figure 2. Distribution of Family Physicians participated in the study by the workplace.



APPENDICES

Appendix #1

IN-DEPTH INTERVIEW GUIDE

SECTION 1 Demographic data

1. How old are you? □ less than 25
   □ 25-35
   □ 35-45
   □ 45-55
   □ more than 55
2. What is your background education
   a. pediatrics
   b. general physician
   c. other (specify) _____
3. Where do you work?
   a. Polyclinic #17
   b. Erebuni polyclinic
   c. Rural Ambulatory
   d. Gyumri FCC
   e. Other (specify) _____

4. What is your current position? _____ If other than FP than stop the interview

5. How long do you occupy your current position □ 0-1 years?
   □ 1-3years
   □ more than 3 years

6. How long do you work as a physician? _____
7. When did you finish your training in Family Medicine? _____

7. Where did you study Family Medicine? □ At the National Institute of Health
   □ At the State Medical University
   □ Other (specify) _____

SECTION 2 Interview questions

---

1. What do you think about legislative field for Family Medicine? *Probe:* Are there any laws about family medicine? Are there laws defining the extent of FP permissions? Does the law that assures the work of family physician define satisfactory procedures?

2. What do you think about reimbursement mechanisms of family physicians? *Probe:* Of other physicians? Are they fair to your mind? Are they going to work? Are they feasible?

3. What do you think about relationships between narrow specialists and FP? *Probe:* Are there any interest conflicts between narrow specialists and family physicians? What is the source of those conflicts? In what field?

4. Tell me please, what you think about patients' aptitude towards Family Physicians. *Probe:* Do they trust Family Physicians more than other specialists? Are they willing to go to FP practice?

5. What do you think needs or can be done to improve situation (if there is a need to do so)? *Probe*: What can facilitate your work? What kind of changes can lead to improvement in your work conditions? Changes in legislation? Changes of organizational structure? Reimbursement mechanisms? Volume of work?

Appendix#2

AMERICAN UNIVERSITY OF ARMENIA

INSTITUTIONAL REVIEW BOARD # 1/COMMITTEE ON HUMAN RESEARCH

COLLEGE OF HEALTH SCIENCES SUBCOMMITTEE FOR STUDENT THESES

40 Baghramian Ave.,

Yerevan, Armenia, 375019

Phone (3741) 51 25 70/ FAX (3741) 51 25 66

APPLICATION FORM

PLEASE PRINT OR TYPE. INCOMPLETE FORMS WILL NOT BE PROCESSED

Principal Investigator: _Michael Thompson_____Dept: ____MPH_____Phone: _512592__
(Must be a faculty member)
Email: ____*mthompso@aua.am*_____

Co-Investigator(s): ____Krikor Soghikian_____
Student Investigator: Kamilla Petrosyan_____
Project Title: External factors influencing the work of Family Physicians in Armenia. A qualitative research study.

Proposed Start Date—May 1, 2005---------- Anticipated Duration of Research-------2 month----------

Population: Proposed Inclusion Criteria
(Check all that apply)

_+_ Males
_+_ Females
__ Children (under 12 yrs. of age)
__ Adolescents (12-17 yrs. of age)
__ Pregnant Women/Fetuses
__ Elderly (over 65 years)
__ Prisoners
__ Cognitively Impaired

Type of Study:
(Check all that apply)

__ Survey
_+_ In-depth Interview
__ Focus Group Discussions
__ Experiment
__ Secondary Data Analysis
__ Program/ Project Evaluation
__ Clinical/Community Trial
__ Case Control Study
__ Longitudinal Study
__ Record Review

__ Course Activity
__Other:

]Participant risk

Yes/No

no Is information recorded in such a manner that subjects can be identified from information provided directly or through identifiers linked to the subjects?

no Does the research deal with sensitive aspects of the subject's behavior; sexual behavior, alcohol use or illegal conduct such as drug use?

Could the information recorded about the individual if it became know outside of the research:

no a. place the subject at risk of criminal or civil liability?

no b. damage the subject's financial standing, reputation, or employability?

Do you consider this research: *(Check one)*

___a. greater than minimal risk?

_+_ b. minimal risk?
___ c. no risk?

