

Tackling Health Inequities in Rural Ukraine: Evidence Based Approach

by

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Abstract

Ukraine is experiencing an internationally recognized health crisis. Rural residents bear a disproportionate burden of this crisis due to challenging socioeconomic conditions in villages and disintegration of rural health care. Currently, Ukraine is piloting its first major health care reform, focused on changing the health care system from the patient-specialist to the primary care model. The reform has been critiqued for lack of attention to the social determinants of health and insufficient public consultation. Also, little is known from the Ukrainian rural population about their health concerns. This study attempts to bridge this knowledge gap in rural health policy in Ukraine. Fourteen interviews with health professionals and local representatives were conducted to identify the intermediate results of the pilot reform and barriers in accessing primary care in villages. The secondary analysis of five community consultations (funded by the Canadian Institutes of Health Research, PI – Dr. Olena Hankivsky) presents a picture of health concerns in rural Ukraine. Together, these findings inform the final recommendation, which combines community-level health initiatives, the creation of the *Rural Health Framework* and reviving the profession of a feldsher (analogous to a nurse practitioner) in Ukraine.

Keywords: Health care reform; access to primary care; social determinants of health; community-led health initiative; rural Ukraine; feldsher

*To my sons - Bohdan and Nazariy, who inspire
me to live out my Ukrainian identity so far
from home.*

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List of Acronyms

CBALD	Community-based approach to local development
CVD	Cardiovascular disease
FAP	Feldsher-aid post
FD	Family doctor
MoH	Ministry of Health
MLA	Member of the legislative assembly
NP	Nurse practitioner
SFU	Simon Fraser University

Executive Summary

The population of Ukraine has been in the midst of the health crisis since the end of 1990s. In an attempt to address this crisis, in 2012, the government of Ukraine initiated a major health care reform initiative. This plan, centered on strengthening primary care, was piloted in four regions of the country. This reform, however, did not prioritize the needs of rural residents, even though, as in many jurisdictions, these populations are particularly vulnerable in terms of health and access to health care services because of their socio-economic position and geographic location. In general in the Ukrainian context, there is limited information about the health experiences of rural populations. And even more specifically, there is little knowledge of how the pilot reform has impacted on the rural-urban health and health care gap.

This research project is the first study published in English about rural health and health care experiences that uses primary and secondary data collected from the citizens of Ukraine. The capstone presents data from fourteen interviews with health professionals and politicians from the two regions with the reform, as well as secondary analysis of the community consultations in five rural locations in Ukraine. The data reveal that poverty, unsatisfactory condition of roads, transportation and health facilities, and a critical shortage of medical professionals in villages create significant barriers for rural populations in accessing primary care. The pilot reform does not address these problems adequately and disregards the wider social determinants of health, which must be considered when improving rural health and health care.

Policy options recommended in this study are grounded in the social determinants of health framework and provide evidence-based solutions that may alleviate the inadequate health care conditions in rural Ukraine. The recommendation attempts to address each of the identified barriers to accessing care: expanding the training of a feldsher to fill the need for rural primary care providers; and initiating the Rural Health Framework and community-led health interventions, which would address some of the deeper reasons for the rural-urban health and health care gap. Given the current political and economic turmoil in Ukraine, community town hall meetings figure prominently in the policy recommendation. They are low in cost and require no formal

government intervention, and thus are easier to implement, especially in the immediate term, to make incremental albeit important change in relation to health within rural areas.

Chapter 1.

Introduction

At the moment, Ukraine is undergoing its first major health care reform since independence (1991 onwards) to modernize and improve the quality of health services. One of the goals of the reform is to make health care delivery cost-effective through restructuring health facilities and strengthening the primary care component in Ukraine's health care system. Among other things, the reform has been critiqued for lack of attention to the social determinants of health and insufficient public consultation (Hankivsky, Salnykova, Vorobyova 2012). Also, apart from a few studies (Bakirov et al. 2013; Abbott and Wallace 2007; Cockerham et al. 2006; Semigina 2009), little is known from the Ukrainian population first-hand about their health concerns and access to the health care system. Even less is known about the health experiences of the rural residents of Ukraine. To bridge the gap between existing knowledge and health policy reforms in Ukraine, this capstone analyzes health experiences and access to health care of the Ukrainian rural population. Specifically, the research investigates whether the current health reforms adequately respond to the needs of the rural dwellers who are among the most vulnerable populations in the country (Skryzhevskya and Karasconyj 2012). The study also examines the broader challenges of health care access in rural Ukraine.

This study presents the information from interviews with local authorities and health providers in Ukraine conducted in the summer of 2013. Additionally, analysis of secondary data collected through community consultations funded by the Canadian Institutes of Health Research in 2012 (PI – Dr. Olena Hankivsky) and conducted in eleven regions of Ukraine is presented. Importantly, this capstone project highlights that rural residents in Ukraine are not a homogenous group and have different health and health care needs, depending on their age, proximity to urban centres, and socioeconomic status. Based on the data and literature review, I develop and evaluate

policy options for further reforms of primary care in rural Ukraine. The literature review focused on the jurisdictions, which have a significant rural-urban divide with respect to health care provision and have developed practices or mechanisms for bridging this divide. The best practices from Australia, Canada, England, Scotland, Slovenia, and Romania will be examined in the policy options section.

With the break-up of the USSR and transition to the free market, rural populations in Ukraine started experiencing harsh socioeconomic realities. Some believe that this transition affected rural areas in the former USSR most severely (Lohlein, Jütting, and Wehrheim 2003) creating such an urban-rural divide in the post-Soviet countries that is generally associated with the developing countries in Africa (Ibid.). This urban-rural divide is especially evident in the provision and quality of social services such as health care (Lohlein, Jütting, and Wehrheim 2003). These services, which were formerly funded and provided by the collective farming enterprises, have been in the state of decline just as the agricultural industry since the 1990s. In Ukraine there was a 2.1 times decline in manufacturing of agricultural products in 1991—1999, including a 3.4 times decline at the agricultural enterprises (Cabinet of Ministers of Ukraine, 2007, Resolution # 1158). The State Target Program on the development of Ukrainian rural areas for the period till 2015 concludes that poverty, unemployment, social infrastructure breakdown, expansion of demographic crisis and die-off of villages are the most critical problems of rural areas (Ibid.).

The 2008 WHO report on social determinants of health states: “the lower the socioeconomic position, the worse the health” (WHO, 2008a: 1). In Ukraine, rural populations are among the poorest: annual average salary within the agricultural sector, which is one of the main sources of employment in villages, is the lowest among other economy sectors (Ibid.). In 2009 a quarter of the rural population of Ukraine lived below the poverty line, with an average monthly income of \$117 (Lekhan, Rudi, and Richardson, 2010: 5). Deteriorating health condition, especially the situation with chronic illness, is becoming an urgent issue in rural Ukraine (Skryzhevskaya and Karasconyi 2012). The socio-economic problems in rural areas have been negatively affecting health and access to care among village dwellers. In one study rural residents reported that they delayed seeking health care due to their inability to pay for medical services twice as often as urban residents (Lekhan, Rudi, and Richardson 2010: 164).

Currently, the Government of Ukraine does not have a specific program for improving health condition or access to health care among rural dwellers. There is only a small section devoted to rural health and health care services in the State Target Program on the development of Ukrainian rural areas for the period till 2015, which does not contain specific policy steps to improve rural health and health care access. One of the first comprehensive government programs that looked at improving the health of Ukrainians was the intersectoral program *The Health of the Nation for the period from 2002-2011*. This document had few positive suggestions and significant problems with implementation (Hankivsky 2012) but the Program entirely omitted the specific challenges faced by the rural residents of Ukraine in maintaining satisfactory health and accessing health care. In 2011 the Cabinet came out with the National Conception for Healthcare Reform, which acknowledged that the access to health care is “distributed disproportionately between rural and urban territories”, but did not suggest any solutions to this problem.

Central to this capstone is the premise that without addressing the root causes of health inequities, such as unequal distribution of income, social services, housing and other social determinants of health it is impossible to bridge health outcome gaps (WHO 2008a). Nevertheless, this paper focuses on the issue of providing adequate primary care in rural Ukraine for the following reasons. First, the country is in the midst of pilot health care reforms, which are aimed at modernizing primary care in Ukraine. Next, there is more data and literature discussing the health care gap between rural and urban residents in Ukraine, which provides more evidence for the study on access to health care, rather than on broader determinants of health. Finally, addressing the underlying causes of health crisis in rural Ukraine, such as poverty, demographic and socioeconomic problems, is beyond the limited scope of this research project. Because the pilot reform attempts to

1.1. Policy Problem

The challenges associated with providing health care in rural areas are not unique to Ukraine. Both transitional and developed countries with significant proportions of citizens residing in rural and remote areas experience some of the similar problems

with providing rural health services as Ukraine. For instance, in Romania rural populations have comparable financial barriers in accessing health care as do village residents in Ukraine (Sandu 2009). In Australia dwellers of rural and remote territories benefit from a smaller portion of health care expenditures, wait longer for an appointment with a GP than urban residents, and have to travel longer to receive primary and specialized care (National Strategic Framework for Rural and Remote Health 2012, 9). In Canada, towns under 10,000 account for 22.2% of the population, and yet they are served by only 10.1% of physicians (Society of Rural Physicians of Canada 2012).

At the same time, the government of Ukraine has not responded adequately to the challenges of providing health care in non-urban settings. To date, the issue of rural health has neither been prioritized nor examined. Since healthcare planning in Ukraine suffers from the lack of systemized knowledge about rural health care experiences, the pilot health care reform may exacerbate health inequities among the rural population of Ukraine. While the government actions are still at the stage of pilot reform and its evaluation, it is important to consider their interim results in the rural areas and to adjust the national health care reform accordingly.

1.2. Health Care Organization in Ukraine

For the most part, Ukraine still uses the healthcare system inherited from the Soviet Union, which is funded, owned, managed, and delivered entirely by the state. Although successful in treating contagious diseases, the system as a whole served wider political agenda of the Communist party and suffered from inadequate service quality and excess capacity (Healey, Pugatch and Disney 2010, 11; Lekhan, Rudy and Richardson 2010, 36).

While the general architecture of the Semashko model remains intact, a number of shifts have taken place in the post-independence years. First, due to financial pressures, Ukraine has reduced its number of hospital beds by one third, and as a result the structure of health expenditures has changed from inpatient care taking up 80% of expenditures in the 1980s to 25% in 2008. The portion of health expenditures devoted to

primary care has increased from 5% in the 1980s to 9% in 2008 but is still inadequate for responding to the population's need for continuous care, and especially for chronic illnesses, which are responsible for the high mortality and morbidity rates in Ukraine (Menon, 2010).

Family medicine was introduced in the early 2000s, but the uptake of this idea has been slow in Ukraine. The number of family doctors (FD) varies considerably - from 77.8% in Zakarpatska oblast¹ in the West to only 6% in Kyiv (Lekhan, Rudi and Richardson 2010, 150-151). One of the main reasons for this contrast is that the local authorities, responsible for implementing family medicine, had different dispositions towards the new system of primary care (Ibid.). More conservative regions were slower in adopting family medicine, while the Western regions were more open to the idea of FDs. In 2009, 35.7% of the general population was covered by FDs (78% of the rural population and 17% of the urban population) (Ibid.). This difference reflects the fact that the Western regions, which are traditionally more rural, have been faster in accepting family medicine. Also, family medicine clinics were opened mainly in rural areas because it was easier to reorganize small rural facilities into FD offices than urban multi-profile clinics (Ibid.).

Ukrainian and international observers agree that the health care system in Ukraine is in need of large scale reforms (Kizilov et al. 2013; Tarantino et al. 2011; Menon 2010). Yet until recently, the government of Ukraine had only introduced fragmented organizational reforms of the health care system (Hankivsky 2012; Menon 2010). The situation with reorganization of the rural health care is equally deficient. For instance, in 2008, after the Orange revolution, the government of Yulia Tymoshenko released the program of reforms "*Ukrainian Breakthrough: for the People and not for the Politicians*". This document (although guided by ideals of changing policies into more transparent and beneficial for the public) suffered from proclaiming a number of positive goals without indicating the pathways of reaching these goals. A good example of this was the program "Rural Doctor". It proposed to develop rural health care by means of creating new or restoring the existing rural ambulatories, as well as equipping these

¹ Oblast is the name for the largest administrative-territorial unit in Ukraine. This term will be used interchangeably with "region" in this capstone.

facilities with appropriate equipment (Cabinet of Ministers of Ukraine, 2008, Resolution #14-2008 from 16.01.2008). This program did not show any rationale for the creation of new rural ambulatories and no evidence about the health and health care needs specific to rural areas, which would justify the program suggestions. The Orange government did not survive long due to internal political conflicts, and the program “*Rural Doctor*” was never elaborated on or implemented.

Recently, the MoH developed targeted programs in the areas of HIV/AIDS, reproductive health, infectious diseases, and diabetes.² These programs do not consider specific needs of rural residents who live with these chronic conditions or struggle with cancer or HIV/AIDS. Rural populations in general are among the most vulnerable social groups in Ukraine (Skryzhevskya and Karasconyj, 2012; Lekhan, Rudyi, and Richardson, 2010) in terms of accessing health care and socioeconomic resources. This means that rural populations living with chronic conditions discussed in the programs named above may have a higher need in pharmaceuticals and specialized care than urban populations living with the same illnesses. Finally, the MoH cited only general documents as the foundation for providing health care in rural areas in their correspondence with the author (13.09.2012, letter # 3.09-17/1157/11932). Overall, from the analysis of the information and documents available through the MoH website, it appears that the health and health care needs of the rural population are largely absent.

1.3. Pilot Health Care Reform in Ukraine

In July 2011 the government of Ukraine formally initiated its first major health sector reform. The objective of the reform is to reorient the health care system from an inpatient/specialist model to a primary care-focused model. The ultimate goal of the reform is ambitious – to improve population health outcomes and to make health care services more accessible to the citizens. According to the MoH spokesperson, the pilot

² *The Concept of National Program to Combat Cancer for 2007-2016, The National Target Program “Diabetes” for 2009-2013, The National Program for Immunization and Protection of the Population against Infectious Diseases for 2007-2015, and the Program for preventing HIV and for treatment, support, and care of people with HIV/AIDS.* MoH, http://www.moz.gov.ua/ua/portal/ms_programs/ (Accessed November 30, 2010).

reform started “a deep transformation of the health care system” in Ukraine (Ministry of Health, 2014). The rationale for the reform is two-fold: to optimize the use of the inpatient sector in order to make it cost-effective and to improve the quality of health care services by strengthening the primary care component. The 2011 bill “On Changes to the Foundational Health Care Law of Ukraine Regarding Improvements in the Health Care Delivery” introduced the pilot reform, which is supposed to change the network of public health facilities according to the demand and needs of the population in a specific area, making health care more accessible, timely, of better quality, and cost-effective (Verkhovna Rada, 2011). The health care facilities will be improved by means of centralizing the network of hospitals and making the primary care facilities closer to the population.

In 2012 the first step of the health care reform was initiated in the four regions of the country: Vinnytsia, Dnipropetrovsk, Donetsk oblasts, and the capital Kyiv. The first step entails modernization and restructuring of the primary care and emergency services, which was piloted in these four regions (Ministry of Health, 2014). The primary care services have been neglected in Ukraine’s health care system, and for this reason the reform started with strengthening the first point of contact services (IER, 2013). The pilot reform is intended to address the following problems in the primary care services: insufficient funding, low prestige of the GPs, low levels of early preventive services, underutilization of the GP services and high levels of referrals to specialists (Ibid.). The new model of the health care system will be based upon the principles of family medicine, which is supposed to resolve these problems in primary care. The rationale for adopting the institute of family medicine is that FDs offer continuous care, are familiar with the lifestyle of their patients, and bear responsibility for their treatment. Before the reform, GPs were not responsible for the process of treatment of their patients. Also, the pilot reform allowed individuals to choose their FD, which was not the case with GPs who served population based on the territory attached to their clinic. It is believed that FDs will be better suited than current GPs for improving health outcomes among their clients, conducting more preventive work and reducing specialist referral and hospitalization rates. Importantly, this reorientation from the specialist-focused to primary care model, as a result of the pilot reform, is called to achieve better health and equity in the health care system (Starfield 2009).

Because the pilot reform is supposed to strengthen the primary care component of the health care system, primary care in rural Ukraine will be the focus of this research project, although at times references will be made to broader issues of primary health care. The pilot reform legislation in Ukraine does not clearly distinguish between the two – the primary care and primary health care – so it is important to make this distinction here to clarify the focus of this research project. Primary care usually describes those services delivered to individuals that are best described as the first point of contact in the system, most often with a family physician. Primary health care is a broader term that includes public health, mental health and dental services, which often can be community-based (Muldoon et al. 2006). Barbara Starfield further details that the essential features of the primary care services are: first point of contact and continuity of services, person-oriented instead of the disease-oriented approach in care, and finally coordination of care when a condition is too uncommon or too complex to be treated in a primary care setting (Starfield 2009). According to these definitions, my research project is mostly concerned with improving primary care access in rural settings.

The pilot reform includes the following specific mechanisms: increasing the number of FDs, of which Ukraine has a shortage, clearly delineating levels of care and separating the budget sources for primary and specialized care. The delineation of the primary and secondary levels of care is accomplished through restructuring polyclinics (health facilities that are staffed with both GPs and specialists) into primary care centres and attaching specialists to nearest hospitals. The budgetary delineation of the levels of care entails financing primary care through local (city or town) budgets and secondary level of care – through larger regional budgets.

Initially, the evaluation of these pilot projects was expected to be completed in 2013, followed by a system wide national reform in 2014. However, to date the MoH has not released any systematic evaluations of the pilot initiatives. The mass media questions the results and the goals of the pilot reform, as do the citizens of the pilot regions (Eriomina, 2012; Rakurs.ua, 2013; Virtosu, 2012). Among other criticisms, people protest the closing down of small rural hospitals. People living in such communities believe that this move infringes on their proper and timely health care since public transportation to alternative health centres is both infrequent and expensive. In

response to this criticism, on May 17, 2013 the Parliament of Ukraine voted to put a moratorium on the reorganization of the health care institutions.

Domestic expert opinions are divided in their evaluations of the pilot reform. Some say that its direction is modern and that the centralization of hospitals will lead to the better quality of care and financial efficiency in the health care sector (Kizilov et al., 2013). Researchers from Kharkiv emphasize that rural hospitals in Ukraine spend only a minor portion of their budgets directly on patient care, due to inefficiencies of running a small rural hospital. The details of their 2009 estimates are below:

Table 1.1. Costs break-down in rural and regional hospitals in Ukraine in 2009.

Indicators	Rural hospital	Regional hospital
Percentage spent on maintenance of the hospital	93.9	63.1
Percentage spent on providing inpatient care	6.1	36.9
Annual amount spent on one patient, UAH	2048	2494

Note. Adapted from Kizilov et al., 2013, p. 308.

These researchers highlight that it is impossible to provide the same quality of care in rural hospitals as in facilities located in urban centres. Though many rural hospitals have been downsized already, there is still a significant cost for maintaining their infrastructure and paying the personnel without real benefit to the residents of the village due to the low level of care they can receive in such facilities (Kizilov et al. 2013).

