

Intercultural individual report

**Some cultural aspects in the activity of family
physicians in primary health care in Republic
of Moldova**

In this report I tried to describe the cultural context in my country within the family physicians work. Before you start to read it I have to highlight that these are my own perceptions. May be other people from the same country will not agree with the things written down. In order to give more objectivity to this work I used the results of surveys done by UNICEF to assess the primary health care in Republic of Moldova, before and after the establishment of Mandatory Health Insurance. The surveys pretend to be representative for the country. As another source served the data from the Centre for Public Health and Management which I work in. I hope that this mix of subjectivity and objectivity will more or less give you a complete picture on the primary healthcare service in my country, especially concerning the work of family doctors.

Republic of Moldova has a rich mosaic of mix of ethnic groups comprising ethnic Romanians (around 67%), Ukrainians and Russians (25%), Gagauzian Turks (3.54%), and others such as Jewish and Bulgarian which comprise the rest. People have different attitudes and patterns, as well as different styles of interaction, interpersonal communication and reactions. Even there are some variations between the behaviour of persons representing different ethnics; the general countrywide picture doesn't really make difference. Living in this multicultural and multinational ambience for long time, people arrive more or less to behaviour homogeneity. The official language is the Romanian (Moldovan), but most of people speak Russian also.

This multinational pattern of the country is due to the history. This piece of world between two rivers Prut and Nistru, named also Basarabia, was a subject for numerous territorial negotiations between the biggest political powers in the region during the whole history. Basarabia was attached to the Soviet Union in 1940, conforming to the Molotov-Rebentrop pact. As with other post-Soviet countries, Republic of Moldova declared its independence from the Soviet Union in August 1991 and inherited a centralised health system based on the Semashko model. This one emphasised on the secondary and tertiary healthcare. It was a very extensive and expensive experience, which leded to the collapse of the soviet healthcare system. Since independence to consolidate the primary healthcare has been one of the objectives of the Ministry of Health. The selected model to develop this type of care is based on the family medicine.

In the transition period, the wage differentials between the public and private sector widened, with consequent movement of many public sector staff to the private sector. Low salaries and lack of incentives have resulted in low motivation levels and also encouraged rent seeking behaviour. Informal payments increased substantially. This led to erosion of public confidence in the health sector and health professionals and also adversely affected the quality and scope of services delivered. Many health professionals left the health sector or emigrated abroad. Although, this natural wastage has helped address the presence of excess human resources most of those who left the service are ancillary staff and nurses who are difficult to attract and retain in the service as they have few other means of generating additional income. However, while the attrition in the number of health professionals in the health system alleviated some of the excesses in the health system it created significant problems in rural areas. The decline in the number of health professionals working in rural areas was much higher than that observed in urban areas.

Salaries, paid to physicians and middle-level medical staff, are determined according to the "Law on Remuneration of the Republic of Moldova" and levels reflect years of service, qualifications and position held rather than performance. The Law does not provide any incentives to encourage improved performance or provision of high quality services. The competence and notoriety of doctors are remunerated by the under table payment, like a bribe. The Health Insurance Fund uses the per capita payment system to remunerate the family doctors. It means the number of insured persons on the family doctor's list.

Corresponding to the national guidelines as primary healthcare they understand the services delivered by family physicians and urgent pre-hospital healthcare. The term 'primary healthcare', where 'primary' describes health rather than care; primary healthcare suggests responsibility for everyday, continuing, general health concerns. This is concerned with the assessment of the primary problems coming from the street straight into the. The primary assessment is usually focused on all age groups. This is the primary assessment skill, assessing undifferentiated illness, very often in its early stages. Second, there is a family component whose importance increases from year to year. A third component is working in the home – the domiciliary aspect of physician job. One of the features is continuity of care, and what it means for a patient and a doctor to see each other over time, perhaps over decades, perhaps over

generations. This description is more idealistic than there is in the daily practice. That represents the gap in our expectations between the aspirations and the reality.