If you consider this proposal to merit expedited or exempt status, indicate the justification below (check all that apply)

____ Secondary analysis of a previously approved dataset

____ Research is purely for a course assignment and poses no risk

____ Protocol has already been reviewed and

Consent Process: (*Check all that apply)*

__ Written

+Oral

+Armenian language

__English language

+Russian language

__Other language:

__ None

Minimal Risk *is a risk where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical, psychological examinations or tests. For example, the risk of drawing a small amount of blood from a healthy individual for research purposes is no greater than the risk of doing so as a part of routine physical examination.*

approved by another IRB

SUBMIT ONE HARD COPY PLUS ELECTRONIC FILE OF THE ENTIRE APPLICATION/ THESIS PROPOSAL TO THE TEACHING ASSOCIATE (YELENA AMIRKHANYAN, ROOM 49b).

Name of Contact Person (if applicable)	Telephone #
Yelena Amirkhanyan	/3741/ 512592
Signature of Principal Investigator	Date

American University of Armenia

Institutional Review Board # 1/Committee On Human Research
College Of Health Sciences Subcommittee For Student Theses

NEW RESEARCH PROJECT

RESEARCH PLAN

1. RESEARCH QUESTION ADDRESSED BY THIS PROPOSAL:

The goal of the project proposed is to study perceptions by Family Physicians of external factors such as legislative, reimbursement mechanisms, patient attitude towards FP; relationships with narrow specialists that have impact on their work.

2. RATIONALE for RESEARCH:

The motivation for the research is that Family Medicine is actively developing in Armenia. The National Health Policy of the Republic of Armenia for 2004-2015 stresses the importance of PHC development and as a main provider of PHC level the institution of Family Medicine. The of Armenia has formally approved the specialty of Family Medicine. Family Medicine is an expert medical specialty that involves all-round, comprehensive medical care to people of all ages regardless the gender for common medical conditions. Within the framework of AST (Armenia Social Transition) project PADCO Abt. started a program in pilot sites in Yerevan pol#17 and Erebuni, and in Vanadzor pol#4.

The aim of the study proposed is identification of external factors that influence work of family Physicians in Armenia.

3. METHODS:

The study design is cross -sectional
The study population are Certified Family Physicians who work at the position of Family Physician.
As there ia aformative research will the sample size is not going to be determined prospectively interviews will be made until the same answers will be obtained. Inclusion criteria are: Family Pysician who work at the position of Family Physician, who work at the pilot site of PADCO Abt, and in rural ambulatories in Ararat Marz, . Exclusion criteria are all other specialties of physicians and FP who do not occupy the position of Family Physicians.
During the study participants will undergo the in-depth interview (the guide is attached)

4. RISK/BENEFIT:

It is anticipated that minimal risk is going to be for study participants. As from the

demographic data interviewee identity can be identified, only the research team will have access to this data. No taping or videotaping will be used during the interview. Only written notes will be kept.

The only discomfort will be for participants is their time spent for interview.

There are no benefits from participation neither monetary nor in privileges.

5. DISCLOSURE/CONSENT PROCESSES:

An oral consent form is developed (see attachment) for interviewees. The study participants will be assured that their consent is a process

6. CONFIDENTIALITY ASSURANCES:

Data collected will be coded. No names of participants will be mentioned in notes. Although there is chance to identify the identity of interviewee, nobody except the research team members will have access to those data. They will be kept separately in a safe place. Data obtained from the interview will be coded and only research team will have access to identifiable data. After completion of the study the data that contain identifiable information will be destroyed after analysis will be complete.