Still others point to the fact that reduction in the numbers of health care institutions is unconstitutional because according to Article 49 of the Constitution of Ukraine (1996) “State and communal health protection institutions provide medical care free of charge; the existing network of such institutions shall not be reduced” (Constitution of Ukraine, 1996). Others name the Constitutional provisions about free healthcare as limiting health reform and as hurdles that need to be overcome on the way to modernize the health care system (Tarantino et al. 2011, 17, 23). Another criticism is that the pilot reform was introduced hastily, without harmonization with other legislation and consideration of regional differences (Rokhansky et al. 2012). It is also generally understood that the Ukrainian public has not been adequately consulted or informed about the purpose and value of such reform initiatives, which somewhat undermines the legitimacy of these policy initiatives (Hankivsky, Salnykova and Vorobyova 2012).

A US-led Health System Assessment (HSA) team concluded that the pilot health reform “reflects international best practices and lessons learned from the region”, meaning other post-Soviet states (Tarantino et al. 2011, 24). Central European countries, which started transition with similar health indicators to Ukraine, have now come closer to the EU countries in terms of population health status (Healey, Pugach and Disney 2010). The reforms undertaken in those countries targeted the overcapacity and low quality care of the Semashko system of the end of 1980s by providing incentives for the care providers to deliver cost-effective and higher quality care (World Bank 2009, 52). At the same time, the HSA researchers emphasize the political risk associated with the pilot reform in Ukraine since its effective implementation will take years but citizens are very sensitive to changes in the way their health care is delivered (Tarantino et al. 2011, 23).

In the absence of the pilot reform evaluations from the government, some NGOs have undertaken informal reviews of the results of the new initiatives in health care, and collected evaluations of these experiments from consumers and physicians in the pilot regions. For example, the report published recently by the Renaissance Foundation in Ukraine revealed that people are dissatisfied with the following aspects of the reform: centralization of clinics, closures of small rural hospitals, the institute of FD, and the breakdown of pediatric care and clinics (Rokhansky et al. 2012). The publication argues that centralization of health services violates people’s rights to timely care and describes stories of numerous individuals in rural locations who could not access the care they needed because the health facility in their village was shut down. Importantly, these sentiments are similar to the opinions shared by the participants of a nationally representative study that took place at the very beginning of the reform (Hankivsky, Salnykova and Vorobyova 2012). The negative feelings people have about the cost-effectiveness as one of the goals of this reform fit well in the context of system-wide corruption and declining quality of life enjoyed by Ukrainians.

Finally, the pilot reform does not consider the cost and quality of prescription drugs and how it affects the residents of Ukraine. Pharmaceuticals constitute a large portion of out-of-pocket payments in Ukraine and the pharmacare subsidies are limited to certain groups of populations: people living with CVD, diabetes, HIV/AIDS, and those affected by the Chernobyl nuclear disaster (Lekhan, Rudy and Richardson 2010). At the

same time, consumers complain of the high cost and low quality of prescription drugs, and corruption schemes existing between the pharmacies and doctors to prescribe a more expensive kind of a drug (Hankivsky, Salnykova and Vorobyova 2012).

1.4. Health Status and Health Care Challenges in Rural Ukraine

1.4.1. Rural Health and Socioeconomic Conditions

Thirty three percent of Ukraine's population reside in villages. This number has been steadily declining since late 1970s, reaching dramatic drawdown rates by the 1990s (State Statistics Committee of Ukraine 2011). Recently, rural population birth rate per 1000 persons dropped down from 13,7 to 9,4 persons, death rate rose from 14,4 to 20,5 persons and exceeded the urban population death rate in 1,4 times (Cabinet of Ministers of Ukraine, 2007, Resolution # 1158). Ukrainian scholars describe the rural situation as a demographic crisis, characterized by worsening health condition, decreased level of education, aging, outmigration, depopulation, low fertility rates, and lowered life expectancy (Libanova et al. 2007). These indicators are worse for rural dwellers in Ukraine compared to both urban Ukrainians and rural dwellers of other European countries. For example, in 2007 the average life expectancy constituted 67.2 years for a rural and 68.1 – for an urban Ukrainian (Skryzhevskya and Karacsonyi 2012, 52). The total loss of rural population between 1989 and 2006 in Ukraine was 2.2 million people – the highest among the Central European countries (Ibid.).

Unfortunately, the detailed data on the health status of Ukrainian rural residents is limited. The MoH does not currently analyze health issues of the rural population, and even the pilot health care reform does not address the issue of collecting systematic data on rural health and health care access. In 2009 the MoH approved 15 priority directions for research and development of the health system. One of them was “refining the organization of medical services in rural communities”. The Ukrainian Institute for Strategic Research was assigned to study the prioritized areas of health care under the guidance of the MoH, but financing for this research project was not provided (Lekhan, Rudy and Richardson 2010: 76-77). The State Statistics Committee of Ukraine gathers

data on the health status of Ukrainians disaggregated, among other identifiers, by the place of residence – urban or rural. Unfortunately, this data is not easily accessible online through the State Statistics Committee. As a result, the data on health and health care access in rural Ukraine used in this project is dated and comes mostly from other publications, rather than the source of statistical information in Ukraine. Even other publications on rural Ukraine use data from early 2000s. For example, Skryzhevskya and Karasconyj (2012) cite that in 2001 the leading cause of death in rural areas that exceeds other causes by the order of ten or more is cardiovascular disease (CVD). Although more than ten years old, it is unlikely that this information has changed, given the CVD dynamics since 1970s (see below in Table 1.2.) and the data about CVD being the leading cause of mortality crisis in Ukraine overall (Menon 2010).

Table 1.2. Causes of Death in Rural Areas of Ukraine, 1970-2001

Indicators	1970	1980	1990	2001
Mortality by causes of death (per 10,000):				
Cardiovascular disease	564.4	907.6	834.7	1,088.3
Cancer	114.8	139.7	207.4	197.6
Accidents and poisoning	84.2	121.7	126.4	157.4
Respiratory disease	184.0	163.5	127.4	109.2
Digestive system disease	22.6	28.0	32.7	39.0
Infectious disease	29.8	18.6	14.4	24.2
Other causes	41.5	38.9	267.3	247.2

Note. State Statistics Committee of Ukraine 2007.

To paint a fuller picture of health issues surrounding rural population in Ukraine, I discuss findings of the CIHR-funded community consultations from rural locations of Pryvovchanske, Okhrimivka, Busha, Korolivka, and Andrushivka. Two of these villages – Pryvovchanske and Busha – are located in the pilot reform regions – Dnipropetrovsk and Vinnytsia oblasts respectively. I present themes that emerged from the data analysis throughout this and the following sections, as many of them relate to various aspects of rural health and health care. The details about the schedule, recruitment methodology, and data analysis of the community consultations can be found in the Appendix (B).

When asked about major health issues in their communities, consultation participants living in urban and rural locations cited similar problems, such as: cardiovascular and muscular-skeletal diseases, cancer, stress, and overall tiredness. While the health problems seem to be the same, the differences in health status were

often discussed as a result of unequal access to preventive treatments in cities and villages. Regarding the social determinants of health of people living in rural Ukraine, the opinions were divided. Some people were adamant about higher vulnerability of the villagers who work as sustenance farmer, which means no paid sick days and zero social welfare available. Many talked about hard manual labour and how it takes toll on rural population. Residents of the Southern regions complained about greenhouses, and how people working there exhibit higher rates of respiratory diseases and cancer due to working with pesticides in an enclosed space. At the same time, some optimism was shared about how village life makes people stronger and more enduring, less stressed and provides opportunities to consume more natural produce and dairy products than urban dwellers who rely mostly on supermarkets in their shopping. On the other hand, in some rural locations the factor of a better environment with less pollution in villages was discussed as a myth. One participant from the village of Busha shared:

Another problem is that we are located in the valley and all the fields are on top, so their pesticides are flowing down to us. And the water in our village is undrinkable. We have lots of complaints about digestive problems. There are a lot of chemicals that farming uses in the field and then it all goes into our rivers and then into our food.

One of the major themes about health and health care experiences in Ukraine was around stark differences between rural and urban areas. Participants in the villages talked about harsh socio-economic conditions in the countryside and difficult manual labour. One village resident said the following:

And what about how difficult this physical work of a farmer is... Especially for a woman... Working in the field, growing melons and tending cows, it is impossible to feel like a woman when you work like this and get very little money for it. You feel like cattle. From early morning to late night. We are only dreaming about having a shower and crashing to sleep.

When people discussed unemployment and dilapidated infrastructure, they often compared it to the Soviet times that provided rural areas with employment and many public services through collective farming. Different participants shared:

We used to have work and a salary, and now we don't and we are poor.

I remember this village 20 years ago and there was a hospital and doctors, I do not want to say that the Soviet time was better than the independent Ukraine but there is no infrastructure now.

Economic and moral situation in the village affects our health. Infrastructure was here but it was all destroyed, nobody wants to do anything. Money is coming from the district but it goes nowhere.

The stories people told at consultations are consistent with the Skryzhevskya and Karacsonyi (2012) study that provides an in-depth description of the worsening condition of the Ukrainian villages and calls for immediate government action. The scholars concluded that what makes the situation for the Ukrainian rural population markedly different from other countries with declining rural population is the deteriorating quality of life due to depopulation, low life expectancy, unemployment, alcohol addiction, and lower opportunities for development (Skryzhevskya and Karacsonyi 2012, 49).

Rural areas rely heavily on agriculture, which has been in a depressed condition since the 1980s. Agricultural workers earn wages that are much lower than the national average or lose their paid employment altogether. For instance, during 2001-2008 in the Odesa region the number of agricultural workers decreased by 72 percent (State Statistics Committee of Ukraine, 2007). And these jobs have not been replaced by employment in other sectors. High unemployment rates in villages are causing massive out-migration of younger and middle age individuals to urban areas and abroad. This results in a break-up of family structures, with the proportion of single-parent households and lonely seniors growing rapidly.

Another alarming trend is that, if in urban areas the level of population living in poverty decreased during 1999-2006, the rural levels of poverty remained higher than in urban areas (Skryzhevskya and Karacsonyi 2012, 74). In 2008, 17.7% of the population in Ukraine earned less than the subsistence minimum of 607 UAH (75 USD) – 27.2% in rural and 13% in urban areas (Lekhan, Rudi and Richardson 2010, 5). The structure of the monthly household income differs for rural and urban dwellers as well. Only one third of rural household income comes from salaries, the rest – is either a state retirement payment or the income received from sold produce, dairy and poultry. In urban households 50 percent of income comes from salaries, which makes urban residents less vulnerable economically (Skryzhevskya and Karacsonyi 2012, 73).

With the period of economic stabilization in the early 2000s and financial support for new parents initiated in 2004, some rural regions – exclusively in Western Ukraine – have experienced population growth (Skryzhevskaya and Karacsonyi 2012, 64). Although positive, this trend also means that a growing number of children in villages have no access to pediatric care – sometimes the children are 7 and even older when they see a pediatrician for the first time (Lekhan, Richardson and Rudy 2010, 123). Also, many families with young children experience a family break-up due to unemployment and one of the parents leaving elsewhere to find work, which is especially characteristic of the rural areas in Western Ukraine.

Finally, the overall quality of life in rural areas is much lower than in urban areas because of the rundown condition of the social infrastructure in villages. According to the Institute of Rural Development, in 2006 71 percent of villages did not have preschools, 41 percent had no places for cultural or leisure activities and 98 percent – no hospitals (Ostashko 2006). One of the participants from Korolivka in the capital region shared:

our community centre is always closed and in the winter time there is no coal for warming it up so I don't even remember the last time we had some cultural evenings there. And since the bars and stores are warm, the young people hang out there...

It is important to note that the concentration of rural population in Ukraine is not homogenous: the rural population is concentrated in the South and North-West, while the Eastern and Central parts of Ukraine are largely urbanized. The Western regions of Ukraine have a much higher proportion of rural administrative units than the Eastern and Southern regions (Skryzhevskaya and Karacsonyi 2012, 64). Traditional lifestyle, with such indicators as: higher birth rates, lower divorce rates, and more people practicing religion has been always a strong feature of Western Ukraine (Libanova et al. 2009). Some attribute traditional values in the West to the high concentration of rural and ethnically diverse settlements that place more importance on family as a social institution (Skryzhevskaya and Karacsonyi 2012, 64). Another reason for a higher value of the traditional culture among Ukrainians in the West could be a shorter period lived under

and a higher resistance towards the Soviet ideology in Western Ukraine.³ These differences in the distribution of the rural population across Ukraine, as well as demographic peculiarities of villages in various regions (e.g., higher level of population ageing in the North, higher birth rates in the West, Odessa and Crimea regions) require a differentiated policy response from the government of Ukraine in improving rural health care services.

1.4.2. Access to Rural Health Care

The main primary health care (PHC) provider in rural areas is the physician ambulatory, which is a small facility with 2 to 6 rooms (Cammarano 2009, 4). These are basic facilities, providing general care for adults and children, chronic disease care, treatment of some infectious diseases, rehabilitation, completion of treatments, and simple obstetric care. Rural outpatient clinics are located in the administrative and/or economic centre of the catchment area. In 2000, the PHC network in rural areas comprised about 3,800 rural physician catchment areas. There is a plan currently underway in the MoH to restructure the catchment areas in order to bring primary care closer to the rural population. However, there is no further information regarding the criteria to be considered by MoH when redesigning these catchment areas. Smaller and more remote rural settlements are served by feldsher-midwife posts (FAP), where a feldsher is a mid-level medical professional, who can provide first aid, limited curative and prescriptive services, as well as ante- and postnatal care. According to the WHO classification of health professionals, feldshers are equivalent to physician assistants (PA) in the US and comparable to nurse practitioners (NP) in Canada (WHO, 2010b). There are more than 15,000 FAPs that provide first aid in such rural areas (Lekhan, Rudyi and Richardson 2010, 81). Rural areas have only 15% of pharmacies (Ibid., 92), which means that about half of rural dwellers do not have access to a pharmacy in their village since rural residents constitute 33% of the total population in Ukraine.

³ The Eastern regions of Ukraine became a part of the USSR in 1924, whereas the Western regions of Ukraine, which were a part of Poland, were occupied by the Soviet troops at the end of the World War II. Ukrainian Resistance Armies were active in the West until late 1950s.

With an average rural density of 30 ppl/sq. km. (Cammarano 2009) Ukraine is among the least densely populated countries in Europe, compared to the average European Union population density of 117 ppl/sq. km. (European Commission Eurostat, 2012). Additionally, Ukrainian rural roads are of terrible condition and public transportation is infrequent and unreliable (Cammarano 2009). Distance to the nearest acute care facility ranges from 10 to 60 km for most rural populations (Ibid., 18-19) and 30 to 70 km for those living in more remote areas (Lekhan, Rudy and Richardson 2010, 123). Since few Ukrainians living in rural areas own a car and a large number of rural health facilities do not own a running ambulance the problem of access to emergency care is critical. Access to primary care facilities is also unsatisfactory. Due to economic crisis and negative population growth, in 1997-98 the hospital beds in Ukraine were cut by one-third, mostly in rural areas (Lekhan, Rudy and Richardson 2010, 80). With the introduction of family medicine in 2000 more than half of the rural clinics and FAPs were reorganized into primary care outpatient clinics (Ibid., 82). This can be interpreted as a positive trend to optimize the use of the inpatient sector and to provide infrastructure for the newly introduced family medicine. However, both of these reforms were highly unpopular. There was a lack of planning and analysis on the part of the government, rural hospitals were closed and reorganized haphazardly, without prior assessment of quality of care provided or impact on the community in terms of alternative care available. In a number of cases, the closure of these facilities was dictated not so much by expediency as by the limited resistance to their closure (Ibid., 167).

As a result of these poorly planned centralization efforts, rural health facilities became less accessible. In 2010 the WHO recommended that the government of Ukraine further centralize health facilities, and the pilot reform was launched as a result. In total, from 1991, the number of inpatient facilities fell by 27.8%. However, the network of small rural hospitals shrank by 60%, while the number of secondary care hospitals in towns decreased much less (by 20%), and the number of tertiary care level facilities remained unchanged (Lekhan, Rudy and Richardson 2010, 167). In 2006, of the total number of beds under the scope of the MoH, 7.9% are in tertiary care facilities (regional hospitals for adults and children), 55.3% in multi-profile secondary care hospitals, 31.2% in specialized secondary and tertiary care facilities (specialized clinics, psychiatric and addiction clinics, etc.) and only 5.5% in rural hospitals (Ibid.). The number of rural clinics

has been further decreasing and in 2008, they accounted for only 2.1% of beds (Ibid., 126), which indicates that rural residents in Ukraine are underserved by hospital facilities.

At the community consultations, the problem of health care access in rural areas was often discussed as the main difference between rural and urban areas and as one of the most challenging barriers to receiving appropriate and timely care. Many participants shared that even basic medical services are often not accessible for residents of rural areas, either due to the lack of a nearby health facility or because of the transportation barriers. Public transportation between a village and the nearest health facility is not only costly, but also infrequent and unreliable. In Pryvovchans'ke, due to the pilot hospital reorganization, residents complained that they had to go to a larger village to see their FD and to get a referral to a specialist, who is stationed in a town in the opposite direction. On a positive note, the Pryvovchans'ke residents had seen a significant improvement in the ambulance services since the reform had started. People from other villages shared that they cannot rely on ambulance services because the village either does not have a running ambulance car or does not dedicate money for the gas. One participant from a village that is 25 km away from the nearest hospital said:

My grandchild had a strep throat—a really bad one—and then one day he couldn't open his mouth anymore. So I sent him to the doctor. They gave me the ambulance car, but I had to pay for the gas and for the doctor's visit, and for the medication, and the following day we had to go into town again for a follow-up. So all my pension went towards these 2 days, and it's good that I had this money because my grandchild is alive.

Another problem is rural roads, which are unpaved and not serviced by snow plows, so that even if there is a running and fueled ambulance car in the village, there is still a problem of access. As one participant described:

I think the main barrier is our roads—they're terrible. In the wintertime it is almost impossible to drive a car. So even though we have our own ambulance that belongs to the medical centre, sometimes it takes them so long to come. Otherwise they're always there in five minutes.

The problem of inequitable access to health facilities as a result of geographic location also surfaced in the Health in the Times of Transition survey of the residents of

Ukraine (Kizilov et al. 2013, 315). Rural residents had to travel longer than urban residents to receive medical help (Table 1.3):

Table 1.3. Times Required for Travelling to the Nearest Health Facility by Place of Residence in Ukraine, 2010.

	Care provided at home	15-minute trip	16- to 30-minute trip	Over a 30-minute trip
Cities	13%	29%	28%	30%
Small towns	10%	25%	30%	35%
Villages	12%	20%	30%	38%

Note. Kizilov et al., 2013, p.316.

In addition to geographic barriers in accessing health care in rural areas, financial burden of out-of-pocket payments for medical services deters economically vulnerable groups from accessing care (*Table 1.4*). Vulnerable groups include elderly people who rely on their state pensions as their main source of income and people with low educational attainment as they find it hard to find well-paid employment (Skryzhevskaya and Karaschonyj 2012, 61; Lekhan, Rudyi and Richardson 2010, 164). Since rural residents have very high unemployment rates and are low-wage earners, they tend to delay seeking medical care at higher levels than urban residents.