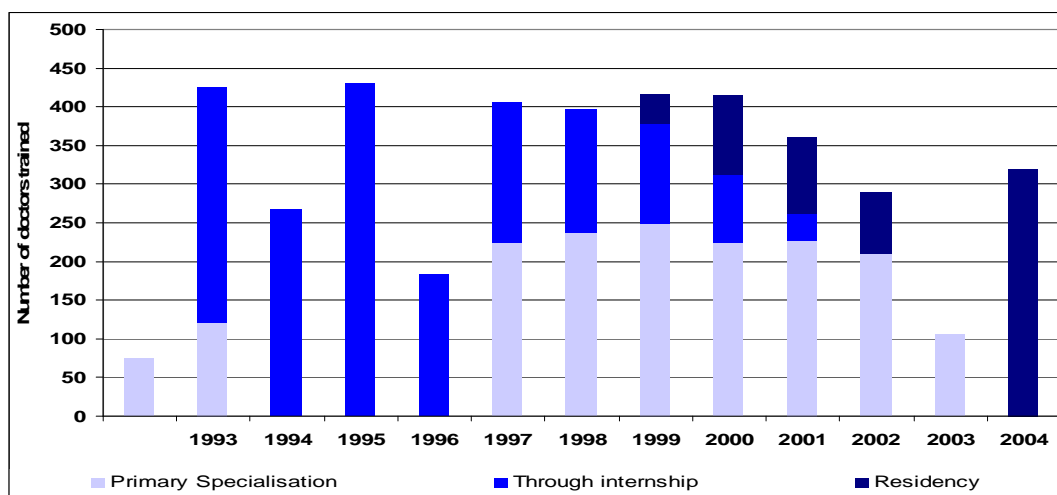
I selected as narrow topic the activity of family physicians. This choice is due to the interesting perception through our culture of the new imported concept, of the changes in the organisation of primary healthcare system.

Family doctor training programme began in Moldova in 1996. The Faculty of Family Medicine was established at the State Medical University in 1998. The Faculty has been providing three different training programmes to train family physicians: (i) A three-year specialist residency programme in family medicine; (ii) Four-month retraining course, which started in 1998, and; (iii) Six-week retraining course, supported by the World Bank and UNICEF, which started in 2003.

According to data from different sources the numbers of family physicians in Moldova vary between 2,000 to almost 3,000. However, many statistics do not distinguish between a therapist, a general practitioner with no special training in family medicine and those retrained in family medicine. According to the Centre of Public Health and Management, in 2003, there were 2,200 family doctors. Each family doctor has around 1500-1800 patients. The repartition of patients for each of family physicians is done by territorial principle. The geographical access to a primary healthcare structure is very good in my country. The average distance to attend this kind of institution is no more than 5 km. The problems are posed by the economical access. Since the implementation of the Mandatory Health Insurance this sort of accessibility has been improved. The free package of assistance, especially at the level of primary healthcare, is covered by the National Health Insurance Fund.

The most of new family physicians have been therapists and have converted in after some trainings attended at the State Medical University which I mentioned upper. These changes are due to the reforms of health care system in the field of primary healthcare. It was done in a centralised manner. The physicians with residency curricula in family medicine have been involved later than the process of reform's implementation run (figure 1).

Figure 1. Number of trained family doctors in Moldova



Source: Faculty of Family Medicine, State Medical University

The concept of family medicine is something new for our medical staff and for population. To change the knowledge and attitudes of people they need few years, to change the practices it takes at least 8-10 years after a countrywide implementation. For instance this new philosophy is going to be understood and accepted by the society. What about practices? The activity's spectrum of family doctor is much larger than the therapist's one was. The newly-fledged retrained family physicians keep in mind the soviet period time, they accept with difficulties to improve their activity to orient to the family medicine concept. This one makes harder the work, because of new tasks, like paediatrics illnesses. The young specialists who didn't work in the soviet time accept easier this philosophy than the retrained physicians. During the Soviet Union time to be a therapist was not so prestigiously. The general tendency was to attend a narrow speciality. At that time the people attending narrow specialities have been selected corresponding to the average award in the university degree diploma. The most popular specialities have been achieved by the most awarded students or with "famous" family name, like in the whole world. The therapist has been like a sorter to referral the patients to other specialists and prescribe a sick-list. I can not neglect that there were someone very competent and they received the respect of patients. The therapist has been more respected in rural area than in urban one, due to the same causes like today in the case of family physicians.

Since the reform of primary healthcare has run the available number of places to attend the residency curricula in a narrow speciality has been substantially reduced. That is why the attitudes of medical society changed. For instance the family physicians are regarded with compassion due to the huge volume of work they do. Tasks of doctors working in this type of care are very different from specialized doctors' tasks. They carry more responsibilities, because of the first contact with patients they have. Their abilities to diagnosis, to treat or to referral to secondary or tertiary level appropriately, determine the success and the satisfaction of patients. The ideal of family physician is not achieved yet, because of soviet traditions. There are several concerns regarding training of family doctors: (i) The short nature of the training; (ii) No career structure for graduates of FM programmes; (iii) Inadequate incentives for FM physicians. It has been estimated that 20–30% of family medicine graduates go back to work in posts in hospitals.

Family medicine is presented in the public healthcare institution. The liberal medical activity in this field is not developed. In my country there are not private GPs cabinets like in the Western Europe. The most of private cabinets are opened by the narrow specialists. To open a private cabinet, the physician has to have an award, have a big experience. The state doesn't offer the licence to young doctors.