American University of Armenia
American University of Armenia

Institutional Review Board # 1/Committee On Human Research
College Of Health Sciences Subcommittee For Student Theses

CONSENT FORM TEMPLATE

Title of Research Project: External factors influencing work of family physicians in Yerevan polyclinic #17 and rural ambulatories in Ararat Marz. The qualitative research study

---

Explanation of Research Project:
Good day.
I am Kamilla Petrosyan, a second-year student of the AUA School of Public Health. I am pleased to invite you to participate in my study.
The study is aiming to reveal the opinion of family physicians about external factors influencing their work. The research group is going to collect data via in-depth interviews.
You were selected for this study because of place of your work and your position of Family Physician.
We will ensure the confidentiality of your responses. Data obtained from your responses will be coded and published in aggregate form without mentioning your name. It is your decision whether or not to be in this study. You are free to stop the interview at any time. You are also free to refuse answering any question you do not want to. Your decision will not affect your job.
Your only discomfort will be the necessity to spend about 30 minutes of your time.
You will not have any monetary benefit or other privilege from this study.
After the study will be completed, the research group will share with you its findings.
With your questions regarding to our study you should contact Yelena Amirkhanyan by telephone number: /3741/ 512592.She will answer your questions regarding the study.
The interview itself will last 20 minutes. We anticipate your sincere responses.
Thank you in Advance

Interviewer _____
Date: _____

CHECKLIST FOR CONSENT DOCUMNET

#	**Does this Consent Form contain EACH element, i*f appropriate*:**	Check all that apply			If you respond N or NA, please explain
		Y	N	NA	
1.	The study involves research	+			
2.	An explanation of the purposes of the research	+			
3.	That study is being conducted by the American University of Armenia and the [Name of the Principal Investigator/Donor]	+			
4.	An explanation of how selected for the study	+			
5.	An explanation of why selected for the study	+			
6.	The expected duration of the subject's participation	+			
7.	A description of the procedures to be followed	+			
8	Identification of any procedures which are experimental			+	There is no experiment performed

9.	A description of any benefits to the subject or to others which may reasonably be expected from the research	+			
10.	A description of any reasonably foreseeable risks or discomforts to the subjects	+			
11.	A disclosure of appropriate alternative procedures or courses of treatment if any.			+	There is no treatment

(OVER)

#	**Does this Consent Form contain EACH element, i*f appropriate*:**	Check all that apply			If you answered N or NA, please explain.
		Y	N	NA	
12.	A statement that participation is voluntary	+			
13.	A statement that the subject can withdraw at any time and will not affect any benefits that they would normally receive or they will not be penalized for withdrawing from the study.	+			
14	The consequences of a subject's decision to withdraw from the study.	+			
15.	A statement under which the subject's participation may be terminated by the investigator, where appropriate.			+	No such case is anticipated
16.	A statement describing the extent, if any, to which confidentiality of records identifying the subjects will be maintained	+			
17.	An explanation of whom to contact for information about the research study itself [name and phone number for primary investigator]	+			

18.	An explanation of whom to contact for answers to pertinent questions about the research and research subject's rights	+			
19.	For research involving more that minimal risk, a statement that AUA does not have a program to provide compensation any injuries or bad effects which may be incurred by the subject which are not the fault of the investigator.			+	A research involves a minimal risk
20.	Language is understandable and written at the eighth-grade level and in no smaller than 12-point type. If not written at 8th grade level, please provide at what reading level the consent form was written	+			

Completed by Kamilla Petrosyan

Appendix #3

Oral consent form
Good day.
I am Kamilla Petrosyan, a second-year student of the AUA School of Public Health. I am pleased to invite you to participate in my study.
The study is aiming to reveal the opinion of family physicians about external factors influencing their work. The research group is going to collect data via in-depth interviews.
You were selected for this study because of place of your work and your position of Family Physician.
We will ensure the confidentiality of your responses. Data obtained from your responses will be coded and published in aggregate form without mentioning your name. It is your decision whether or not to be in this study. You are free to stop the interview at any time. You are also free to refuse answering any question you do not want to. Your decision will not affect your job.
Your only discomfort will be the necessity to spend about 30 minutes of your time.
You will not have any monetary benefit or other privilege from this study.
After the study will be completed, the research group will share with you its findings.
For any questions regarding to our study you should contact Yelena Amirkhanyan by telephone number: /3741/ 512592.She will answer your questions regarding the study.
The interview itself will last 20 minutes. We anticipate your sincere responses.
Thank you in Advance
Interviewer _____
Date: _____

Appendix#4

Summary of data collection results.