Research also shows that in the poorer – mostly rural – regions in Western Ukraine financial access to health services is lower than in the wealthier regions in Eastern and Central Ukraine (Lekhan & Shishkin, 2007). Overall, the number of outpatient visits in rural areas remains significantly lower than in urban areas and the majority of them (61%) are visits to mid-level medical specialists (Lekhan, Rudyi and Richardson 2010, 124).

Table 1.4. Frequency of Delaying Seeking, Utilizing and Being Refused Health Care, 2006.

Frequencies	Monthly household income level		Place of residence	
	Low	High	Low	High
Delaying seeking health care due to the inability to pay for services	16.8	6.7	17.3	8.9
Utilizing health care	68.2	84.7	70.3	81.4
Being refused health care	19.6	10.0	-	-

Note. Data in %; adapted from Lekhan, Rudyi, & Richardson, 2010, p. 164.

Comparing challenges associated with accessing health care by rural populations in Ukraine with some other countries, it is troubling that financial barriers are very pronounced in Ukraine. For instance, the National Strategic Framework for Rural and Remote Health discusses travel times, scarcity of medical personnel and longer waiting times as the main barriers in accessing health care by rural population in Australia (National Strategic Framework for Rural and Remote Health 2012, 9). The document does not mention the inability to pay for services as a barrier when seeking and receiving medical care. Similarly, for the First Nations, who reside in rural and remote regions of Canada, inability to afford health care is not named as a barrier among the multiple challenges they experience (First Nations Health Council, 2011). Even compared with countries in similar economic situations, Ukraine exhibits less favourable outcomes in terms of health care access for its rural populations. A study on health care access in rural Russia found that income was not a determinant of people seeking and receiving primary care, and only became a barrier once a rural resident needed to access more specialized care (Lohlein, Jutting, & Wehrheim, 2003). The financial barrier, and its magnitude in rural areas, therefore seems to be a uniquely Ukrainian phenomenon.

1.4.3. Quality of Rural Health Care

The issue of rural health care quality can be divided into challenges with the capital stock of rural health facilities, alarming shortages of health professionals, and inconsistency in the quality of services provided.

The State Sanitary-Epidemiological Service of Ukraine found that in 2007 only 29.6% of health facilities were on water mains and only 21.1% had mains sewerage. Such unsatisfactory sanitary conditions are found most often in rural areas (Lekhan, Rudy and Richardson 2010, xviii). Many medical facilities in rural areas face severe structural problems: dilapidated buildings, outdated and broken equipment (Ibid., 73). Based on the survey of primary care facilities and units conducted by the MoH in 2007 (Order No. 237, issued 11 May 2007), major repairs are required by 19.5% of rural clinics, and 16.4% of FAPs; 1% and 2% respectively are in a critical condition. More than two-thirds of the rural health structures have been used for over 25 years, and 20% have

been used for over 50 years (Ibid., 84). Similarly, the quality of equipment in rural clinics is very outdated (Cammarano 2009).

The existence of a rural health facility, even in poor condition, is not a guarantee of acting medical services in the village. The key medical staff shortages in Ukraine are in rural areas and in primary care, which has a high turnover (Lekhan, Rudiya and Richardson 2010, xviii). For instance, in 2006 every post was vacant in 273 rural outpatient clinics and in 386 FAPs (Ibid., 98). The government attempted to change this situation, by offering 500 fee-paying students the possibility of switching to government-financed education in 2008/2009, on condition that they will fill posts in the most wanted specialties, primarily in rural areas (Ibid., 104). However, this did not produce the desired results, and many rural clinics are still either understaffed or do not have any health professionals (Ibid., 104). One of the reasons for this shortage of doctors in rural areas is that number of patients for a rural physician is in reality higher than the national average. The number of doctors serving more than 2500 patients in rural areas is almost ten percent higher (29.1%) than in cities (20.4%). These limits are significantly exceeding the legislated norm of up to a 1,200 patients in rural and up to 1,600 in urban areas (Lekhan, Rudiya and Richardson 2010, 123). Other important reasons that prevent new medical school graduates from working in villages are more obvious ones: the absence of public infrastructure, insufficient financial incentives, and unsatisfactory condition of medical facilities. In recent years, increasing numbers of graduating doctors prefer employment as pharmacist or medical representatives of pharmaceutical companies, which offer a much higher remuneration than medical practice (Lekhan, Rudiya and Richardson 2010). Even those doctors who practice are connected to pharmaceutical companies. Community consultation participants repeatedly complained that doctors often prescribe either certain brands of medication, which are more expensive than others, or refer them to a specific pharmacy, which supplies them with a commission payment (Hankivsky, Salnykova and Vorobyova 2012).

Cammarano (2009), in his qualitative study of rural health facilities in the Kharkiv region, found that the quality of services varies widely due to the personal factor of medical personnel. Cammarano reports that the American International Health Alliance (AIHA), in selecting a clinic for its pilot project on improving health care services in the Izyum district, has visited and interviewed doctors in eleven rural ambulatories and they

found that the medical workers in the clinic of Korobochkino were much more open and willing to participate in such a project. The AIHA project was to open a primary care clinic on the basis of a rural ambulatory which would provide a wider spectrum of services to the patients, including counselling and family planning. The Korobochkino clinic staff received training and newer equipment from AIHA, as well as implemented six clinical guidelines. After one year of the primary care clinic's operation the rate of referral to specialists decreased in Korobochkino from 60% to 25% of visits per month. The use of the guidelines improved the process of examinations, involved nurses more in the care of the patient and reduced treatment costs. The rates of hospitalizations decreased significantly (from 22.2 to 5.5 per thousand) in Korobochkino since the project's initiation (Cammarano 2009, 14). In his own work, Cammarano interviewed staff and visited eleven rural clinics in the Izyum district and concluded that the only difference between the clinic in Korobochkino and other villages was enthusiasm and motivation of its staff.

Similarly, community consultations revealed that in villages enthusiastic medical workers are central to population's satisfaction with healthcare services and even to their willingness to turn for help to the local clinic (Hankivsky, Salnykova and Vorobyova 2012). In urban health facilities residents have more options when seeking care, between different doctors and even clinics, including private health care facilities. However, in rural areas there is no choice of a primary healthcare provider. As one consultation participant in Okhrimivka said: *"In the city they can choose between doctors. Here we don't have any options"*. In some villages medical workers are highly praised and trusted by the residents. In other places – the doctor has a reputation of "the last resort only" and people avoid receiving care from such an individual, even though it may be their only option. In one village a participant shared:

The doctor that we do have now—she wouldn't even touch a sick person. I saw it myself. I don't know if it's her personality or what, but we do not trust her. And the person who used to work in the hospital is now in our pharmacy, and we still go to ask her questions about how to treat ourselves and our kids. Nobody goes to the clinic, because it is scary to go there.

Ukraine is different from Romania, Australia or Canada, where some rural populations avoid accessing health care due to ethnic or racial discrimination. For example, in Romania the Roma populations report limited access to health care due to

discrimination and their marginalised status in the country (Fota and Zahorka, n.d.). In Canada, 15% of respondents in the survey led by the National Aboriginal Health Organization reported receiving unfair or inappropriate health services because they were Aboriginal (National Aboriginal Health Organization, 2003). Although there is no evidence of ethnic discrimination when accessing health care in rural Ukraine, village residents there experience discrimination along the lines of age, as was mentioned repeatedly by the consultation participants. For instance, when talking about ambulance services, one participant shared:

Another thing is, if you phone for the ambulance to Yakimivka [town with the nearest hospital], they ask how old you are. If you're 70 or older, they won't come for you.

Ageism in rural health care becomes especially troubling when one considers that Ukraine has a very high level of elderly population in rural areas – 24 percent nationally and up to 38 percent in Northern rural areas. The level of population aging is significantly lower in urban areas – 18.5 percent nationally (Skryzhevskya and Karasconyj 2012, 62). Retirement payments in the villages tend to be smaller than in the cities because their amount depends on the type of job held in the past (skilled/unskilled), which means that the majority of retired village dwellers, who worked at collective farms, receive a monthly payment of about 800 UAH (100 USD). Thus, a significant proportion of rural residents, who are elderly, experience both discrimination on the basis of age and financial barriers when accessing the care they need.

Chapter 2.

Methodology

This qualitative study uses both primary and secondary data, gathered in Ukraine from the general public and health care professionals in 2012 and 2013. The secondary data comes from the community consultations conducted in 2012 in Ukraine and funded by the Canadian Institutes of Health Research (PI – Dr. Olena Hankivsky). Specifically, the project focuses on five rural consultations to present information about health and health care concerns of village dwellers. The analysis of this data was presented in the background sections on rural health and health care problems in Ukraine and is also used for developing policy options and recommendation in the later sections.

The primary data was collected in Ukraine by the author in the summer of 2013. In total, fourteen interviews were conducted: two online, two in-person, and ten over the phone. The author developed a schedule for structured interviews, which were conducted in three areas of Ukraine: two in the pilot regions of Vinnytsia and Dnipropetrovsk and one in the non-pilot region of Zaporizhzhia (Figure 2). The participants were mostly from rural areas: the village of Okhrimivka in Zaporizhzhia, the Pavlohrad district of Dnipropetrovsk and the Jampil district of Vinnytsia oblasts.

The main reason these pilot regions were selected is their difference in terms of geography (Vinnytsia is in the West and Dnipropetrovsk is in the East of Ukraine), the level of economic development (Vinnytsia is less developed than Dnipropetrovsk) and the urban-rural population structure (the Vinnytsia region is more rural than the Dnipropetrovsk region). The other two pilot regions – Donetsk oblast and the municipality of Kyiv – were not useful for this project because of its focus on rural healthcare. More specifically, Donetsk is the most urbanized region in Ukraine while Kyiv is the capital of Ukraine. Since the author was stationed in a rural area of Zaporizhzhia

oblast (non-pilot region) for the duration of the field work, four interviews were conducted in this region to supplement the findings from the two pilot regions.

The initial idea was to interview an approximately equal number of participants from the two pilot regions to compare if the opinions about the pilot reform are different in a more rural Vinnytsia oblast from Dnipropetrovsk oblast. However, recruitment in the Dnipropetrovsk region was much more difficult than in the Vinnytsia region for no obvious reason. There were seven participants from the Vinnytsia region and only three from the Dnipropetrovsk, two of which were online interviews that have not provided much in-depth information. Therefore, the idea of a comparative analysis of the pilot reform evaluations was not fulfilled. Nevertheless, the data from the interviews in the pilot regions provides insightful perspectives of the professionals working with the implementation of the reform. Their feedback was essential for the policy analysis section.

Interviews were chosen instead of a survey for a number of reasons. First of all, community consultations revealed that the public in Ukraine has not been consulted about the pilot reform. In this way, qualitative methodology was able to fill this gap and provide rich descriptive data about how health care providers evaluate the intermediate results of the pilot reform. In addition, qualitative data increases the breadth of data and thus improves the quality of evidence in policy-making (Sutcliffe and Courte 2005). Finally, because of the limited time the author was able to spend in Ukraine and difficulties with recruiting from abroad, interviews were chosen as a more feasible methodology than a survey.

I interviewed a variety of individuals, whose opinions on the pilot reform would be pertinent to this study: eleven health professionals, including five FDs, one rural pharmacist (trained also as a feldsher), one ambulance doctor and a nurse, as well as three MLAs – one each from regional, district and village councils. It should be noted that the authorities interviewed for the study were members of the local representative bodies, and thus the study lacks the perspective of the executive branch of power – both the MoH and the regional health authorities. Their position and especially their feedback on the policy options would have provided for a more realistic evaluation and recommendation in the study. However, there was no response from the initial contacts

in the MoH, and the limited timeframe of the project, including the political crisis in Ukraine which began in the late fall of 2013, did not afford any further connections with the public servants. I did not interview consumers because I had a similar data already from the community consultations, which provided the opinion of regular citizens on the pilot reform. Also, the interviews were important for learning about the implementation details of the reform, and it was unlikely that consumers could provide me with this type of information.

The data collected was coded manually and was analyzed using thematic analysis methodology of Braun and Clarke (2006). Both the coding and analysis process is discussed in more detail in the next chapter.

2.1. Phone Interviews

The main reason I conducted the majority of the interviews on the phone was time and geographic constraint. Because I based in the Zaporizhzhia region of Ukraine, it would have challenging in terms of time and to arrange for accommodation and travel to both Dnipropetrovsk and Vinnytsia regions to interview participants in person. The practicality of telephone interviews in such instances has been long established in the literature (Oppenheim 1992; Barriball et al. 1996), which confirmed my decision to conduct telephone instead of face-to-face interviews.

The literature on the use of telephone interviews is extensive, and studies that used this method of data collection cover a wide range of health-related topics from postoperative experiences of pain to referral behaviours of GPs in rural Scotland (Harris et al. 1993). Most of the studies agree that the quality of data collected through this medium is not inferior to face-to-face interviews (Carr and Worth 2001). Some of the advantages of the telephone interviews are: silence is rare on the phone, both parties are required to actively participate, people are compelled to answer a ringing phone and are more reluctant to just hang up (Frey 1983). Also, socially desirable responses are less common on the phone, and the interviewer effect is less significant (Robson 1993). In my experience, the latter two advantages were especially beneficial for this project in terms of data validity. Telephone interviews allowed for more anonymity to those

participants, who would otherwise be more reluctant to speak about the sensitive issue of the pilot reform. At the same time, telephone as a medium was advantageous for me because of my age.. The culture of inter-generational subordination is still present in Ukraine, which means that a younger person does not have the same privileges when interacting with an older person. Additional details about the validity of the data and intercultural communication during my field work can be found in the reflexivity analysis in the Appendix C.

While both structured and unstructured schedules are acceptable for telephone interviews (Carr and Worth 2001), I decided against a semi-structured version due to the technical nature of the topic and my lack of experience with telephone interviews. Some of the interview questions were not as much about the participant's opinion of the pilot reform, but rather about the details of how it is working on the ground. I needed this kind of information for the study because the official and media sources about the pilot reform were scarce and one-sided in their evaluation. Therefore, my goal for these interviews was to gather information about the current results of the pilot initiative. I judged that a structured interview agenda would allow me to collect more concrete details about the pilot reform than an unstructured schedule, as some studies suggest that telephone interviews produce more focused responses (Frey 1983, Lavracas 1987). The duration of the interviews was another concern due to the summer vacation time and my limited budget for cell phone charges. Because of these reasons, a structured interview schedule planned for thirty minutes seemed as a better alternative. This duration has been suggested as a maximum time for telephone interviews (Lavracas 1987). At the same time, some of the telephone interviews changed into unstructured and lasted much longer than half an hour because certain participants were more willing to discuss the issue in depth and had much information to share because of their work positions. One of such participants was an MLA from Vinnytsia, a doctor by training and a counsellor in the regional health authority. Another participant was a head doctor/manager in the newly created Centre of Primary Medical Sanitary Help in one of the rural districts of the Dnipropetrovsk region. It was important to readjust my structured agenda with these participants and to find follow up questions as these interviews revealed unanticipated layers of information.

Interview questions were designed slightly differently for the pilot and non-pilot regions, to reflect various levels of familiarity with the pilot health initiative. Specifically, since health professionals in the pilot regions have been working under the new conditions since April 2012, I asked them to evaluate the results of the pilot initiative. The purpose of interviewing in pilot and non-pilot regions enabled useful comparisons between the regions. Participants from Vinnytsia and Dnipropetrovsk evaluated the effectiveness of the reform in improving access to health care in rural areas based on their direct experience with the initiative, while informants from the Zaporizhzhia oblast shared their opinions about the reform that is soon to be implemented in their region and how they perceive its prospects in solving some problems of health care in rural Ukraine. Also, certain aspects of the pilot reform have been introduced in the non-pilot regions, such as changes in the ambulance services and capital improvements in the primary care sector. Both interview schedules can be found in the Appendix A.

2.2. Recruitment

The SFU Research Ethics Board gave approval for the interviews in the middle of June, which left two months for the recruitment process and conducting interviews. The timing for finding participants was not the most beneficial because of the summer vacation time. The process of recruitment in the pilot regions was aided by the two NGO activists, who have contacts with local authorities and extensive networks of clients, some of whom were health care professionals. I was able to provide a modest honorarium to one of the recruiters from the grant I received for this field work from the SFU Graduate Student Society. This funding also helped with the cost of interviewing participants over the phone.

Some of the interviewees in Dnipropetrovsk and Vinnytsia regions were recruited through the snowball method and were not from the initial participant list forwarded by the NGO recruiters. The snowball recruitment method allowed me to interview rural health care professionals, who were the crucial segment of the population for this study. In the Vinnytsia region I interviewed three local representatives, two doctors from the district level and two rural FDs. In the Dnipropetrovsk region I interviewed three rural

FDs. The participating health professionals from the rural areas of Vinnytsia asked me not to name the villages they worked in to avoid their identification.

Participants from the Zaporizhzhia region, where I was based during my field work in Ukraine, were recruited directly by me through personal networks and directly at the local rural clinic and pharmacy. Two of the interviews were face-to-face – one with the rural doctor and another one with the pharmacist who used to work at the rural clinic as a feldsher-midwife. The third interviewee was a doctor from the district ambulance and the last one – a head nurse from the regional hospital.

2.3. Rapport Building

Because I did not have any previous contact with the interviewees, establishing rapport was very important and at the same time challenging. There were two stages of creating a relationship with participants in this study – before the interview and at the initial point of contact between myself and the participant. First, to get people interested in participating I created a description of the research project, which also included my short bio and a consent form that the NGO recruiters sent out to their contacts. It was important to include the reasons I was interested in studying the pilot health care reform into this research advertisement to establish my legitimacy with the participants as a Ukrainian-Canadian scholar. Including some of the personal details, such as my parents living in a rural area in Ukraine, my previous involvement with community-based research in Ukraine was also significant. Some of the interviewees asked me further details about myself in the interviews. Still, a number of participants were reluctant to share information about the pilot reform, which demonstrates that this issue is politically sensitive. Several doctors told me they were afraid of being fired for criticising the reform. I was prepared for such reaction because media reports (Racurs.ua 2013; Virtosu 2012; Eriomina 2012) indicated that pilot reforms are very controversial in Ukraine. My NGO contacts warned me of this as well. Only after I have reiterated to the participants that I am a student from Canada and will not disclose their personal details in my research or anywhere else did they relax and agreed to share the information. These details shed light on how confidentiality is understood differently across cultures and depends on power structures in the country.

2.4. Data Limitations

One of the limitations of the data is that I was taking notes instead of recording the interviews. The most important reason for not using a recorder was to make interviewees more comfortable participating in a study on a topic that was so politically sensitive. Also, I had funding, technical and time limitations in completing this field work, which made it impossible to obtain software or a professional tool for recording specifically the telephone interviews. Since the majority of the participants and myself were located in rural areas of Ukraine with a limited Internet access, I could not use online services for recording purposes. Also, the quality of voice transmission when my cell phone was turned to a speaker phone regime was quite low, which made it impractical to record the interviews using a digital voice recorder. At the same time, I was prepared to take notes and developed a short-hand system for writing down the conversations almost word for word. The notes were transferred into a Word document within a short time period after each interview to maximize recollection. Previous experience with such note taking gave me confidence that I would capture the most important information. For example, during the community consultations conducted in Ukraine part of my responsibilities was to take notes of the discussions, in case our digital recorders were lost or broken. Once compared to the digital recordings, my notes proved very close to the recorded material.