Since two or three years ago each student at the Moldovan State Medical University before to start the residency curricula has signed a paper specifying that he/she will work for four years in the medical institution proposed by the national repartition. This repartition of work places is done every year by the Ministry of Health. The given explanations for that are the high expenditures supported by the state to form a mature doctor. Using such kind of methods the authorities try to cover the deficit of doctors in rural area. But it is not a strong law, always. Young doctors choose among the proposed sites or try to escape finding another solution. Sometimes the most convenient workplaces are not officially published and are distributed among the "preferred" people. In this case young doctors try to find a work place and to agree with the authorities. Sometimes this agreement can have a "financial" substrate like the bride. The paradox is that for some specialities the Ministry of Health doesn't offer enough number of sites in comparison with the number of young specialists. Especially in the case of narrow specialities, the health care institutions are saturated. In the field of family medicine the deficit of doctors in

rural area is a ten fold bigger than in urban area.

For a physician with experience is simpler to change the institution, due to the fact that he/him is acquainted with the system and people working into. They don't have to participate in the national repartition, only in the vacancy announced competition. The advertisement of a vacancy is not published. The physicians learn about vacancy at the regional authority, at the Ministry of Health or at the healthcare institution administration. That is why the competition is only a formal procedure. Sometimes the results of this formal procedure can be a paradox, because they can have a "financial" substrate like the bride. It is available more for narrow specialities, especially vacancies in big hospitals. The signed agreement is not detailed, but all physicians know what are their tasks. It is in the culture. Some of them don't know the whole spectrum of activities from the beginning like what kind of records they have to do, etc. In time they learn it. Usually it is not so difficult to get a family physician vacancy in rural area. The choice can be done between the villages, in dependence of quality of life in.

Working in rural area for a family physician is different than to work in urban area. The rural area is less attractive for the young specialists because of living conditions, quality of roads, especially during the raining seasons, difficulties to move, absence of narrow specialists to consult them in ambiguous cases. Going to the villages, it creates an impression like to cut the link with the rest of the world. But living there after some period of time the specialists understand that they are more respected, they are like "kings", if their qualification is enough to achieve the expectations of rural people. The respect towards the doctors in rural area is bigger than in urban, because rural people are less informed, have less possibilities to choose the doctors, to do investigations. The level of vaccination is higher in rural area (98%) than in urban (93%). This can serve as confirmation of the respect and big credit for doctors. Maybe the rural people are more credulous in the achievements of the modern sciences and believe more in the effects of pharmaceutical products even if the traditional methods of treatment go deeply in the culture. In financial aspect to live in rural area is difficult. With the offered salary they can survive better than in urban area, where the prices a much higher. The surviving of family doctors in rural area is due to the farming. Maybe for you it is a little bit strange to hear, but it is the true. Of course, this farming is not a really farming in the understanding of

Western European people. Each family house has an area around which they cultivate vegetables, fruits on. The cereals are cultivated on the area around the village. Each family has her part of. The repartition is done corresponding to the reforms started at the independence time. This natural "income" offers to the whole rural population, inclusive to the doctors, the possibility to survive during the crisis period which has been prolonged, unfortunately. The informal payment is present in rural area, but the prevalent is the offer of services and agricultural products as recompense. It is in the culture to thank the doctors for their good job, for their understanding. The rural people are more receptive to well spoken words, these words become even loader than a successful treatment. If a doctor behaves in certain ways, the outcomes can be better or worse for patients. In fact, this unwritten ethics pervade the smallest and simplest health issue, and serve to provide a framework for everyday practice. Some of physicians working in rural area wage money opening pharmacies, because they are "the kings" in the field of drugs.

The life at the limits of surviving brings to a person with a university medical degree some "degradation" of knowledge, of competencies. Each 5 years the state offers to physicians the possibilities to attend free courses to perfect their competencies and to achieve some professional degrees. To live away of the centre of events affix the seal on the quality of care, a little bit. There are some physicians who try to update continuously their competencies, some physicians who disregard to the differences between the progress done by the modern medicine and their own practices. This phenomenon is available for the whole world, it is a pattern of human being, and in the conditions of socio-economical degradation it highlights. How the today's socio-economical conditions in Moldova are not the same like 10 years ago, the interest of physician to enhance their practices grows from year to year. The biggest part of rural people is sustained by the relatives living and working abroad that is why they have more money to get a treatment. Today's tendency among rural physicians is to grow in their competencies.