1. *What do you think about legislative field for Family Medicine? Probe: Are there any laws about family medicine? Are there laws defining the extent of FP permissions? Are there satisfactory* procedures defined by the law that assure the work of family physician?

The majority of respondents mentioned that the legislative field in Armenia concerned to Family medicine is imperfect, that it needs reforming. Other idea expressed was that family physicians only know their obligations but they do not know their rights. Many of them mentioned that they do not feel safe and secure with current legislation. Some of them said that they do not now any laws accepted in Armenia about Family Medicine. All of them mentioned Family Physician Regulations as a document that defines extent of their permission. But many of respondents were not sure if Regulations have legislative power. Many respondents still mentioned that they did not have a feeling that FP Regulations give clear definition of their working protocols.

2. *What do you think about reimbursement mechanisms of family physicians? Probe: Of other physicians? Are they fair to your mind? Are they going to work? Are they feasible?*

The entire group of respondents was dissatisfied with reimbursement size. Everybody mentioned that with the level of responsibility and burden of work that is required from Family Physician the reimbursement is insufficient and unfair. All of respondents mentioned that one part of their salary is calculated on per capita basis, but there were discrepancies about minimum and maximum of adult and children population served for one wage. The number ranged fro 500 to 2500. Also the capitation payment also varied among respondents from 23 to 50 AMD. Respondents' answers also differed when they described other parts of salary: some of them

mentioned that they are paid for providing narrow specialist consultations such as neurological, endocrinology, otolaryngology, and cardiology; others mentioned that they were not paid for this. Many of them mentioned the presence of ceiling after which all services delivered were not reimbursed. For example doctors from rural ambulatories complained that they cannot avoid going for emergency calls, but after certain number they were not paid for this. Surprisingly few words were said about under table payments.

3. *What do you think about relationships between narrow specialists and FP? Probe: Are there any interest conflicts between narrow specialists and family physicians? What is the source of those conflicts? In what field?*

Concerning to relationships with narrow specialists respondents' answers can be divided into two groups: First group is that there is a big conflict with narrow specialists with the reason lying in mercantile sphere. But respondents mentioned that conflict comes from misunderstanding by narrow specialists of role of family physicians.

And the other group of answers was that there is no conflict with narrow specialists. They are communicating with each other very well and full of mutual understanding.

4. *Tell me please, what you think about patients' aptitude towards Family Physicians. Probe: Do they trust Family Physicians more than other specialists? Are they willing to go to FP practice?*

All of respondents said that patient attitude is generally positive though there are certain layers of population who avoid attending primary care physicians preferring to go directly to hospitals. Another thread was that at the very beginning patients were mistrustful and were scared that they would be charged for FP services. Once they became convinced that it is not so they started to trust and attend more. The other idea expressed by respondents was that patients' trust relies primarily on the knowledge and skills of physician rather then on the label of family physician. About doctors trainings there were different opinions. Some respondents said that their patients value their work on self-improvement, while the others were discontent that they often come and do not see their physician because they are off for training. Many physician mentioned increase in trust and attendance of patients connecting it with change of their own style of work. Many patient families started to perceive according to respondents their family physician as the person who will not only deliver health services, but also will help in everyday situation, like a priest.

5. *What do you think needs or can be done to improve situation (if there is a need to do so)? Probe: What can facilitate your work? What kind of changes can lead to improvement in your work conditions? Changes in legislation? Changes of organizational structure? Reimbursement mechanisms? Volume of work?*

Among suggestions made the vast majority of them were dedicated to in crease of reimbursement in various ways: increase per capita payments, establish co-payment system, legalization of under table payments, and establishment of insurance system. The other major point that was raised was clear definition of FP extent of permissions and provision of safety and defense by the law for FP. All of respondents although there was no specific question about it mentioned the necessity of continuous education and all of them stressed that this need to have

more practical nature particularly in narrow specialties area. Many of respondents mentioned that equipment and laboratory diagnostic capacity of their practices should be improved. In organizational structure approximately one third of respondents were willing to have opportunity to work separately in their practices. Half of respondents were happy with volume of work (number of population served), and another half considered the burden of work too high to perform their duties on the appropriate quality level.

Apprndix 5

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