While it is possible to question the validity of the data due to the interviews not being recorded, there is literature discussing the situations in which note taking is equally good and in some cases better than recording interviews. Thomas et al. (2001) mention that note taking works well in structured interviews, which is the case with the interview schedule I developed. Also, Weiss (1994) and Zinsser (1985) state that note-taking forces the researcher to concentrate more closely on what is being said and to be more present during the interview. Note-taking made the interviews I conducted more interactive because at times I asked the participant to pause or to repeat an important idea to make sure I wrote it down word for word. This added interaction was important in telephone interviews where you do not see the participant and are not able to reassure them that they have your full attention through your posture and eye contact. I also

asked permission from the participants to email them the transcripts of the interviews once I typed them up so that they could check and correct some of their responses.

Another limitation in the data collected is lower than anticipated numbers of rural doctors who participated in the study. In total, I conducted seven out of fourteen interviews with rural health professionals, however, two of them were online interviews, which produced less in-depth material than telephone or in-person interviews. Also, two of the remaining five interviews with rural doctors were conducted in the non-pilot region, leaving only three interviews conducted with rural doctors – one from Dnipropetrovsk and two – from Vinnytsia oblasts. One of the main reasons for such a low response rate from rural professionals was their anxiety about losing their jobs if they participate in a study on the pilot reform. Several rural doctors I contacted declined the opportunity to share their views because of this factor. Another major reason was that the NGO recruiters provided me with the contacts from their client networks, which were mostly doctors from urban areas or MLAs. While the perspective of local authorities was important for this research, my intent was to focus on the opinions of rural health professionals who work most closely with the pilot reform. Doctors working in cities also shared much valuable information about the goals and progress of the reform, but their opinions were less informed about how the pilot initiative is working in the villages. Finally, the field work was conducted in the summer time, which was another reason for a lower turnout rate because it is a vacation time, and many of the rural professionals I managed to find through the snowball method were on vacation.

Despite their limitations, these interviews are novel and provide unique information about the preliminary results of the pilot health care reform in rural areas of Ukraine.

Chapter 3.

Data Analysis

I chose to code the transcribed notes of the interviews manually, without the aid of qualitative research software. The main reasons for this choice were a manageable amount of information and my desire to work with the text in front of me, to be able to write, underline and colour code directly in the text to enhance my understanding of the data. Also, my previous experience with data coding using software showed that there are no definite advantages to software coding besides facilitating management of a large amount of data.

I analyzed the data using thematic analysis, which allows more flexibility than content analysis. Content analysis focuses on the frequency of themes more than on how they were emphasized by participants. Because the amount of data collected was not large in quantity but rich in quality, I decided against content analysis and concentrated on both the frequency and importance of themes. My analysis below presents interview findings through the most recurrent and powerful themes in the participants' discourses. The discussion of themes will follow after a brief commentary on thematic analysis and my application of this method.

3.1. Thematic Analysis and Application

One of the important articles on thematic analysis was published by Braun and Clarke in 2006. According to them, a theme is a patterned response as it relates to the research question. Because there cannot be a rigid rule about what constitutes a theme due to the nature of qualitative analysis, Braun and Clarke suggest to be flexible and to avoid focusing on the "frequency" of the response patterns. Rather, the importance of a certain theme in relation to the research question is what matters in thematic analysis.

Braun and Clarke argue there is no right or wrong way to identify a prevailing theme, rather what matters is consistency in how you apply your decision (Braun and Clarke 2006: 11). In identifying prevalent themes, I focused on the number of times a particular topic was mentioned in the whole data set and the emphasis placed on this theme by participants. Another important consideration was the relevancy of a given theme to my research question, which is whether the pilot reform is able to improve the health care needs of the rural residents of Ukraine.

In terms of scope, I pursued a description and analysis of the entire data set, which may lose some depth of meaning but maintains a rich overall picture. Braun and Clarke argue this method is applicable when there is a strict word limit, an under-researched area or participants whose opinions are not known (Ibid.). All of these reasons apply to my project. In my research I came across only one report (Rokhansky et al. 2012), produced by an NGO in Ukraine that included some opinions of the health care providers about the pilot initiative. Also, there have been no formal studies published on the progress of the pilot reform at this point, which makes this project exploratory in nature and for this reason it was important to discuss the whole data set.

I was guided by a combination of inductive and theoretical, or deductive, thematic analysis. The reason I chose to be data-driven, or inductive, was because the opinions of Ukrainians on health care system in the country and pilot reform in particular are understudied (Hankivsky 2012), and there is no established theoretical framework for studying rural health care reforms in the transition societies. At the same time, a theoretical approach suited my research interest and structured interview schedule because I had specific questions that I wanted answered when approaching the data. Since policy analysis involves measuring policy options against certain criteria, it was reasonable to see if the participants referred to the essence of these criteria in the interviews. Hence, when analyzing the data I was both open to what the text had to offer and at the same time I was searching for the answer to my research question about whether or not the pilot reform will respond to the health care needs of the rural population.

The process of identifying themes was focused exclusively on the semantic or “explicit” level (Braun and Clarke 2006: 13), which includes only the direct meaning from

the participants' discourses, described and summarized in my interpretations. As a result of data analysis, I have identified the following main themes: critique of the pilot reform, pilot reform as a step in the right direction, budgetary considerations, community involvement in health care, and rural problems.

3.2. Critique of the pilot reform

This theme was the most prominent. Several interviewees could not stop criticizing the pilot initiative, its idea, the implementation process, and the immediate results. A couple of participants offered a more balanced, however, still negative opinion about the reform. They emphasized that the government of Ukraine has not adequately considered the legislative and financial foundation when approaching the task of reforming the health care system: *"It is all being done very hastily, just to change something; they did not pay attention to the budget, the economic crisis, and social problems, such as poverty which affects the reform as well"* (FD and medical school professor from Vinnytsia). One rural physician from the Pavlohrad district said: *"The pilot reform will be detrimental to the rural health care: they will shut down rural hospitals and decrease the work load of rural doctors."*

Several individuals shared that they do not understand the need for the pilot reform because they believe that the Soviet system worked fine and perhaps needed to be adjusted, but not completely destroyed. One doctor from Vinnytsia argued: *"Just to copy this institute [family medicine] from other developed countries that have more money to invest in health care is impossible; the WHO recognized Semashko system as the best in the world, and it just needed to be tweaked and modernized."* A similar opinion was expressed by a rural doctor from Okhrimivka in Zaporizhzhia oblast: *"I do not understand the need for this reform, why to break everything we have and to start with this family medicine. What they are offering is not better than what we had."*

A major sub-theme in this discussion was the absence of consultations with doctors and the public about the goal and design of the pilot initiative. A number of participants felt that the reform was: *"top down, without any consultations with doctors"*, *"separate from people"*, *"there was no alternative offered, top down completely, and you*

cannot just change all of reality by a directive from the government.” A physician from Vinnytsia explained: *“No one consulted with me even though I have worked as a doctor for over 30 years... This is supposed to be an experiment, but it will be for certain, they will not be reasonably evaluating the results and will just expand the reform for the whole country. This is not a scientific approach.”* Indeed to date, the government of Ukraine has not presented any evaluations of the pilot reform to the public. The only information publicly accessible on the MoH website is about the numbers of new clinics opened, ambulances purchased, and visits of the officials to the pilot regions. It is not surprising, that the dearth of analysis and assessment of the pilot results coming from the government only heighten the mistrust among doctors and consumers.

The feelings of frustration shared by the interviewees about the manner in which the government of Ukraine introduced the pilot health care reform reflect the expert opinions from the round table “Health Care Reform in Ukraine: the Idea and the Reality” that took place in Kyiv on October 31, 2013. Oleksandra Betliy, the consultant at the Institute for Economic Research and Policy Consultation in Kyiv shared that: *“The government has yet to explain what health care model will be built as a result of the pilot reform. There was no information campaign surrounding the introduction of the reform, and both consumers and physicians were lost in the midst of the changes.”* Serhiy Severyn, Chair of the Physician Association in the Donetsk region echoed the opinion of one of the interviewees (a physician from Vinnytsia): *“The main problem of the pilot reform is absence of an effective feedback mechanism to correct the mistakes that are apparent during the implementation of the reform”* (UNIAN, 2013).

Many participants criticized specific aspects of reform initiatives, namely the institute of FD and the reorganization of health care facilities. In addition to the critique of FDs who have been retrained from other specializations in six months to meet the deficit of family physicians in Ukraine, the participants put forward a number of general concerns about family medicine: 1) FDs cannot know everything about human bodies; 2) family medicine destroys pediatric services because pediatricians are no longer the first point of contact for children; 3) financial incentives for FDs to be gatekeepers to the inpatient facilities; and lastly that 4) the reform makes it increasing difficult to access specialists. These criticisms are consistent with the overview of the public opinion in the pilot regions (Rokhansky et al. 2012), with the results of the nation-wide community

consultations (Hankivsky, Salnykova, Vorobyova 2012), and earlier findings about the lack of trust towards FDs acting as pediatricians (Lekhan, Rudiya and Richardson 2010).

On the other hand, the same participants talked about positive sides of FDs: *“family doctors are more convenient for the patient”* (medical school professor and physician from Vinnytsia) and *“it is good that now a person does not choose the specialist doctor but has to go through the family doctor first because a regular person is not a doctor and does not know which specialist she needs, and a person, rightly referred, saves time for themselves and money for the government”* (pediatrician and an MLA from Vinnytsia). It is possible that misunderstanding and contradictory positions about FDs is a result of how recent this change is and how few of them practice in the pilot regions. Every single interviewee highlighted the shortages of FDs. The official statistics are limited on the numbers of FDs per region, which makes it difficult to establish the extent of the problem. As was pointed before, implementation of the FD institute has been inconsistent across the country. One of the findings from the 2012 community consultations was that L'viv city residents were the only ones who evaluated FDs consistently in a positive manner. In Ukraine, L'viv region was one of the pioneers in introducing the institute of family doctors as early as 1994 (Dzhafanova, 2006). It is possible that the interviewed doctors from Dnipropetrovsk, Vinnytsia and Zaporizhzhia regions, due to less experience with fully trained FDs, expressed the most negative opinions.

At the same time, some interviewees talked about the advantage of being a FD specifically in a rural setting. For example, in the words of doctor from the village of Okhrimivka: *“I have worked as a GP in this village for 25 years and because of this I had to deal with gynecological and pediatric issues, as well as the general population and the elderly; only because of my extensive practice and the nature of being a village doctor is that I can currently fulfill the obligations of a family physician.”* Another doctor said that in the village setting a FD is more likely to function as a physician who knows the people and is kind because of the close contact with her/his patients. This opinion was echoed by a rural FD from the village near Vinnytsia who said: *“patients get a better and a pretty much around the clock medical help, at least in my case.”*

Although many participants had a one-sided, very critical evaluation of the pilot reform as a whole, some other criticisms were specific and substantiated with evidence. This theme has an important aspect of constructive feedback that should be considered by the government of Ukraine when scaling up the pilot reform to other regions.

3.3. Pilot reform as a step in the right direction

This theme was unexpected because media reports, community consultations, and anecdotal evidence (such as my NGO contacts) showed that the citizens of Ukraine are highly sceptical of the pilot reform. I consider this theme as one of the valuable findings from my field work because positive evaluations of the pilot reform are rare and come mostly from the MoH of Ukraine.

Two interviewees, as evidenced by the following quotes, gave an overall positive evaluation of the pilot reform: *“the reform is definitely **for** [emphasis of the interviewee] the people, so that every rural corner has access to health care, that pregnant women do not have to go a long way for their prenatal care”* (head physician from the Juriv district), *“the pilot reform will change the outdated, conservative Soviet health care which neither encouraged the patient to be healthy nor improved the professionalism of doctors”* (FD from a village near Vinnytsia). Importantly, both of these participants were rural health professionals and shared detailed and specific evidence about the workings of the reform and reasons for why they praised it. They asserted that the reform has resulted in: better continuity of care and capital improvements in equipment and infrastructure. According to the head physician from the Juriv Centre of Primary Medical and Sanitary Help *“It has already improved it [access to care], especially in the villages because we can see that there are less people who have to go to the district clinic to seek specialist health because they get primary care from their family doctors”*.

Only these interviewees emphasized that consumers reacted with negativity towards the reform because they do not like change in general. They said: *“It is easy to criticise, it is harder to be constructive and offer a solution to the problem. And that is why I don’t criticize, but understand that there will be problems. Everyone is taking this reform too hard”* (FD from a village near Vinnytsia) and *“People did not like the reform at*

first because they did not know where to go, it was a change, and people do not like change. But I think now people have seen that it is more convenient for them” (head physician from the Juriv district). Similarly, the conservative nature of public opinion regarding their health care was highlighted as one of the obstacles to the pilot reform in Ukraine in the Health System Assessment report (Tarantino et al. 2011: 23). Tatiana Bakhteeva, a Ukrainian MP, in her interview to the BBC Ukraine, argues that citizens in any country are sensitive to changes in the health care system and cites the criticisms voiced to the Obamacare in the USA (Karpjak, 2013).

In addition to these two overall positive assessments of the reform, some participants talked about how the pilot initiative improved certain aspects of health care, such as: FDs, capital stock, or ambulance services. A rural doctor from Okhrimivka said: *“we have received new diagnostic equipment to diagnose certain diseases of ears and eyes”* and an ambulance doctor from Yakymivka shared: *“after the reform it became much better: first of all, we have medication in every ambulance now, and it is free for patients; we also regularly get enough gas and we got new cars”*. One of the rural physicians from the Pavlohrad district gave a high evaluation to the institute of FDs (5 out of 5), as well as a doctor from Vinnytsia who said about FDs: *“if it is an ideal situation, it is 4 out of 5 because it is very convenient for the patient.”* Other individuals assessed the institute of FD as a positive idea but pointed out that the way it has been done in Ukraine is not satisfactory. For instance, an MLA from Khmilnyk in Vinnytsia region considers that: *“The idea of family medicine is good, but not at the moment because we do not have enough qualified doctors.”*

Importantly, a number of participants distinguished between the design or principles of the reform and their implementation. The majority of participants gave a negative assessment to both the design and the implementation of the reform. However, some of them concluded that although the implementation of the reform is not well planned, the idea of the reform is still beneficial for the health care system. A former village head from the Yampil district shared the following about the pilot reform: *“if according to the European standards, then it is a good idea. But we need to learn more...”* And an MLA from Khmilnyk echoed: *“The idea is good, and it would be great if it all turned out the way it had been designed”*. Such a distinction made between the goals of the reform and problems with its implementation is important because it supports the

general direction of the pilot reform while recognizing that existing implementation problems can be corrected. This understanding is especially important for developing compliance among the physicians who can either impede or facilitate the pilot reform implementation. For example, both of the rural physicians who gave overall positive evaluations to the health care reform, highlighted that whenever they had any inquiries about the specific workings of the pilot initiative their managers at a district level always provided assistance. They shared that the directions given by their health authorities were vague at first, but this was not the reason to criticize the pilot initiative. Instead, these doctors asked for clarification from their managers and were willing to adjust to the new conditions in the workplace.

Finally, several participants expressed their hopeful feelings about the pilot reform and that the government of Ukraine has finally turned attention to improving the health care system in the country. One interviewee said: *“I hope for the best, I believe that this reform will be for improvement. The problem will be the transition period until the people will get adjusted to it. There should be a serious public information campaign before the reform comes here at the end of 2014”* (ambulance doctor from Yakymivka, Zaporizhzhia region).

3.4. Budgetary considerations

Although I did not ask a question on the financial aspects of the reform, almost every interviewee mentioned budgetary aspects of health care. This was surprising because the most discussed aspects of the reform in the media are the shift to family medicine and reorganization of health care facilities. The second goal of the pilot reform – which is a more efficient use of the financial resources – is often overlooked in the popular discussions, particularly, the technical mechanism of separating the budget flows for the primary and secondary levels of care. According to the pilot initiative, the primary care clinics are to be financed through local budgets (town or district) and the secondary level hospitals – through the bigger, regional budgets.

This theme was filled with contradictory discourses, fragmented knowledge about medical insurance, and criticisms of government insufficient financing of the health care

system in Ukraine. Nevertheless, it was also punctuated with discussions about cost-effective funding mechanisms. Some of the most important sub-themes in the discussion of health care funding were cost-effectiveness and purposeful use of the budget. Participants discussed cost-effective spending at some point in their interview referring to different aspects of the health care system, such as: capital improvements, remuneration of physicians or purchasing supplies: *“With the pilot reform there was a lot of show put up with the emergency vehicles, some diagnostic equipment is too old. Too much money was spent on these cars”* (MLA from Khmilnyk).

The most unexpected remark came from the MLA and a pediatrician from Vinnytsia, who said: *“Unfortunately, as far as I understand the reason and the goal of the reform is to use the budget more economically, and spend the money in a more cost-effective manner: more for the outpatient clinics and less on hospitals because not all ill people need to be hospitalized.”* At the same time, as an MLA who deals with budgetary issues, she also spoke in a positive way about family medicine, which *“saves time for the people and money for the government”*, as well as a need to calculate the demand for care and medication in every facility, based on the numbers of residents in the area. Rather than being inconsistent or misinformed in her opinions about the pilot reform, she appears to perceive the need for the health care system to be cost-effective as incompatible with its humanitarian aspect of serving people. This idea was echoed in Okhrimivka: *“Health care cannot be so expensive that no one even will look at you, until you bring money. I think that the government needs to give money at least for emergency cases, such as traumas, or accidents”* (rural pharmacist) and *“We [rural clinic] have not got any medication for over a year, we have to fund this ourselves to be able to give people necessary care. We ask them to buy and return medicine afterwards, but often we do not get this back. I cannot ask people for money.”*

The head physician from the Juriv district shared her affirmative view of the reform’s financial aspect: *“The idea itself is good, economically efficient, good for the budget because there is too much waste in the infrastructure, so many hospitals where no one gets actual help. With the reform the use of the existing infrastructure has been improved, hospitals changed into day inpatient facilities, polyclinics – into clinics.”* She also gave a positive evaluation to the separation of budgets for the primary and secondary care: *“Now our [primary care] financing is three times bigger because the*

large hospital is now on the regional budget as a secondary level. We have seen such an improvement in what we can do because of this change in financing.”

