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# A note from the motherland of polyclinics

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Soviet leaders had utmost trust in the efficacy of large production units as advocated by Marxist political economy. The USSR was plagued by all kind of giants – from a huge paper production factory at Lake Baikal (which to this day is contaminating this largest fresh water reservoir in the world) to polyclinics (still serving urban inhabitants in Russia). The idea of creating bigger and bigger polyclinics was underpinned by a desire to create big centres of healthcare expertise and to improve access to a variety of specialists' services and technology. These considerations also seem to underpin the latest healthcare reforms in London.[1]

Polyclinics were mostly built in large cities to serve a catchment area generating about 1000 visits of adult patients per day. To increase mass production the services for children and obstetric and gynaecological services were provided by specialised polyclinics (called *konsultatsii* or consulting rooms). Furthermore, there was a network of *dispansery* (dispensaries) providing specialist service to the patients requiring dermatological, neurological, psychiatric and oncological services as well as tuberculosis and sexually transmitted diseases care.

It is a well known fact that conveyor belt technology was introduced at factories to use low skilled labour of the low-paid proletariat. The less known fact is that when trained people start to work at a conveyor belt their professional abilities degrade. Soviet front line physicians working at polyclinics were called *terapevty* (therapists). There was one therapist for a catchment area of about 1700 adults. These doctors provided a limited spectrum of services – they did not treat sinusitis or ingrown toenails and could not even start antihypertensive therapy without a consultation by a cardiologist. The structure of the polyclinics remained virtually unchanged since the Soviet times.

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The list of specialists in polyclinics is impressive. It includes gynaecologists, ophthalmologists, pulmonologists, surgeons, urologists etc. These professionals, however, may hardly be called true specialists. Surgeons do not practice surgery except for small interventions usual for UK GPs, cardiologists do measure BP and read ECGs sometimes, but provide very few interventions. The same would apply to gastroenterologists etc.
Why has this situation arisen? Why are therapists so "limited" and why are specialists so "underdeveloped"? To a large extent this is dictated by the mere fact that they work in polyclinics. They are the products of the polyclinic system. If specialists are within arms reach, there is little need for professional development of generalists. Conversely, many patients referred to specialists in polyclinics could be easily managed in primary care. Because therapists do not make decisions in relation to most conditions,

patients' management becomes fragmented and patients may easily ignore and bypass therapists. For the last 30 years the motto of the patients' demand to polyclinics was: "Open access to specialists!" When the access to specialists became open in the 1990s, patients naturally started consulting specialists for minor procedures. It would not be unusual for instance for patients with ear wax to consult an ENT surgeon or to consult an ophthalmologist for glasses prescription.

Polyclinics may create undesirable incentives. If a GP refers about 10% of his or her patients to specialists, there is a need to have 10 GPs for 1 specialist in a polyclinic. Because the range of specialists is needed, e.g. 5, then to have them busy a polyclinic needs to have 50 GPs. Of course, specialists may practice part time in a polyclinic. But in this case the waiting time for a specialist's consultation is increasing. So GPs tend to send more patients to specialists, just to "keep them busy". This may result in ineffective gate keeping and a transformation of the specialists' group to "collective GP", with GPs (therapists) serving as a relay station and providing patient support – a system characteristic of Communist society.

There is another problem which arises from the size of polyclinics. If a polyclinic is big, there is a number of GPs each serving a catchment area. The total catchment area of a polyclinic becomes very big indeed. It has implications for patients' travel and makes home visits more difficult - the visits may be delayed, might have to be scheduled well in advance or there may even be a need for a permanent on-call GP. This could make continuity of care problematic and may worsen doctors' relationship with patients. This is especially damaging for paediatric home visits – parents may not welcome an unfamiliar doctor especially when the visit is delayed for many hours.

Russia was said to be a country signalling, with its unhappy experience, to others where not to go.[2] It would be a pity if the lessons from Russia are not learnt. The UK with its GP-based system runs a risk of getting into the polyclinic trouble.

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