In rural area the physician can visit the patients to their home independently of daytime, whenever the patients need. They are responsible also for the emergency healthcare assistance. The emergency health assistance facilities usually are located into cities and the travel takes time. The rural medical staff can be invited at home through the phone calls, transmitting the information by relatives or neighbours. How

in a village the people know each other, some times physicians or nurses know that they can be called to visit an ill person at home due to the aggravation of the health status. The next few days the news about are discussed and transmitted from person to person and the whole village arrives to know that somebody has some health problems and how serious they are. If somebody comes back from hospital the medical staff can know about before the official announcement of the health facility is done. The people can not lie about their health status because the neighbours see and tell to others about. The rural people know practically all about the home-folks. That is why a doctor can learn the medical anamnesis of a person or family with out to answer directly. This is not a rule, of courses. It is good for a doctor who comes from another village.

The daily heavy work doesn't offer the possibilities to the home-folks to communicate enough between them. To come for a visit to family physician is an opportunity to meet the home-folks, to learn much that was new. It is available more for elderly people. Unfortunately our villages are aging. The specific of our village's culture is that the people live at one. They are not so separated like in West of Europe. That is why if a physician attends the respect of the village the whole population will help him to make some changes, to improve the quality of his life. The village itself can help and can destroy him. It depends of the respect it gives him. Doctors working in rural areas during the mentioned before surveys were more statistically likely to use or have on site equipment for minor surgery. The family physicians need it to deliver more services to the rural population in order to not send them to a hospital. It takes time and money. They have to be able to deliver the first aid before the emergency arrives. If it is done on the place, in village, the respect of the people increases. Family physicians from rural primary healthcare centers during the mentioned before surveys were more likely to provide family planning, antenatal and intrapartum care services than those from urban areas. In general the activities of a rural doctor are more to help and to follow-up the patient. The treatment is done more for routine diseases.

For a family to move from one village to other is a big event and has to have some important causes. Mostly of strangers in a village are the young specialists coming from others regions or districts as result of national professional repartition. They are not so numerous than in soviet time. It is not the same rule for villages

which are close to big cities, because some people living in the town can buy houses in the neighbourhood. The youth leave the village to attend high schools and universities' degrees in urban area. Most of them try to remain there because of better living conditions and more incentive life. Some of them come back as specialists. If young physicians decide to go to live in rural area, they refer to region of born to be financially sustained by the family.

To work in urban area is the scope of the most of young physicians. Usually they can survive helping by parents. The amount of the salary is not enough to maintain themselves and own families. If the parents live in rural area usually they sustain with alimentary products. It is deeply cultural that the parents maintain financially the children until they are able to do it themselves, it doesn't matter how old they are. The parents feel well, I can say even happy, if they are able to help their children, to give them something when they visit them, doesn't matter the age of last ones. It is deeply cultural in my country.

Generally the content of the family physicians' work in urban area doesn't differ from this one in rural area. They investigate, treat patients, and do records of the own activities. To go deeply, the urban family physicians are close to other specialists and they prefer to refer the patients to or to consult with them. The differences are due to the urban lifestyle of physicians and patients. The people don't live at one, don't know each other. Patients are more informed, can visit internet to get some information on the own diseases. It more likes a general practitioner activity than family physician. Probably it will become in time.

In urban area, before to go to a physician, the patient has to call the facility to establish the day and the hours. It is like a waiting-list. The maximum time in which the patient can be received by the family physician is not more than 2 days. Even this is too long. This duration is available more for narrow specialists than for a family physician. Home visits are something usual for our physicians. The patients have to call the health facility within works they family doctors and to say that they have health problems which make them unable to move to the facility. The doctor will visit the patient the next day. If the patient has some acute problems he calls the emergency. The emergency is not among the tasks of family physicians. Only in the case if the patient comes directly to health facility and asks for help.

Doctors working in urban areas during the mentioned before surveys were

more statistically more likely to use or have access to diagnostic or therapeutic equipment on site in their health centres used by their colleagues. Their activities are more oriented to a good diagnosis and a good treatment. That is why they referral so often the patients to a narrow specialist.

A large majority of the doctors during the mentioned before surveys interviewed 'strongly' or 'more-or-less' agreed that they were interested in their work and also found real enjoyment. This proportion was similar for family physicians working in urban and rural regions and there was no statistically significant difference. However, around 70 percent of the doctors felt that much of their efforts were wasted and over 80 percent felt that they were overloaded with administration. Only 10-15 percent of doctors felt that the rewards matched the effort made by them but only around 20 percent would take a non-medical job if the chance arose. Taking into account the all economical difficulties, the results of survey show the devotion of doctors to their job.

I hope that I succeeded to offer you an understandable picture on the topic which I selected. Republic of Moldova is an amazing country where you can find the interweaving of traditions and modernism. In urban area the people are fascinated by the computers and science fiction. Then they go to rural area their behavior changes and the traditions prevail.