The separate flow of financing for primary and secondary levels of care is not the first change in the funding of the health care system in Ukraine. In 2005 the government transferred the rural health care facilities to be financed from the district level budget. The critics of this decision claimed that such transfer deprives local communities of the self-government rights, and in 2008 this change was annulled (Lekhan, Rudyi and Richardson 2010: 55). In principle, this criticism is deserved. Yet, the underlying reason for this transfer was to improve the financial flow to the rural health facilities because the village budgets in Ukraine have a very constrained financial basis (Ibid.). In 2011, even before the pilot reform, this transfer was brought back, and the two health professionals from Okhrimivka shared: *“At least it is good they are now on the district clinic budget, and not on the village council, because back then it was a horror. We lost everything because they did not give any money... But the health care professionals from the district know better”* and *“our clinic used to be financed out of the village budget and now we are on the district budget. The money we get has not really changed, but it is just easier to work with medical professionals directly in the central municipal hospital instead of the village head. They understand our needs better.”* In both cases, the change in funding mechanisms is supposed to centralize the expenditures and make the spending more cost-effective in the health care system. The first-hand experience seems positive for rural doctors in both pilot and non-pilot regions.

One participant agreed that the health care system should be cost-effective, but he did not think that the pilot initiatives were cost-effective. He shared his suspicion that the new ambulance cars purchased for the pilot regions were a way to funnel the budget money. He said: *“The goal is to save the money but the real question is whether the services will be improved. I understand the need to save money but what is this cost-saving mechanism going to result in? And what is the purpose of restoring FAPs and putting in Euro toilets there, if they do not have enough medical staff to serve the people. Is this money spent wisely?”* Looking beyond the sarcasm of his comment, he was making an important point that modernization does not automatically create cost-effectiveness in the health care system, especially when corruption is present. He raised another valid criticism of the pilot innovation, which is the absence of mechanisms to

ensure quality of care. Specifically, he was concerned about the new financial incentives for FDs who are serving now as gatekeepers for the specialist care: *“My criticism is that family doctors are now going to have a raise based on the amount of people they referred to a specialist and to the hospital, of course it is a disincentive for them.”*

Many participants talked about cost-effectiveness as a trade-off to the quality of care, particularly when discussing the question of FDs rotating their services between the adjacent villages. The opinions divided almost evenly. Some thought that this alternative is both a cost-effective and a quality improving solution to the status quo of no FDs in some villages: *“This is a good idea, the rural doctors do not have much work, especially ours, they maybe get two visitors a day. So she should work the money she gets. This would be a real solution for those villages that have no one at all”* (rural pharmacist from Okhrimivka). Other participants argued that it was cost-effective but not beneficial for the continuity of care: *“No, because this destroys the idea of the continuity of service, every village needs a doctor, their own. Such a policy would only improve the remuneration of doctors, that is all”* (FD from a village near Vinnytsia) and *“It is not cost-effective, unless a doctor does not have enough population/work in one village. It is too hard for the doctor. Also, family doctors need to know their patients, on such a part time basis it is hard to do so. It can work as an exception, but not as a rule”* (MLA and pediatrician from Vinnytsia).

The participants raised a valid issue about the quality of care and cost-effectiveness trade-off, and whether it is a valid or an artificial trade-off. The pilot reform claims the goals of improving the quality of care and making the health care system more efficient. However, it is not clear from the progress of the pilot reform as evaluated by the interviewees that the government of Ukraine has considered the balance between saving money and ensuring optimal care for the rural patient.

3.5. Community involvement in health care

Similarly to the budgetary considerations theme, the theme of community involvement in health care did not originate as an answer to a specific question asked. Several participants spontaneously brought it up, and although this theme was not as

prominent in terms of frequency as the other four themes, I could not ignore the amount of space devoted to it and the emphasis placed by those who did speak about community involvement. The two kinds of community involvement in health care system discussed by some participants were the way communities and local authorities can improve or hinder the development of the health care system in their location. From these accounts, it seems that the personality and interests of the village head and council influences if this involvement will be negative or positive.

The doctor from Okhrimivka shared her frustration at the way the village head of 15 c years has impeded the health care services in this large rural community. She shared that this individual is only concerned with getting as much land as he can get, that he is not even a local, and is not interested in improving health services because there is no political gain after the clinic has been transferred to the district budget. For example, a mobile x-ray facility is supposed to visit every village twice a year. The doctor shared that it has not come in a while to Okhrimivka because the village council is supposed to pay for the gas, and they *“do not care enough to pay for it for several years”*. The doctor said with frustration: *“Even when we were on the local budget, we were told by the mayor that we are a bone in his throat and that he is happy to get rid of us when our budget was sent to the district hospital”*.

Unfortunately, in this rural community the indifference to improving health services goes beyond the authorities. The Okhrimivka doctor talked about the new physio and diagnostic equipment they received in preparation for the pilot reform, which has not been in use for over a year because the clinic needs an updated electrical and a room with panel dividers to hook up the equipment, but there is no money in the district budget to do that. I asked if they could find volunteer electricians and carpenters in the village, and the doctor just shook her head and that she is afraid to approach people because everyone is busy making their ends meet. As a result of both the regular people and authorities' myopia about the importance of prevention, the whole community is missing out from not using this diagnostic equipment.

Three other interviewees shared opposite stories of how communities can work together to improve their health services. The head physician from Juriv district told a story about two enthusiastic village heads who worked hard with the district health

authorities to solicit two scholarships for the local graduates to study as feldshers on the condition that they return to the sending villages. They also encouraged the communities that had no primary care provider before to pitch in and build or renovate houses where these returning feldshers could live while practicing in their villages. In her own words: *“We have several rural heads who are VERY [participant’s emphasis] interested in improving health care in their villages. I think local people need to think about their needs first of all, in one village a local farmer gave financial incentives for a doctor to come to work there. Rural councils need to work with high school students and get them motivated to study medicine and come back.”* And a similar situation was described by the interviewee from Yakymivka in Zaporizhzhia region where the community is constructing an apartment building for new medical school graduates to motivate them to practice in their small rural town.

Finally, the MLA and a paediatrician from Vinnytsia confirmed that the community’s initiative matters even more than a government decision in tackling some problems in rural health care. She shared that in 2013 the regional council in Vinnytsia passed a regulation about improving incentives for doctors who will be choosing to work in villages. The regulation creates a legal basis and public financing for any rural community to sign a contract with a medical school student who agrees to work in this rural community in return for providing accommodation and a work vehicle upon their graduation. However, throughout 2013 only eight rural doctors had a house provided for them by communities in the whole region that has more than a hundred villages. On one hand, this appears as a failure, but on the other hand it could be seen as an improvement because in just one year eight rural communities were able to secure a primary care provider in their village. Creating a legal basis and providing some funding for signing a contract with a medical student may not be sufficient for those villages that have corruption in the leadership and weak community cohesion. At the same time, it can help other communities with less internal barriers to create local health care initiatives.

This brief discussion revealed that in Ukraine grass-roots involvement in health care is an important but often overlooked element in improving health services in villages. Participants who raised this issue talked about the need to empower rural communities to advocate for themselves. Strengthened communities, who are aware of

their specific health care needs can become a powerful catalyst in making incremental improvements for the rural residents.

3.6. Rural problems

The final prevalent theme in the interviews focused on the socioeconomic problems of rural communities. The problems under this category include poverty, inaccessible services, destroyed roads and village infrastructures. These issues are among the social determinants of health, which the WHO describes as “the conditions in which people live and die are, in turn, shaped by political, social, and economic forces” (WHO, 2008a). Experts agree that in many locations people living in rural areas have shorter lives and higher levels of disease risk factors than those in cities due to lower levels of income and worse employment opportunities than urban residents (Kovacs, 2012).

Almost every participant had something to say about socioeconomic deprivation of rural areas in Ukraine, making connections between the success of the pilot reform and the need to solve these issues. The most succinct summary on this topic was provided by a pediatrician and the MLA from Vinnytsia: *“There are too many factors involved in the success or failure of the reform. Our villages have more problems that go beyond the narrow medical sphere. Roads, infrastructure, poverty, depopulation – all of this can play against any reform.”* A FD from Vinnytsia said: *“the government did not pay attention to the budget, the economic crisis, and socioeconomic problems, such as poverty which affects the reform as well. I think it’s now in dead end, and even those who designed it at the top understand this now. There is not enough financing, and even the social insurance model cannot get started because of how poor everyone is.”* The interviewees did not elaborate on the details of poverty perhaps because my interview schedule did not contain a question on this. However, the issue of poverty was brought up spontaneously by many and mentioned as an overarching condition in villages. On the other hand, participants at rural community consultations talked at length about unemployment, outmigration, depopulation in villages, as well as no activities or playgrounds for the children who take up harmful lifestyles in the absence of healthy activities in their lives.

Several participants emphasized that no incentives can bring doctors to villages because *“the conditions are really bad there”* (FD from Vinnytsia). At the same time, others talked about how even providing a place to live can make a difference for a new graduate because renting an apartment in a city is financially unrealistic for many of them: *“Since life is so hard, if they get a place to live in a village I think they would agree.”*

The terrible conditions of roads were mentioned almost by every participant: *“the roads are in horrible condition”* (MLA from Vinnytsia), *“of course, the roads are horrible, especially in winter time, so we have to go in such a way as to not break the new cars”* (emergency doctor from Yakymivka), *“ambulances are late because the villages are remote, the roads are broken down, people cannot access the nearest hospital because there is no regular public transportation”* (rural doctor from near Pavlohrad), *“the roads condition here is one of the best in the district, but even so in the winter time we cannot manage some of the streets on our vehicle and I have to walk in the snow and often even get a frost bite”* (rural physician from Okhrimivka). Importantly, transportation barriers have been cited by village dwellers as their biggest problem in the community consultations in 2012 (Hankivsky, Salnykova, Vorobyova 2012), which should bring this obstacle in accessing health services to the forefront of policy solutions.

The regions where I conducted interviews do not have very remote villages, as in the Carpathian mountain regions or in scarcely populated obalsts where the distance to the nearest health care facility could be up to 60 km (Cammarano 2009). Still, some participants complained about the distances when accessing health services: *“from our town to Vinnytsia it is 120 km, the emergency vehicle has to arrive to the ill person within 15 min, but in our district villages are located 30 km one from another. Every village needs to have an emergency car”* (former village head from Yampil).

Going beyond transportation barriers, some interviewees discussed the overall impoverished condition of rural residents and the need to address the wider socioeconomic problems as a part of health care reforms in villages. A rural pharmacist explained: *“people live in such poverty in villages, they cannot buy proper good quality nourishing food or do preventive care because the medicine is so expensive. People with hypertension need to have IV treatments twice a year to prevent crisis, and we used*

to be able to do it for them, right here, in our rural hospital, for free, but now they cannot afford it.” A rural doctor from the Vinnytsia region echoed this opinion by saying: “The cost of drugs is too high, and the people cannot afford preventive medication.”

In conclusion, in the words of the doctor from Vinnytsia: *“there needs to be political will to change and to rebirth our village, so that it again represents the heart of our nation... some villages that are close to towns are still surviving, but those that are a bit farther are simply dying off”*. Even without being asked about determinants of health, participants brought up these socioeconomic issues in the context of the pilot reform. As has been pointed out, the government of Ukraine needs to include broader determinants in health reforms (Hankivsky 2012). In rural areas, it needs to respond to the acute socioeconomic crisis in the Ukrainian villages with solutions that go beyond providing new ambulance cars or renovating rural health clinics.

Chapter 4.

Policy Objectives and Options

The main policy objective guiding this project is improving primary health care access for rural residents in Ukraine. The recently introduced pilot reform, in its status quo form, is not an appropriate solution for closing the health care gap between the rural and urban residents in Ukraine. Therefore, the status quo pilot reform is not considered among the policy options.

The main challenges in reaching the policy objective of reducing inequities in access to care among rural residents are: lack of concerted government effort in this area of public policy, shortage of FDs and health professionals in rural areas, financial and transportation barriers, and finally, the overall depressed condition in the Ukrainian villages. The first three challenges are specific and short-term, while the last one would require long-term solutions and improvement in the social determinants of health for rural populations in Ukraine. This research recognizes that the challenging socioeconomic situation, rather than inadequate provision of health care services is the major contributor to the poor health outcomes among residents of rural Ukraine. At the same time, finding ways to improve the overall condition of villages in Ukraine is beyond the scope of this project. Hence, the proposed policy options respond mainly to the challenges of providing primary care services to rural populations. However, it is also the case that the first option – community town hall meetings - does reach beyond the health system per say to address the wider social determinants of health.

The proposed policies were identified from the interviews and literature, and are aimed at short-term and long-term improvement in health care access for rural residents, which may lead to improved health outcomes over time. The scope of interventions varies according to the cost and the level of implementation – whether they will be enacted by the local community or the central government. Clearly, at present, the

ongoing political crisis in Ukraine makes it much more difficult to propose government driven policy reforms. Therefore, special attention was given to exploring community level initiatives that could reach the policy objective.

4.1. Community Town Hall Meetings

The first policy option is based on the idea that incremental solutions to improving health care access, and even health outcomes, can originate from communities without any large scale government interventions. Although the primary concern of this capstone is with improving primary care access, this policy option is not limited to this objective because the specific kind of intervention resulting from the town hall meetings will depend on the community's decision. Such interventions will be unique to each village and range from establishing afterschool activities for youth to renovating a house for a medical school graduate to attract this professional to work in their community. As such, these local health initiatives could be focused on solving some of the barriers to health care access or on addressing some of the social determinants of health. The shape of a particular intervention would originate from the community members, depending on what they see as the most pressing issues in their village. Since the community is at the center of the decision-making process, this policy option is not prescriptive and does not limit the particular intervention to the primary objective of improving health care access.

This option was inspired by the 2012 CIHR-funded consultations, where many participants shared how important it was for them to gather around the table with people from their community, discuss their health care needs and brainstorm solutions (Hankivsky, Salnykova, Vorobyova 2012). Upon completion of the project, our research team was told that in some rural locations people continued gathering spontaneously and sharing their views. This recommendation is also consistent with the interview findings about the role of community in improving health care. Communities can act as a beneficial and innovative force or as a stagnating and destructive one, like in the case of the village in Zaporizhzhia oblast where the doctor would not ask for volunteers to install the new diagnostic equipment in the clinic.

There are a number of examples across the world where rural communities have organized themselves around their health care needs with little or no external intervention. For example, in India and Bangladesh there are villages that have organized clean water sources with the help of international donor agencies to tackle the problem of waterborne diseases. While the funding came from the outside, the organization and management of the clean water sources is accomplished by the communities themselves (Water Sanitation Project, 2007; Bhuiya et al. 2002). In some rural parts of Pomurje region in Slovenia, communities have come together for walks, singing and dancing parties, healthy cooking and fitness classes. These “Let’s Live Healthily” initiatives were introduced in 2001 by the Institute of Public Health of the Pomurje region in eight villages and were promptly adopted by these communities and even spread beyond the region (The National Social Marketing Centre, 2010). By 2008 more than fifty villages and 30,000 individuals have been participating in the program “Let’s Live Healthily” (WHO, 2008b). The intervention focuses on specific risk factors of CVD, diabetes, and cancer, such as: sedentary lifestyle, stress, poor diet. The evaluations of these initiatives showed positive results: participants increased their intake of fruit and vegetables, became more physically active, and consumed less sugar and salt (WHO, 2008b). The hallmark of the “Let’s Live Healthily” program is its negligible financial cost and success in targeting harmful social determinants of health, which makes these community-led exercises especially applicable in the Ukrainian rural context. Also, Ukrainian villages used to have a tradition of “vechornytsi”, where community members gathered for dancing, meal preparation, producing clothing and wool, accompanied by singing. Since the consultation participants, especially in rural locations, referred to the need for social life and gatherings in their communities, this policy option could capitalize on that desire and result in community members learning and engaging in healthy lifestyles. In the words of one participant: *“My friend has a very special skill in herbs and in different massage therapies and she is treating her husband who has skin cancer and is paralyzed after a stroke. Recently they danced a waltz together after their anniversary. She has twelve goats and makes her own dairy products. I think we should just have her speak to us about how to live.”*

In rural parts of the UK, local health initiatives have taken on various forms, depending on the specific needs in each community. Some examples include mobile

clinics for farmers in remote areas, food co-operatives, and car pools to primary care clinics or social services (Wood, 2004). The latter initiative is of particular relevance to the needs of many rural communities in Ukraine that are located far from regular transportation routes. The residents of several remote areas in Northern England identified social isolation and limited access to health services as one of their biggest problems. They pulled their resources to finance a mini-bus and called for volunteer drivers from the community. The project proved to be successful and sustainable and has been extended to other adjacent communities (Deaville et al. 2002). As one of the interview participants shared, she is able to deliver better care to the village residents only because the driver who has a part-time job with their rural ambulance works far beyond his duties and is practically always on-call. This suggests that finding volunteer drivers could be possible in rural Ukraine, as long as there is a vehicle and funds for gas, which could also come from community contributions. Since transportation barriers seem to be at the top of the health care access challenges in rural Ukraine the local transport initiative from Northern England could be relevant in many rural locations in Ukraine. Still, it is important that the decision about a specific project should come from within the community to ensure empowerment and building social cohesion among the residents.

Town hall meetings could be initiated by village councils and take place periodically until the community agrees on the problem they are able and want to address. The next step would be locating financial and human resources necessary for accomplishing the chosen health-related project. In some cases, the initiatives will not require any financial costs, and in some others – there may be a need for fundraising. As identified by one interviewee and many consultation participants, some successful farmers are willing to support community projects financially, which could be one of the venues of locating the necessary funds. Another venue could come through the project “Community-Based Approach to Local Development” (CBALD), sponsored in Ukraine by UNDP and the EU. Since 2007, hundreds of villages and rural towns in Ukraine have participated in this project, which provided a portion of funding for community-based and initiated infrastructure development projects. These projects included installation of energy saving technologies in rural schools, renovating health facilities, improving transportation and lighting in villages. The most popular projects chosen by rural communities were renovation of the local health facility and improving the quality of

water (Community-Based Approach to Local Development, 2011). The key to participating in this program was for the community to organize itself, conduct public hearings in the village, choose a project, and collect at least 5% of its funding. The success of the first stage of the program resulted in the EU extending its financial support to the second phase for 2011-2015 (Ibid.). This positive experience with community-organized projects in rural Ukraine suggests that community town hall meetings have the potential to advance community driven health reforms. .

This policy option could be introduced through regional authorities or with the help of NGOs that are working on the problems of rural areas, such as the Institute of Agribusiness and Rural Development in Kyiv. This Institute is a non-profit NGO, created in 2003 by the Agricultural Confederation. The main goal of this Institute is to implement best international practices in the agricultural sector to stimulate rural development (Institute of Agriculture and Rural Development, 2013). Town hall meetings target both health care access and wider social determinants of health but may become effective only in the long run, if the level of social cohesion is low in a particular community and the process of self-organization is slow. At the same time, the most attractive aspect of this policy initiative is that it does not require a concerted government effort and does not involve significant budgetary costs, which is important given the current political and economic situation in Ukraine.

4.2. Rural Health Framework

For any rural health care reforms to become productive, the government of Ukraine needs a vision for the health of its rural population, which can provide continuity and a foundation in the volatile political environment of Ukraine. Since delivery of healthcare is a complex task, it should be approached with a strategic plan that is based on facts rather than ideology or politics. Various Cabinets since Ukraine's independence

have expressed their commitment to improving health care for the rural residents.⁴ However, these initiatives have not proceeded beyond declarations. In addition to political will and financial resources, data and evidence about specific problems of rural residents in the areas of health and health care access need to be systematically gathered and analyzed to produce effective policy solutions.

Ukraine can learn from the example of Romania – a country with a similar socioeconomic situation and rural health care problems (Sandu 2009). Romania has initiated primary health care reform in the mid-1990s, which yielded some positive results in terms of modernizing the post-Soviet health care system but left certain areas of the country underserved. In particular, rural areas in Romania experience many of the same health and health care problems as do the villages in Ukraine (Fota and Zahorka n.d.; Oxford Policy Management 2012; Sandu 2009). Rural populations in Romania have experienced the shortage of FDs, the reduction in the network of primary care facilities, and financial barriers to accessing health care (Oxford Policy Management 2012; Sandu 2009). In response to these challenges, in 2011 the government of Romania assigned a specific project unit in the Ministry of Health with the responsibility to create a Strategy and Action Plan for Primary Care in Underserved Areas. This document contains information about achievements and problems in rural primary care, analyzes the data about health care access in rural areas collected by public health students, and develops a recommendation for improving primary care in rural Romania. Even though this Strategy has not been formally evaluated, yet the creation of such a document in a post-Soviet country suggests that creation of a *Rural Health Framework* should be pursued by the Ukrainian government.

The example of Australia can be also instrumental for Ukraine. Although it is a highly developed country, it also has a significant health care gap between its urban and rural populations (The National Strategic Framework for Rural and Remote Health, 2012). Australia is one of the leaders in innovative rural health policy solutions (Godden

⁴ Some of these initiatives that have never been implemented are: the program “Village Doctor” proposed in 2005, rural populations exemption from any out-of-pocket payments when accessing health services by the Supreme Court of Ukraine ruling in 2001, and the research initiative to create a document on rural health priorities by the Institute for Strategic Political Research.

et al. 2007) and in 2011 the government, together with the NGOs working on the problems of rural health, created *The National Strategic Framework for Rural and Remote Health*. This document lays out a strategy and specific steps to address the health care delivery problems in rural Australia. The country is already reaping positive results since the release of this Strategy, such as expanded incentives for rural FDs, improved care through integration of services in rural and remote areas, and the transportation program for the Tasmanian populations (Rural and Regional Health Australia, 2013). Likewise, in Scotland, the creation of an evidence-based rural health framework was the first step in addressing the needs of rural consumers and health professionals, such as extending roles for rural hospitals and encouraging physicians to work in rural areas through various incentives (Godden et al. 2007). Again, Scotland has more resources than Ukraine. But, just like Australia both of these developing countries have a considerable rural-urban gap in health care access (The National Strategic Framework for Rural and Remote Health, 2012; Godden et al. 2007).

The *Rural Health Framework* should integrate existing evidence about the health of Ukraine's rural population, the specific health care needs of such populations and a blueprint for a long term policy strategy. Local health authorities and representatives of the village councils should be able to provide their input into this document. The agency working on the framework can also solicit perspectives from rural residents and health professionals, as well as any NGOs working in this area to avoid the mistake of the pilot health care reform, which was designed and implemented without any consultations with practitioners or consumers. The input from the community town hall meetings, if this policy option is implemented, should be also incorporated in the framework.

It is important that this framework be rooted in a social determinants of health (SDH) approach. Currently, an appreciation of SDH is lacking in MoH programming and policy decisions. At the same time, the office of WHO-Ukraine is a strong advocate of the social determinants of health in the country, which may present a window of opportunity for the broader determinants to be included in health policies. Currently, the WHO-Ukraine is working with the government of Ukraine in the development of the program *Health of the Nation: 2020* as a part of the all-European analogous program that is founded on the SDH approach. This new approach will require intersectoral government collaboration, where health and health care planning are not overly

medicalized but understood in the context of socioeconomic, ecological, and cultural environments of the people. To accomplish this, the framework needs to contain a national vision of priorities for rural health but at the same time consider local challenges and opportunities of rural communities shaped by their geography, culture, and local economy, as well as considerations of age and gender composition in a specific area. To be consistent with the social determinants of health approach, the delivery of health care services could be integrated with a variety of other community-based services, such as youth programming, aged care, and mental health services, depending on the local needs. As the 2012 community consultations demonstrated, rural communities suffer from the breakdown of publicly funded services to children and youth who step on the path of abusive health behaviours simply for the lack of healthy alternatives available in their villages.

The framework should also consider successful practices and initiatives from other post-communist countries and how they can be tailored to Ukrainian rural health challenges. For example, in Romania a position of community nurse was introduced to provide outreach services and management of chronic diseases to fill the GP shortage in rural areas and a general shift to health oriented, as opposed to care oriented rural health services (Fota and Zahorka, n. d.). Similarly, it is important that the *Rural Health Framework* collects information and analyzes successful local health care projects that have been or will be established in some villages and rural towns of Ukraine so that other communities could learn from and apply these experiences and promising practices.

Because rural populations in Ukraine are not homogenous, depending on specific demographic trends, some regions will need publicly-funded institutionalized or home care provided for the elderly, whereas other – better access to pediatric care. In order to design policies suitable for various needs, government agencies should conduct systematic research and assessment of health and health care issues in rural areas and include local communities in decision-making process, at a minimum as contributors of policy options.

4.3. Rural Primary Care Centralization

While the *Rural Health Framework* will contain a blueprint of priorities for policy changes, the literature review suggests another policy option. Following the recommendations from the WHO report *Health Systems in Transitions* and the HSA *Ukraine 20/20* report, as well as practices in many developed (Godden et al. 2007) and post-communist countries (Disney et al. 2010), health services in Ukraine should be consolidated. This policy option can be viewed as a modified version of the pilot health care reform informed by interview findings and literature. The immediate prerequisite for this policy is an explicit consideration of the health care needs and challenges of the rural residents that would be written into the legislation supporting this option. It is also possible that the centralization of rural primary care will be recognized as a beneficial policy option after the analysis for the *Rural Health Framework* is completed. However, considering the data from interviews and other criticisms of the pilot reform, it is necessary to introduce significant changes to the current design of the pilot reform for it to meet the policy objective.

Studies in developing countries found that provision of primary care improves health outcomes in rural areas (Sandu, 2009; Ito and Kono, 2009; Frankenberg, 1995). One of the goals of the pilot reform is to reorient the health care in Ukraine from the extensive and ineffective network of inpatient facilities towards primary care, which is an important step to improving health outcomes in the country. In the long run the network of rural hospitals in Ukraine is not only unsustainable but also limited in its potential to improve quality of health services. The main reason is that a disproportionate share of finances is spent on the infrastructure and personnel salary in rural hospitals instead of providing preventive and chronic disease care (Kizilov et al. 2013; Sandu, 2009). However, it is essential that inpatient rural facilities are consolidated, rather than primary care facilities. As evident from Romania, reducing the number of rural primary care clinics led to the overutilization of tertiary care by rural residents (Sandu, 2009). Therefore, it is recommended that the decision to close a primary health care facility in a village should be viewed as a last resort only.

Careful planning and evaluation need to come before the decision to close certain health facilities. The evaluation should be carried out by regional health

authorities, in cooperation with local village councils. It is also important to ensure open communication with the affected population about the objectives of this policy. I suggest the following criteria for closing a rural health facility: 1) evaluation of the demographic situation in the hospital/clinic catchment area, 2) road conditions and proximity to the next closest health facility, and 3) the condition of the health facility. The first two criteria were suggested by Cammarano (2009) in his assessment of rural services in the Izyum region of Ukraine, but are modified in this project based on the data gathered and updated literature review. The rationale for the first criterion is to evaluate the health care needs of the population in a specific area, based on their demand for health services, which will substantiate a decision to either keep or close the facility. I suggest adding the demographic projection of migration, aging, gender, and birth rates to this criterion. Depending on the projected composition of residents in a given rural area, a more informed decision could be made about what kinds of health services (e.g., prenatal or aged care) would be most needed in a particular community.

The second criterion is based on the need to balance cost-effectiveness with access to care. This balance can be achieved by allocating a part of the funds from the closed health facilities to providing reliable transportation to the nearest primary care facility. Based on the interview data, the ambulance services have improved with the initiation of the pilot reform. However, it is important to ensure that residents of a village that is too small or too remote for its own primary care unit can easily access another primary care facility. Ukrainians own fewer cars than residents of many other post-communist countries. According to the World Bank data in 2010 there were 141 passenger cars per 1,000 inhabitants in Ukraine, 201 – in Romania, 233 – in Russia, and 427 – in Czech Republic (World Bank Data Catalog, 2013). Also, many villages are located near poor public transportation routes. Therefore, it is necessary to ensure that villages, which will have their health facilities closed, should have access to a reliable public transportation services. Distance to the next nearest primary care centre as a consideration needs to be also included in the decision to close down a facility in a given village.

The final criterion for closing a rural health care facility is based on the fact that many rural clinics/hospitals have not been renovated for decades and would require major investment in order to function properly and to attract health professionals. These

expenses may be hard to justify, especially if a given health facility should be closed according to the first two criteria.

It should be noted that implementation of this policy option must be preceded by a significant legislative change that would allow centralization of health care services. Currently, the Constitution of Ukraine prohibits reduction in publicly funded health facilities. Introducing a change to this constitutional provision would require a vote in favour by the Parliament of Ukraine from at least 300 out of 450 MPs. Such a legislative change is almost impossible, considering the current political crisis in the country and a debt-laden economy.

4.4. Increasing the Numbers of Rural Health Professionals

Implementation of any health care reforms in Ukraine needs to be preceded by solving the shortage of health care professionals in rural areas, which is the focus of the next two policy recommendations. The first problem that needs to be addressed is lack of students who pursue the specialization of FD. As one interviewee shared: *“students want to become specialists and nobody wants to study to be a family doctor, students tell this to me all the time”* (medical school professor and FD from Vinnytsia). In the past, the government of Ukraine introduced a financial incentive – no tuition fees for those students who agreed to practice in rural settings upon graduation. This intervention proved unsuccessful in meeting the shortage of FDs in villages. And yet, no formal evaluation was conducted about the reasons for its failure. It is not clear if students who signed the agreement simply did not comply with the contract conditions or if wider corruption schemes, which are so prevalent in Ukrainian medical schools (Hankivsky, Salnykova, and Vorobyova, 2012), interfered with the implementation of this policy.

Ukraine is not the only country that experiences a shortage of rural health professionals. Both developed countries (such as Scotland and Australia) and developing countries (Romania and Hungary) face challenges in ensuring that their rural populations have adequate numbers of health professionals (Clelland et al. 2012; Godden et al. 2007; The National Framework for Rural and Remote Health, 2012; Sandu, 2009). Ukraine can learn and apply some of the solutions introduced in these

countries to encourage health professionals to work in rural areas. This study proposes two mechanisms for increasing the numbers of rural health professionals – reviving the profession of a feldsher and incentivizing physicians to work in rural settings. As recommended with the previous policy options, specific implementation steps of these policies should be informed by the consultations with the rural health care providers and local communities. Communication with the public and medical workers is likely to result in more productive, innovative, and evidence-based interventions in this area, as well as to ensure higher levels of compliance.

4.4.1. Reviving the Feldsher

One solution for the shortage of FDs is extending the training and responsibilities of feldshers to provide full primary care services. A feldsher is a mid-level health care professional, educated to practice primarily in rural areas. Feldshers are independent in their work from physicians and carry out a limited number of prescriptive and curative services, such as history and physical exams, follow-up evaluations, and referrals to physicians when necessary. The majority of feldsher training is in internal medicine, pediatrics, and gynecology. Upon their graduation, feldshers may also pursue additional specialization. They are also trained in first aid and emergency care. In fact, currently feldshers constitute the majority of health professionals working in emergency services (Lekhan, Rudy and Richardson 2010, 131). Feldshers are analogous to nurse practitioners (NPs) and physician assistants (PAs), according to the WHO classification of health professionals. In her evaluation of feldsher training in Ukraine, Nina Multak, a PA from Pennsylvania, suggests there are significant opportunities for extending the role of the feldsher in emergency hospital departments (Multak, 2010). In the context of this project, it is recommended that feldsher training be expanded to include a wider spectrum of curative procedures, using a variety of diagnostic equipment, and midwifery services. These additional responsibilities would allow feldshers to provide a wider range of primary care in rural areas and reduce the need for referrals to urban centres for physician services.

Although the MoH has not done a formal study about the quality of care provided by feldshers as compared to physicians, the qualitative data from both the community consultations and interviews showed that rural residents are very satisfied with the

quality of care provided by feldshers (Hankivsky, Salnykova, and Vorobyova, 2012). For example, in the village of Pryvovchanske a number of participants described their feldsher as a “magic wand” because of how helpful, knowledgeable and available he was. One interviewee, trained initially as a feldsher, said about herself: *“I had to do so many other things that a GP would do, just because I was eager and because there was a need in the village”* (rural pharmacist, Okhrimivka).

Feldshers complete their degree in three to four years and their tuition fees are much lower than for the medical school students. Because of the lower opportunity costs, more high school graduates from villages are likely to choose a feldsher degree instead of a medical school. In turn, it will be easier to attract such students to return to villages as a rural health care provider. The literature on the positive role of PAs and NPs in providing rural primary care is extensive (Baldwin et al. 1998; Bergeron et al. 1999; Kippenbrock et al. 2002). Ukraine can learn from the experience of Canada where NPs were introduced as a way to meet the health care needs of individuals residing in underserved rural areas (DiCenso, Paech & IBM Corporation, 2003). Comprehensive reviews of the quality of care provided by NPs demonstrate that health outcomes do not differ for the populations served by NPs as compared to those served by physicians (College of Registered Nurses of Nova Scotia, 2011; Horrocks et al. 2002). Also, patients serviced by NPs report high levels of satisfaction and would recommend a NP to others (Ibid.). Not surprisingly, the NPs are now called “a backbone of rural health care” in Canada (Canadian Health Research Foundation, 2010). Similarly, Ukraine can meet the deficit of health professionals in rural areas through increased numbers of feldshers rather than physicians in a more cost-effective way. If implemented, this policy option should be followed by evaluation of the quality of health care provided by feldshers with expanded training and responsibilities, and how their services compare with the services provided by FDs.

4.4.2. Motivating Physicians to Work in Rural Areas

Incentives for attracting medical professionals to rural areas can be divided into financial, professional, and quasi-financial categories. The majority of interviewees discussed financial incentives as a necessary condition for motivating doctors to work in villages. Under the current pilot reform, rural FDs receive a higher base salary,

depending on the size of the population they service. As has been recently reported on the MoH website, the salary of a rural FD has been raised by 50-60% compared to 2010, which, according to the MoH representative Kostiantyn Nadutyj, increased the number of FDs to more than 10,000 for the first time since the introduction of family medicine in the country (The Ministry of Health, 2014). At the same time, several interviewees emphasized that any increase in salary comes with working longer shifts and providing care for bigger catchment areas, which leads to burnout of rural doctors. In the words of one rural doctor from the Dnipropetrovsk oblast: *“In our Juriv district we have 5 family type ambulatories, where in two out of five there is only one family doctor and that is hard, the other three have two doctors and they can work shifts. In those ones where it is just one doctor the per capita is too much for one doctor, instead of 1,100 they serve more than 2000.”* In order to avoid the burnout of rural health care workforce, there is a need to balance financial incentives with adequate professional responsibilities in rural areas. The actual numbers of patients that a FD is supposed to serve should not exceed the legislated 1,200 patients for rural areas.

Together with increased salary, many participants suggested that quasi-financial incentives, such as providing free accommodation or a work vehicle, as other possible means for motivating medical professionals to work in rural settings. Adequate medical equipment and work conditions in rural health facilities have also been named as an attraction for medical school graduates to work in villages. One interviewee was convinced that *“Internet in village clinics would definitely improve medical services and would get the interest of young specialists because Internet is a source of information... Many students from rural areas in my institute do not want to go back to the village. There need to be better conditions in the clinics and better equipment”* (medical school professor from Vinnytsia). The experience of several rural clinics in the Ternopil region confirms this finding from the interviews. In 2010, with the financial support of UNDP Ukraine and village councils, educational-practical centers of primary care were created in five villages of the oblast. The funding was used for capital repairs of the health facilities, providing necessary primary care equipment, Internet connection, computers, and accommodation for medical interns. On the initiative of the Ternopil Medical University (TMU), students in the specialty "General practice and family medicine" were directed to intern in these facilities. Communication via “Skype” with the university

hospital specialists assists the interns in their practice. The TMU brochure reports that the villagers have been very happy with the services and the medical interns received high-quality training in rural areas, which encouraged many of them to stay in these rural facilities upon graduation (Ternopil National Medical University, n.d.). Importantly, Internet access was named as an important attraction to go work in remote areas by medical interns in Scotland as well (Cleland et al. 2012).

In addition to financial and quasi-financial incentives balanced with proper patient volumes, professional incentives can also motivate some physicians to practice in rural settings. The nature of rural doctor's work requires him or her to be a universalist, which suites some people and does not attract others. This universal nature of a rural doctor can be promoted and made more attractive through additional professional development opportunities offered to rural physicians. Studies and surveys of rural health professionals in Scotland and Australia found that some interns can be retained in remote areas if they are offered broader responsibilities and opportunities to practice in other areas of specialization they are interested in (Gadner et al. 2007; The National Framework for Rural and Remote Health, 2012). In Australia, rural health professionals are leaders in such innovations as providing care in multi-disciplinary health teams and closely working with other community services for better preventive and holistic care (The National Framework for Rural and Remote Health, 2012). It is hard to pinpoint what specific professional development opportunities could incentivize physicians in Ukraine to work in rural areas. Perhaps specific steps in this area can start after a nationwide consultation or survey of health workforce which could yield more concrete suggestions.

Taken together, financial (salary increase), quasi-financial (accommodation or vehicle provision), and professional incentives offer a broad base action that could encourage more physicians to choose work in rural areas. It is important that these incentives are also balanced with adequate numbers of personnel in rural clinics and adherence to the prescribed numbers of patients to avoid burnout of rural health professionals.

Chapter 5.

Policy Analysis

5.1. Criteria and Measures

The following criteria will be used in the evaluation of policy options: acceptability, short-term and long-term effectiveness, equity, and ease of implementation. The next section will provide a brief description and explanation of each criterion, as well as the measurement that will be used in assessing how each policy option meets the criteria.

5.1.1. Acceptability

The groups affected the most by the proposed policy options are: residents of rural areas in Ukraine, health professionals (both FDs and feldshers), and local authorities. Since their interests in terms of the provision of health services in rural areas not only vary but could also be at odds with each other, it is important to separate the single criteria of acceptability into three categories: acceptability to rural communities, acceptability to health professionals, and acceptability to local authorities.

Measures

Each of the three acceptability sub-criteria will receive a measurement of “high”, “medium” or “low”, depending on the reaction to a given policy from each of the interest groups – rural residents, health professionals, and authorities. Each of these categories will receive one third of the total score for this criteria to not over weigh it.

Low: the policy option is not likely to get a favourable response from the stakeholder group.

Medium: the policy option will not likely face the opposition from the stakeholders, but at the same time is not the preferred method of intervention.

High: the policy option is likely to be the preferred method of intervention for a particular stakeholder group.

5.1.2. Effectiveness

This criterion captures whether a policy option improves access to health services for rural community members in comparison with the status quo and if it is likely to close the gap in health care access and health status between the rural and urban residents of Ukraine. Specifically, this means evaluating the options according to: whether the rural residents have a health care provider in their village or in close proximity and if not, whether more rural residents are able to travel to a physician; and whether less rural residents are diagnosed with preventable conditions, like diabetes or cardiovascular diseases.

Measures:

Low: the gains in rural community access to health services, or gains in health, are either nonexistent or negligible when compared to the community's overall health and health care access as it exists currently.

Moderate: the gains in rural community access to health services, or gains in health, are significant, but a substantial gap still exists between the health conditions of rural and urban residents of Ukraine.

High: the gains in rural community access to health services, or gains in health, close the gaps in health conditions and access to health services between rural and urban residents of Ukraine, or reduce these gaps to a negligible size.

5.1.3. Ease of Implementation

This criterion evaluates policy options according to how many financial, political, managerial, and legal obstacles could arise when authorizing or delivering the intervention. These obstacles could be both known and/or unanticipated. Examples of such obstacles include: the number of government agencies or branches of power

involved in the policy option, legislation that needs to be passed, or the overall degree of change from the status quo. Importantly, the actual cost of the policy is included in this criterion because in the Ukrainian context the possibility of implementing a policy depends more on its cost than political and even legal constraints. The cost could be either actual financial expenditures or other forms of resources (e.g., time) necessary for implementing a policy option. These financial and non-financial expenses may be borne by the government or by the rural communities.

Measures:

Low: in order to be implemented, the policy option requires either a significant legislative change or cooperation from more than three government agencies or from both the legislative and the executive branches of power. In terms of cost, a policy option will have major added costs associated with its implementation.

Moderate: in order to be implemented, the policy option requires either a less than significant legislative change or cooperation from two government agencies. In terms of cost, a policy option will have moderate added costs associated with its implementation.

High: in order to be implemented, the policy option requires a minor legislative change and does not involve more than one government agency. In terms of cost, a policy option will have little added costs associated with its implementation and thus will receive a high numeric score on this criterion.

5.1.4. Equity

Since rural communities in Ukraine are not homogenous, it is important to consider how well each policy option responds to the health and health care needs of a variety of rural areas. The diversity of villages in Ukraine is represented by their size, proximity to an urban area, distance to the nearest health facility, and community's cohesion. The latter may be hard to measure but one of the proxies for estimating community's cohesion may be presence or absence of any community projects that has been initiated or completed in a given village.

The understanding of equity as between, rather than within rural communities, originates from the main concern of this project with rural-urban gap in health and health care. Although rural residents in Ukraine represent a diversity of ages, genders, educational and religious backgrounds, they are economically more vulnerable than urban residents. The low socioeconomic status is one of the main barriers to accessing health care services, as named by rural populations (Lekhan, Rudiya and Richardson 2010), and is thus viewed here as a unifying identity for otherwise diverse rural populations. Future research on the topic of health in rural Ukraine could investigate the issue of equity in accessing health care within rural communities, and in this way further the findings of this pioneering work.

Measures:

Low: a policy option will likely improve health status and health care access only in select few rural communities, which have a particularly favourable geographic or economic standing and/or which are strong in terms of community cohesion.

Moderate: a policy option will likely improve health status and health care access only in those rural communities, which can boast a strong sense of community but regardless of their geographic or economic position.

High: a policy option will likely improve health status and health care access in the majority of rural communities in Ukraine, regardless of their geographic or economic standing and/or internal community cohesion.

Chapter 6.

Evaluation of Policy Options

In this section each policy option will be evaluated using the developed criteria. The table summarizes the evaluation results and the following sections present the details of the analysis. The measures for each criterion are qualitative and have a ranking of 'low', 'medium', or 'high', depending on the expected consequences of each policy option. Quantitative measures are based on the following scale for all criteria, except for acceptability: a ranking of 'high' scores in the range of 2.1 to 3; a ranking of 'medium' – in the range of 1.1 to 2; and 'low' can have a score of 1 and below. For acceptability, each of the subcategories (acceptability for rural population, health professionals and local authorities) can get a score of 1 for a total of 3 for this criterion. A ranking of 'high' for each acceptability category will get a 1, a 'medium' – can score a 0.5, and a 'low' – a 0.25. For greater transparency, both qualitative and quantitative measures are listed in the table below.

Table 6.1. Summary of Policy Options Evaluation

Policy Options	Town Hall Community Meetings	Rural Health Framework	Rural Primary Care Centralization	Reviving the Feldsher	Incentives for Rural FDs
Effectiveness	High 2.7	Medium 1.9	Medium 2	High 2.5	Medium 2
Ease of Implementation	High 3	Medium 1.7	Low 1	Medium 2	High 1.7
Acceptability	High 3	High 3	Low 0.5	High 3	High 3
Equity	Medium 2	High 3	Medium 2	High 3	Medium 1.7
TOTAL	10.7	9.6	5.5	10.5	8.4

6.1. Community Town Hall Meetings

6.1.1. Effectiveness

Since the implementation of this policy option depends on community cohesion, it is likely to be effective in the long-run as it takes time to build trust and social capital necessary for community self-organizing efforts. At the same time, this policy option can be effective in the short run if a community has had a previous experience with local initiatives. For example, in Okhrimivka several high school graduates organized a gym in one of the buildings that was no longer used by the village council. In the words of a consultation participant: *“They repaired it themselves, bringing in sports equipment. When it’s cold in the winter they go inside and coach the younger ones so they don’t lift too much weight. And when I walk in there, they are not drinking, and they don’t let anyone come and drink or smoke.”* Also, the effectiveness depends on the specific type of an intervention decided by community. Some consultation participants suggested educating one another about health lifestyle and others recommended sporting events or afterschool activities for children, which will likely improve the health outcomes in a village, but not immediately. At the same time, a village can settle on organizing a carpool to the nearest health facility, which can improve health care access right away. Because this policy option could be effective in both short and long run, this option receives a “high” score and ranks 2.7 out of 3 in effectiveness.

6.1.2. Ease of Implementation

Depending on the type of intervention community chooses, financial costs may arise, which will not be borne by the government, but by the community members themselves. Additional time, energy, and other forms of non-financial costs will be involved once a community decides on a specific intervention. However, significant resources should not be required to implement this option. Finally, this policy does not require involvement of government agencies (village councils could get involved but it is not necessary) or any legal changes. Therefore, it receives the highest score 3 out of 3 for the ease of implementation.

6.1.3. Acceptability

Town hall meetings will likely be popular among the community members. Many participants in the consultations spoke of the need to meet and talk as a community: *“We need to encourage people to be more active and participate—to become a community.”* Some commented on the lack of community life and the need to get involved: *“We are not used to taking time for ourselves; we are only used to hard work. Even these holidays that Liudmilla Vasilievna organizes, only a handful of people come to them. It’s such a pity, we have a beautiful choir and they perform songs, but nobody comes. Yes, we have rehearsals in the winter when it’s almost freezing inside, and only a couple of people come to the winter holiday performances. But for the summer events it’s better: there were 300 people who came to Ivana Kupala.”* Since this policy option ranks high on both the ease of implementation and effectiveness criteria, it is not likely to face opposition from the other two stakeholder groups. Hence, this policy option receives a maximum score on the acceptability.

6.1.4. Equity

It is expected that coming together as a community to discuss health issues and solutions will be easier for some communities as opposed to others. A number of factors can influence the likelihood of this policy success. Previous involvement in local initiatives, presence of strong leadership personalities, proximity to the nearest town, and how thriving the local economy is will contribute to the success of this policy option. At the same time, some smaller, remote and economically more deprived communities could have higher levels of social cohesion and may organize collective walks or dances with more ease than bigger communities. Given the variety of barriers and facilitators to community cohesion, as well as how their interplay can affect self-organizing potential of each community, it is hard to predict whether this policy option will have similar outcomes for both more and less developed villages. Yet, since no external actors are involved in the town hall meetings, this option presents equitable spring board for all communities. The equal start may not result in identical outcomes but will likely bring benefits, proportionate to the initial condition of the community. Hence, this option receives a ‘medium’ score for equity, or 2 out of 3.

6.2. Rural Health Framework

6.2.1. Effectiveness

The creation of a visionary document that systematically organizes the knowledge about rural population health, their health care needs and government goals in relation to meeting these needs will be effective in the long-run. Although this policy option is necessary for the effective solutions to the policy problems in rural health care in Ukraine, it is not expected that it will achieve the policy objective immediately. Therefore, it ranks 1.9 in the 'medium' category of effectiveness.

6.2.2. Ease of Implementation

There are no legal changes needed to initiate this policy option since it is not intended as a legally binding document. The development of the *Rural Health Framework* will require collaboration of regional and central authorities with the input from local communities and advocacy organizations. Some of the data will need to come from the State Statistics Committee and the MoH, which will add to the complexity of implementing this option. In addition, employees from a dedicated government agency or from a think tank will be collecting and analyzing the information for the framework, which will involve additional financial (in the case of outsourcing the analysis) or work time resources (in the case if work is performed by government employees). Research costs may be significant, but they could be mitigated through involving students from rural areas in gathering data about their local communities' health care needs and concerns. In the Okhrimivka consultation, a participant shared about a research project on unemployment conducted by a teacher and several high school students. Also, most of the note takers at the community consultations were students, active and interested in the lives of their villages. Still, even if the research costs could be mitigated through the student involvement, the coordination efforts between various government and non-government agencies will complicate the framework design process. Considering these costs, this policy option scores 1.7 in the 'medium' category.

6.2.3. Acceptability

To be effective, the *Rural Health Framework* needs to be drafted with the engagement of all interested groups, especially rural communities and health professionals. Their contribution is essential for creating a realistic and relevant document that could achieve the policy objective of improving health care access for rural populations in Ukraine. As one of the interviewed MLAs said about the pilot reform: *“Here, there is hardly anything done to inform people. People need to be informed about changes like this, public hearings, lectures in schools and big offices. Connection should be from the authorities. And people should be able to give their feedback.”* Since the buy-in of the stakeholders is a prerequisite for this policy option, it is expected to rank high among all three groups and receives a score of 3 out of 3 for acceptability.

6.2.4. Equity

Rooted in the social determinants of health approach, the Rural Health Framework should account for the diverse socioeconomic and environmental conditions affecting health in rural communities in various parts of Ukraine. The Framework is intended for assessing specific needs of villages located in remote or suburban, economically depressed or thriving regions, with aging or growing population. This document is designed to promote the understanding that uniform nation-wide solutions may not be as effective in improving health care access among rural populations in the villages of both Western and Eastern Ukraine. Given the vision of the framework that diverse rural communities require different interventions, it is expected to score ‘high’ on the equity criterion and receives a score of 3 out of 3.

6.3. Rural Primary Care Centralization

6.3.1. Effectiveness

This policy option is intended to improve access to primary health care in rural areas in both the short and the long run. It emphasizes that when a health facility is shut down, a portion of the funds saved from this closing should be used for providing reliable transportation to the nearest health facility. In this way it is expected that access to

primary health care will be improved in rural areas because consolidated, bigger and newer health facilities will be able to provide better care. Providing reliable transportation, included in this course of actions, will also improve access to primary care in rural areas. At the same time, people will have to travel longer distances which may deter many from accessing primary care on a regular basis. Therefore, this policy receives the score of 2.5.

6.3.2. Ease of Implementation

In terms of costs (both financial and non-financial), this policy option is expected to involve the highest amount of resources due to the evaluation that needs to happen before deciding on specific rural health facilities that should be consolidated. At the same time, there will be some financial savings as a result of this policy option because some rural health clinics/hospitals will be shut down. This policy option entails cooperation from the Cabinet, the MoH, regional health authorities and local elected officials, which will slow down the implementation process. Finally, centralization of rural health facilities is currently unconstitutional and would require a parliamentary vote (300 out of 450 MPs in favour) to change article 49 of the Constitution, which declares that the existing network of public health care facilities cannot be reduced. This policy option has the greatest number of barriers to its implementation and therefore receives a low score of 0.5 for this criterion.

6.3.3. Acceptability

Centralization of rural primary care facilities is likely to be very unpopular with rural residents and rural health professionals, who will see primarily loss of security and employment in this policy intervention. Based on the interview and community consultation results, I expect a negative reaction from both of these stakeholder groups towards centralization of rural clinics/hospitals. These criticisms could be mediated to some extent with a large scale public education campaign about how reducing the number of facilities could in fact improve the quality of rural health services. Therefore it is possible to attach a score of 0.25 to both acceptability among rural populations and health professionals.

Acceptability levels of this option among the local authorities in rural areas are not as straightforward as with the other two stakeholder groups. On the one hand centralization of health facilities may be perceived as a relief from undesirable responsibility, but on the other hand, village heads and councils could view this policy as an interference with their authority and may be apprehensive about how it will affect them the next time they choose to run for the office. This tension could result in the 'medium' ranking with a score of 0.5 for acceptability among local authorities. Overall, centralization of rural primary care is likely to rank the lowest among all policy options on the acceptability criterion and receive a score of 1 out of 3.

6.3.4. Equity

Centralization of primary care facilities will negatively affect the smallest rural communities, which will most likely have their health facilities shut down. Importantly, this policy option emphasizes the need to ensure access to primary care through providing reliable transportation in these locations to mediate the inequitable effect of closing some health facilities. Weighing out the trade-off of centralization with providing transportation access, this policy option receives a 'medium' rating and a score of 2 out of 3 for equity.

6.4. Reviving the Feldsher

6.4.1. Effectiveness

Increased numbers of rural health professionals will meet the policy objective of improving health care access in rural Ukraine. The data collected for this project indicates that investing into the profession of feldsher will likely alleviate the deficit of primary care providers in villages in the long run. As one of the interviewees pointed out: *"I think that a feldsher was and is cheaper, better, more cost-effective than such a [part-time or commuting] family doctor. And they [feldsher] tended to live where they worked."* However, this policy option will require some changes to the role and responsibilities of feldshers, as well as a promotion campaign among high school students in villages. This

suggests that this policy option is not likely to yield quick results and thus receives a score of 2.5 out of 3.

6.4.2. Ease of Implementation

Reviving the profession of a feldsher does not require any major legislation changes. Some amendments will be necessary to expand the training and the scope of responsibilities of the feldsher profession, which can be implemented by the MoH and the Ministry of Education who jointly oversee medical schools in Ukraine (Lekhan, Rudyi, and Richardson 2010). In addition, the Cabinet will need to issue an order to increase the numbers of students who can study to obtain the profession of feldsher (Ibid.). In terms of financial costs, there will be moderate additional costs to increase the capacity of schools training feldshers. These costs could be borne either by the government or by the rural communities that choose to sponsor a student who signs a contract to practice as a feldsher in the sponsoring village. Since bureaucrats are conservative in Ukraine, they may resist this expansion. Their disposition could be mitigated by demonstrating the cost-effectiveness of this policy option. Taking into account these implementation considerations, the option of reviving a feldsher profession, receives a 'medium' ranking with a score of 2.

6.4.3. Acceptability

Based on the interview and community consultations data, I anticipate that rural populations will be highly in favour of this policy option because they shared only positive feedback about feldshers practicing in their villages. One of the consultation participants said: *"Our feldsher is very good. He is so helpful. He's always ready to help. You can phone him or come to see him. He can come to your place. He either rides a bicycle or skis in the wintertime. He's a very good professional, and he's kind. He often came by himself to the village council to ask for their car to transport a sick person."* Acceptability among health professionals is also expected to be high because in Ukraine, feldshers do not present competition to physicians, who are not eager to serve in rural locations. Because the profession of feldsher has been traditionally linked to primary care and first aid in villages, their increased numbers will not threaten the physicians' positions in urban clinics. Local authorities in rural areas should be also in

favour of this policy option because it does not involve significant resources from them but could improve health care access to the communities they serve. Overall, reviving the feldsher will rank 'high' and get a score of 3.

6.4.4. Equity

This policy option will likely yield equitable results across the diversity of villages in Ukraine because it would be easier for a range of rural communities to sponsor a feldsher rather than a medical doctor student. It is also expected that promotion of this policy option among the high school students in villages will be more successful because of the lower opportunity costs for an individual to pursue this profession as opposed to a profession of a physician. Rural communities would not need to provide as many amenities to attract feldshers to working in villages because they will be likely rural residents themselves. Therefore, this policy option will receive a maximum score of 3 for equity.

6.5. Incentives for Rural Family Doctors

6.5.1. Effectiveness

Although this policy option was the most popular in the interviews, I do not expect that it will be highly effective because the government of Ukraine has already introduced financial incentives and they have not resulted in a significant increase in rural physicians. Perhaps the salary raise would be more effective if combined with a strictly enforced cap on the number of people served, which is proposed in this policy option. It is also possible that additional non-financial incentives (extra professional development, better equipment, and housing provided) could add attractiveness to rural practice for some doctors. Still, I expect this policy to bring medium improvements in health care access in rural locations and assign it a score of 2.

6.5.2. Ease of Implementation

The MoH has recently prepared a directive for the Cabinet to provide financial incentives to new medical school graduates who will be servicing rural areas (Ministry of Health, 2014). In addition, the MoH proposed a change to the State Target Program on the Development of Ukrainian Village till 2015, which entails giving additional 1 882,6 million UAH to local budgets for building new rural health facilities (ibid.). As was mentioned in the interviews, better equipped and newer health facilities can be a motivating factor for doctors to practice in villages. These proposals are yet to be passed and financed by the Cabinet but the initiative from the central authorities already suggests that this course of actions is likely to be implemented. However, it would require significant additional financial resources, which makes implementation of this policy option more problematic.

Providing additional professional development to rural physicians is exclusively in the MoH responsibilities and would not involve any legislative changes. At the same time, it would involve extra financial costs, which will need to be approved by the Cabinet. Finally, rural communities, which choose to either finance medical students on the condition of their return to practice in their village or to provide free accommodation to incentivize new graduates with their own resources, will bear significant costs as well. Considering all these factors together, incentivizing rural physicians ranks 'medium' among the policy options and receives a score of 1.7 out of 3.

6.5.3. Acceptability

Based on the evaluation of the two previous criteria, this policy option is not likely to face any opposition from rural communities, local authorities, or health professionals. It will rank 'high' and will receive a maximum score of 3 on acceptability.

6.5.4. Equity

This policy option involves both the central government and local communities. On one hand, this means that all villages would have an equal opportunity to benefit from the centrally provided incentives to rural physicians. On the other hand, it is not clear if the government will be financing building new clinics in more deprived or in more

developed communities, according to the current proposal. Also, some rural communities will always be more attractive than others for rural physicians because of their location, climate, and local economy. More developed villages would be also in a better position to provide locally made non-financial incentives for rural FDs. Therefore, it is expected that this policy option will rank 'medium' on equity. It receives 1.7 out of 3 on this criterion.

Chapter 7.

Recommendation

The evaluation of policy options demonstrates that the centralization of rural primary health care is not suitable for providing better access to health care in villages throughout Ukraine. This option, although effective in the long run based on the experience of other countries, will likely exacerbate inequities in health care access between urban and rural populations in Ukraine. As discussed, transportation barriers to health services are significant in rural Ukraine and Ukrainians own fewer cars than populations in other Eastern European countries (World Bank Data Catalog, 2013). Therefore, although centralized rural health centres will likely provide better quality care in the long run, these transportation barriers will prevent the village residents from experiencing the benefits of centralized health facilities. In addition, this policy option is highly unpopular among rural communities and will further contribute to the mistrust of the government.

The policy problem of improving health care access for rural populations in Ukraine is, however, complex and there is no silver bullet solution. Therefore it is recommended that a three-pronged approach is pursued to close the gap between rural and urban residents in relation to health care access. Based on the evaluation of policy options, the combination of community town hall meetings, producing a *Rural Health Framework* and reviving the profession of feldsher, is proposed as the most effective and comprehensive policy solution.

Several participants emphasized that improving rural health care and health should start with reviving the Ukrainian village, which may entail such government steps as subsidizing agriculture, diversifying rural economies, and recovering the infrastructure. Considering the reality of financial and political pressures in Ukraine, this research project was aimed at finding a course of actions that requires minimal

expenditures from the central government. Judging by the discussed successes of the local health initiatives in rural communities of Slovenia, Northern England, and India, small rural communities are able to improve access to health services and to promote active living among residents with minimal or no costs. The accomplishments of the Community-Based Approach to Local Development program in many rural communities in Ukraine suggest that town hall meetings could work effectively in Ukraine as well.

The importance of a government vision for rural health in Ukraine was highlighted earlier, and the town hall meetings could feed into the development of the *Rural Health Framework*. The best practices in reforming rural health care in Romania, Scotland, and Australia demonstrate that before the government decides on a specific course of actions a thorough analysis of current conditions, challenges, and future needs in rural health should be undertaken. Therefore, despite the anticipated low short-term effectiveness and high costs for its implementation, it is recommended that the government of Ukraine develop a *Rural Health Framework* – a visionary and evidence-based document for reforming rural health care.

Finally, the deficit of rural health professionals is a pressing issue, as recognized by rural communities and participants of this research project. The government of Ukraine has made initial steps to solve this problem. Both policy options targeted at increasing the number of rural health professionals scored high and very close to each other. However, it is recommended that the government pursue the option of reviving the profession of feldsher instead of incentivizing FDs to serve in rural areas. First, the government of Ukraine has previously provided some financial incentives for working in villages, but they have not produced expected results (Lekhan, Rudi, and Richardson 2010). Secondly, at a macro-level, the financial costs of this policy option as compared to reviving feldsher are expected to be more significant because educating one FD is more resource-intensive than educating one feldsher. Lastly, on the individual level, the promotion of feldsher among rural high school graduates is anticipated to be more successful because of the lower opportunity costs for the individuals.

This three-pronged approach combines both long-term and short-term solutions to multiple challenges in providing health care in rural Ukraine. The rationale for suggesting three policy options instead of the option that scored the highest (community

town hall meetings) is a need for comprehensive steps at both the community and government levels. In addition, while the policy of reviving a feldsher profession tackles one problem (the deficit of rural health care professionals) and will improve access to primary care, the other two recommended policy options attempt to address social determinants of health through creating a knowledge base about the structural barriers affecting rural health and through initiating community-led health programs. Considering Ukraine's financial realities and the recent negative response of both consumers and providers to the current pilot health care reform, the recommended policy solutions would curb costs and provide access to needed healthcare throughout the country.

Chapter 8.

Concluding Remarks

In many jurisdictions of the world the urban-rural divide in health services delivery has been recognized as a profound policy challenge (The National Strategic Framework for Rural and Remote Health, 2012; Sandu 2009; Godden et al. 2007). Although this challenge exists in Ukraine, the government of the country has yet to address this divide in its health policies. This exploratory study about the ways to improve the provision of primary health services in rural Ukraine makes a contribution to the literature and to the process of health care reforms in the country. In addition to evaluating the pilot initiative, this paper highlights the importance of social determinants of health and evidence-based approaches that need to be incorporated by the government of Ukraine in their future health reforms.

This research project contributes to the literature by collecting primary data from individuals working in the area of health and in presenting secondary data from rural community consultations. The analysis of how people view health care needs and the current condition of health services in rural Ukraine is important because studies about first-hand health experiences of Ukrainians are scarce (Hankivsky 2012). For this project, I identified only one relevant peer-reviewed journal article about rural Ukraine in English by Skryzhevskya and Karasconyj (2012). While providing much information and analysis about the socioeconomic and health crisis in rural areas of Ukraine, this study was limited to statistical data analysis. This means that this capstone project is the first study published in English about rural health and health care experiences that uses primary and secondary data collected from the citizens of Ukraine. The information shared at the community consultations adds narratives to the macro indicators about socioeconomic crisis in Ukrainian villages, and in this way serves as an “anchor to statistical data” (Brownson et al. 2009: 1578). The interviews with health care professionals discuss the intermediate results of the pilot health care reform. To date,

the government of Ukraine has not presented any evaluations of the pilot initiative. In this context, this research produces especially valuable evidence from the stakeholders who have been directly involved with the implementation of the health care reform and are in the position to assess its results. Incorporating this kind of evidence into the MoH decision-making would advance the quality of health care policies by assuring effective results and stakeholder compliance (Policy Horizons Canada, 2013).

The specific policy context for the study was evaluation of the results of the pilot health care reform in rural areas. Based on the findings from the field work and available evaluations of the pilot initiative, this project argues that the national pilot reform does not provide adequate responses to rural health care problems. The pilot reform, with its emphasis on family medicine and delineation of primary and secondary care, is the first necessary step in the direction of creating a better quality and more efficient health care system in Ukraine. At the same time, it is a short-sighted initiative because it does not consider social determinants of health. In its report, "Closing the Gap in a Generation", the WHO Commission on Social Determinants of Health argues that national health ministries must advocate for solutions to health inequities through the social determinants of health approach (WHO, 2008). As demonstrated by data analysis in this project, poverty and a lack of opportunities characterize life in Ukrainian villages. Even though this study did not focus explicitly on the underlying causes of health inequities, it underscores the need to address the socioeconomic crisis in rural Ukraine in conjunction with the more immediate barriers in accessing primary care.

Going beyond the pilot reform evaluation, this project recommends policy options that combine the social determinants of health and evidence-based approaches to reforming primary care in rural Ukraine. Because of the limited scope of the study the recommended interventions should be viewed only as first steps in addressing underlying causes of health inequities. The policy options that attempt to tackle the unfavourable social determinants of health in rural Ukraine are the community town hall meetings and the creation of the *Rural Health Framework*. Altogether, the recommended interventions are focused on creating both short-term (increasing the number of rural health professionals) and long-term solutions (community town hall meetings and *the Rural Health Framework*). The policy options also try to balance the immediate health needs of rural populations with the lack of finances and political turmoil in the country by

designing low or medium-cost interventions. This recommendation is based on the solid evidence coming out of primary and secondary data analysis, as well as literature review and international best practices.

The lack of evidence regarding health condition and health care access among the Ukrainian rural population was one of the problems encountered during this research project. The effectiveness of any of the policy options rests on creating a systematic knowledge base about health and health care services in rural Ukraine, which is currently lacking. In addition, the interviews, community forums, and the survey of the literature revealed a considerable level of dissatisfaction with the lack of government consultations and transparency around the pilot health care reform. This dissatisfaction creates non-compliance and denial of even the positive sides of the reform among both consumers and providers of health services. As a solution to these two problems, this study suggests that any future government initiative in the area of health should be evidence-based and created in collaboration with health professionals and representatives of the general public. Specifically, the process of the *Rural Health Framework* creation is recommended to follow community town hall meetings so that the results of these forums could be incorporated in the document. Also, it is indicated that this program should be created in consultation with regional health authorities and rural health professionals. Similarly, it is advised that the option of reviving the profession of a feldsher should be followed by an evaluative comparison between the qualities of service by feldshers and physicians.

In terms of the broader policy directions, the analysis of socioeconomic conditions in Ukrainian villages proves that the efforts to improve the health of rural residents must go beyond the health ministries and be expanded to the government offices dealing with social development, economy, agriculture, and education. As spelled out in the WHO Adelaide Statement *Health in All Policies*, “to harness health and well-being, governments need institutionalized processes which value cross-sector problem solving and address power imbalances” (WHO, 2010). This statement emphasizes that because health outcomes are influenced by the structural inequalities in a country, the health care system alone is not able to respond to the causes of these inequalities. Therefore, in the long-run, the Ministry of Health in Ukraine should engage in cooperation with other ministries to address the deep roots of the urban-rural health

inequities in the country, such as rampant unemployment, low wages in the agricultural sector, and deteriorated condition of the rural public infrastructure.

Finally, the current turmoil in the country, which resulted in the resignation of the Cabinet and the impeachment of the President who initiated the pilot health care reforms, makes the future of these pilot initiatives unknown. The legitimacy of the pilot reform is in question altogether because of the undemocratic actions by the Yanukovich government in the political crisis of late 2013-early 2014. It is also not clear whether the health care reforms will be at the forefront of the newly elected government policy agenda due to the economic crisis in the country. In the case of the regime change after the presidential elections in May 2014, it is possible that a policy window will open for rethinking policies and priorities in the health system reform. As a result of the regime change in Ukraine, including social determinants of health and evidence-based decision-making in health reforms may be propelled up to the top of the policy agenda. In this case, the findings and policy options presented in this research project may become particularly relevant for the decision-makers in Ukraine.

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Appendix A.

Interview Questions

Pilot reform region questions:

1. On a scale from 1 to 5, with 1 being negative and 5 – positive, how do you evaluate the idea of family medicine? Could you share the reasons for your evaluation?
2. How does emergency medical service function in your community? What would be some ways to improve it?
3. Please describe how you understand the goals and reasons for the health care pilot reform in your region.
4. Please describe whether and how you receive information about the pilot reform.
5. On a scale from 1 to 5, with 1 being negative and 5 – positive, how do you evaluate the effectiveness of the pilot reform design? Could you share the reasons for your evaluation?
6. On a scale from 1 to 5, with 1 being negative and 5 – positive, how do you evaluate the effectiveness of the pilot reform execution? Could you share the reasons for your evaluation?
7. Do you think pilot reform will be able to improve health outcomes and health care access for people residing in rural areas?
8. Are you familiar with telemedicine (remote provision of health care with the aid of technology)? If yes, do you think telemedicine has the potential to solve some of the problems with accessing health care in your community?
9. Do you think that providing incentives (financial or non-financial) for family doctors working in rural areas could solve some of the health care problems in your community?
10. Would access to health care in rural areas improve if family doctors worked part-time in two or three adjacent villages instead of being stationed in a larger village full time?
11. Would you change anything, and if yes, what would you change to improve the health care in your community?

Non-pilot reform region questions:

1. On a scale from 1 to 5, with 1 being negative and 5 – positive, how do you evaluate the idea of family medicine? Could you share the reasons for your evaluation?
2. How does emergency medical service function in your community? What would be some ways to improve it?
3. Do you think pilot reform will be able to improve health outcomes and health care access for people residing in rural areas?
4. Are you familiar with telemedicine (remote provision of health care with the aid of technology)? If yes, do you think telemedicine has the potential to solve some of the problems with accessing health care in your community?
5. Do you think that providing incentives (financial or non-financial) for family doctors working in rural areas could solve some of the health care problems in your community?

6. Would access to health care in rural areas improve if family doctors worked part-time in two or three adjacent villages instead of being stationed in a larger village full time?
7. Would you change anything, and if yes, what would you change to improve the health care in your community?

Appendix B.

Community Consultations

In 2012 over a four-month period community consultations were held by the Canadian-Ukrainian research team in 11 regions of Ukraine as part of the research project “Exploring Pathways to Equity in Health Reform: a Case of Ukraine” funded in 2011-2012 by the Canadian Institutes of Health Research (PI – Dr. Olena Hankivsky). The purpose of these events was to provide a venue for the citizens of Ukraine to speak about their health and experiences in seeking health care. To our best knowledge, these were the first community consultations of such magnitude in the area of health care in Ukraine. In total, 21 public forums were undertaken in the Autonomous Republic of Crimea, Cherkasy, Dnipropetrovsk, Donetsk, Kherson, Kyiv, Lviv, Sumy, Zaporizhia, Vinnytsia, and Zhytomyr, regions representative of Ukraine’s demographics, culture, and geography. This study will use the data collected during consultations in rural locations of Pryvovchanske, Okhrimivka, Busha, Korolivka, and Andrushivka. Two of these villages – Pryvovchanske and Busha – are located in the regions with the pilot health care reform.

The consultations targeted consumers, health service providers, and local government representatives, and were held in an equal mix of rural and urban settings. Advertisement was by invitation and public advertisement (facilitated by local NGOs), and specifically targeted a diversity of representation, especially from marginalized and vulnerable groups. Each forum was attended by 35-50 persons, and overall more than a thousand people representing diverse ages and occupations participated in the consultations. Female participants accounted for two thirds of those in attendance.

The guiding questions for the community consultations were organized around the central themes of health status, experiences with the health care system and services, and key issues of health concern and priority. Consistent with an intersectionality framework (Hankivsky & Cormier, 2010), this form of consultation can foster an increased desire among citizens to participate in decisions that will affect them (Fishkin, 2009) and aligns with the increasing need for the policy development process to be informed by input from diverse sources regarding ‘lived experiences’, especially

from those involved or affected (Lovan et al., 2004; Venkatesan & Abraham, 2010). Consultations are also effective processes for knowledge exchange, which is critical for policy change. In Ukraine, for example, although it is understood that policy change is undertaken by government, it has been recognized that public perception and understandings of health issues must also be transformed in order for transformative change to be realized (Salo et al., 2010; World Bank, 2009; SIDA, 2003).

The coding process of the community consultations was conducted by three researchers, including the author. The coding process consists of identifying and describing patterns, themes, categories and relationships informed by the theoretical framework of intersectionality, aided by MAXQDA 10 software. To ensure that data are analyzed from the perspective of multiple social locations embedded in diverse contexts, a two-step hybrid analysis developed by Bilge (2009), which incorporates an inductive thematic analysis and a deductive template approach to capture the experiences of marginalized populations, is being used. This analysis first identifies central themes and patterns, and then re-analyzes these by relating and associating individual accounts to broader social relations structured by diverse experiences of gender, race/ethnicity, class, geography, and age. This approach is intended to provide better analytic purchase on people's diverse social positions and diverse vantage points regarding health-related concerns.

Community Consultation Questions

1. What do you think are the main problems or issues affecting life in [your region] of Ukraine?
2. How would you describe the health of people in your community?
 - What do you think affects people's health here?
 - What do you think are the main health problems
 - Who in your community do you think experiences poor health and why)?
3. What are the main barriers in your community for accessing health care?
4. How would you describe the health care system and services that you are able to access?

5. Which three things would you change (if you could) to improve people's health in your region and in your community?

6. Is there anything else you would like to share with us?

Supplemental Question For Rural Communities.....

7. What are the main differences between urban and rural communities when it comes to health?

Appendix C.

Reflexivity Analysis

Throughout the field work, I was keenly aware of my identity and how it influenced the data collection process. I will briefly discuss the following most influential aspects of my identity: Ukrainian educated in Canada, young researcher, daughter of Ukrainian village dwellers, and mother of a young child. My mixed identity as a researcher was highly beneficial for establishing relationships with the participants. Since I was studying in Canada participants were more relaxed in sharing information about the sensitive issue of the pilot reform. Also, the fact that a foreign researcher is interested in the rural health care issues in Ukraine presented this policy area in a more important light to them. For a number of them it was probably their only experience speaking to a person from Canada, which sparked their curiosity and made me feel awkwardly special. Many participants asked me how health care is organized in Canada, and many were surprised to hear that family medicine has been practiced for years in Canada and other Western countries. At the same time, interviewees were aware of my Ukrainian identity, which enabled them to share information beyond the surface level since I was an insider and had first-hand knowledge of the Ukrainian realities. Not only was I born and lived the majority of my life in Ukraine, but also my parents had recently moved to a village, which made me even more aware of the socioeconomic problems and health care issues in rural Ukraine. Finally, if I was not a Ukrainian, collecting data for this study would be highly difficult and perhaps impossible, since I was able to speak Ukrainian or Russian with the participants who did not have a command of the English language.

Since many of the criticisms of the pilot reform revolved around how this initiative is destroying the pediatrician specialization in Ukraine, my identity as a mother of a young child was also important. The participants could feel that I appreciate their concern that the best care for a child is provided by a pediatrician instead of a family doctor once they knew I had a child. Also, when the informants asked me if I have children or otherwise found out this fact about me, I gained more humanity in their eyes which made our conversations more amiable. Another aspect of my personal life helped me to gain access to interview two rural health professionals from my parents' village.

My father was unwell at one point and required medical attention, which started my conversations with the family doctor and the pharmacist in the village about rural health care and my research project. They agreed to participate in my study, I believe, only because of our initial contact through my father seeking care from them.

My age influenced some of the interviews, especially those with middle-aged males. The telephone interview only revealed my voice to the participants, which sounds quite young, and without an opportunity to present myself more professionally through dress or wearing glasses I may have appeared even younger than I am to my informants. Their perception of my age influenced the power dynamics in our conversations. The older generation in Ukraine comes from the Soviet upbringing when the young people could not be leading the conversation, especially a professional one, with an older person. My position as an interviewer was challenged a couple of times because of my age, particularly, in an interview with a very experienced older male doctor from Vinnytsia. He assumed the leadership role in our conversation from the very beginning and it was very hard to steer him back to my questions, he shared his views without the structure that I suggested and was very sceptical about the questions I prepared. At one point he directly asked me how old I was, sniffed when I responded and referred to me as “a youngster” from then on. This particular conversation lasted more than an hour and turned into an unstructured interview, largely from the initiative of the interviewee. Despite my passive role and divergence from the schedule, this interview resulted in valuable findings because this participant was not only opinionated but also well informed about the pilot reform.

During the study design and data collection phases of this study I was unaware of how my education and experience in Canada shaped my analytical lens. During the course on Qualitative Research Methods in the fall 2013 the instructor encouraged us to do a reflexive analysis of our position as a researcher in our capstone work. It was during this exercise that I realized my sceptical attitude to those participants in my study who shared their criticism of the family doctor institute and their nostalgia of the Soviet medical system. Even though I have not moved onto the data analysis, in my mind I have deemed such views unreasonable and was prepared to discuss them in a critical language in my work. My graduate education in Canada, especially courses in Microeconomics and Health Economics, as well as reading Western literature about

rural health care, largely shaped my position that the pilot reform unfolding in Ukraine is a step in the right direction of optimizing health care delivery in Ukraine. Also, my practical experiences with health care in Canada compared favourably to my contacts with the health care system in Ukraine, which naturally added to my negative view of the Soviet and post-Soviet health services. Finally, my family upbringing influenced me to be highly critical of all things Soviet, and it was my automatic reaction to consider opinions about the benefits of the Semashko health care system as naïve. This reflexive exercise has not dissuaded me from believing that the pilot reform, in its approximation of the Western structure of health care services, is beneficial for Ukraine and has a potential to improve cost-effectiveness, access and quality of the health care in rural Ukraine. At the same time, it was important to realize the analytical lens that I bring into this analysis and my conclusions.