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IMPLEMENTATION OF PATIENT-CENTERED CARE IN PRIMARY MEDICAL CARE REFORM IN UKRAINE 2018-2020: AN EXPLORATORY STUDY OF STAKEHOLDER PERCEPTIONS IN KIEV AND IVANO-FRANKIVSK

MA thesis

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The Master's Thesis was written independently. All previous research and findings of other authors and data from elsewhere used for writing this paper have been referenced.

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ABSTRACT

The Master's Thesis is focused on the perceptions of patient-centered care by different stakeholders on the primary health care level in Ukrainian two cities, Kiev and Ivano-Frankivsk. To improve the quality of primary health care services in Ukraine, population health in general and make sure that the citizens are provided with equal access to health care services at all levels, the new health care reforms were implemented by the Ministry of Health in late 2017. An essential role in these reforms is the focus on the patient, the so called, patient-centered care (PCC), which should improve the quality of care, make the primary care level more reliable and leave satisfied patients and doctors. This is a comparatively new approach for Ukraine, as before there was a doctor-centered model where the patient's point of view was not required, as the healthcare sector worked just as a system and for the system. There is evidence that doctors are not ready for this new approach as they were always considered as the center of the system and were in charge of the patient's health. Therefore, the aim of the research is first of all to find out the main objectives of the PCC approach and understand the perception of PCC from different stakeholders' viewpoints, because the literature review demonstrated that there should be the same understanding of the certain element of the reform by all stakeholders in order to have a successful reform implementation. Last but not least, it is also important to find out how PCC contributes to the quality of care. It is also important to compare and contrast the findings from both cities and to see how the reform is implemented and whether there are different understandings of the PCC approach. The research contributes to the understanding of the PCC approach in health care not only in Ukraine but to the literature regarding PCC. The researcher also identified policy implications that can be introduced for improving the reform implementation process in Ukraine. Additionally, the research findings may have useful applications in other countries who still suffer from the doctor-centered or system-centered healthcare system and wish to implement another approach in health care. The framework may be also useful for conducting similar research.

Keywords: health care reform, primary care, patient-centered care, integrated healthcare system, quality of care, customized care, patient's choice, shared decision-making

LIST OF ABBREVIATIONS

CMC - Computer-mediated communication

GDP - Gross domestic product

GfK - Growth from Knowledge

HIU - Health Index. Ukraine (survey)

ISO - International Organization for Standardization

MoH - Ministry of Health of Ukraine

NSHU - National Service of Health of Ukraine

PCC - Patient-Centered Care

PDCA - Plan-Do-Check-Act (quality evaluation process)

P4P - Pay-for-performance

PHC - Primary health care

SLBs - Street-level bureaucrats

UTC - United Territorial Community

WHO - World Health Organization

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INTRODUCTION

Health is probably one of the most important possessions that a person has. In the world, there is a holistic viewpoint of what health is; and it is not only the absence of diseases, it is a combination of four components - spiritual, physical, mental and social (Sobol, et al., 2020). Thus, in order to deal with health, there is a huge demand in embracing patient-centered care (PCC), which combines all these four components of health in the delivery of healthcare services. Governments all over the world with international organizations and different other organizations are trying to deliver the message that the focus on individual patients and their needs is very important. All EU countries and not only, believe that the philosophy of PCC approach is the core element of health care delivery (Kitson, et al., 2012). In any country of the world, choosing the best healthcare model is essential in order to improve the quality of care and its access. Moreover, the healthcare model dictates the use of resources in a way that they must be used efficiently.

Until recently Ukraine used an old medical system - Semashko one - which provided for the financing of health facilities themselves by the number of beds, the so-called 'pay-per-bed' system, which was not about service and quality at all and was doctor-or system-centered (Semigina, et. al., 2019). Usually, patients ignored the primary health care level, because the physicians were considered to be incompetent, thus lack of trust between the primary care level and the patient was an issue, which limited primary health care access in Ukraine (Fagre, 2019).

There is no doubt that the PCC approach has to be present at all levels of the medical care; however, the primary healthcare level is the first one the patients go through and more often than other levels. Therefore, the implementation of PCC is essential on the primary healthcare level, as the family doctors do not only cure illnesses, but also three other components of health. According to WHO (2018) primary health care is the most important and effective way to prolong the life and health of the citizens (WHO, 2018).

As most of the scholars define person/patient-centered care approach in general as more involvement of the person/patient, this approach can be linked not only with healthcare but to contemporary welfare regulation as well. Cribb and Gewirtz (2012) argue that a shared decision-making and active participation of a person, as elements of person/patient -centered care can also be used in education and social work (Cribb et al., 2012). There is evidence that in education, a student/pupil-centered approach to learning shows positive outcomes regarding learning facilitation, rather than knowledge transferring (Kember, 1997). Regarding social work, a client-, customer-/person-centered approach has become a dominant idea. This dominance manifests itself in having more power/choice and control over services as a service user that are supposed to be customised to users' needs (Beresford, 2014; Juhila et al., 2017).

According to Lipsky (2010), street-level bureaucrats (SLBs), who are the main implementers of the policies, are not always able to implement the government policies, because it may happen that they have to deviate from rules and make decisions based on the individual case, which actually is a dilemma in the proper policy implementation (Lipsky, 2010). Hence, one of the reasons why the implementation process might go wrong pertains to the different perception of the policy by involved stakeholders (Cohen and Ball, 1990; Smit, 2005; Gross, et al., 1971).

In 2017 a law 'Government Financial Guarantees of Health Care Services' initiated by the Ministry of Health of Ukraine headed by Dr. Ulana Suprun was passed by Ukrainian parliament to finally reform the healthcare system in Ukraine (Law 2168). The new law introduced the new model of healthcare reform that required the change of the financial model and reorganization of the healthcare services provision. The reform is to be implemented in three stages - primary healthcare (family doctors), secondary care (specialist), and tertiary health care (special hospitals). On 1st April, 2018, the new institution was created in order to start applying reforms on the primary level - National Health Service of Ukraine (NHSU), which is the Central Public Authority, that operates state budget funds under coordination of the Ministry of Health (Decree No. 1101). NHSU calls themselves a 'client-oriented and human-centered organization' that 'values professionalism and is result-oriented' (NHSU, Report, 2019).

This research focuses on the perceptions of patient-centered care on the primary healthcare level by different stakeholders. It is important to see whether the healthcare providers are ready for this new approach/model of PCC. It is also crucial to know whether the patients are satisfied with this new model to be implemented. Moreover, the most essential is to find out what the objectives are of this new approach in the Ukrainian healthcare reform from the viewpoint of the experts that were involved in the development of the reform. Last but not least it is important for the researcher to see how PCC influences the quality of the health services provisions on the primary healthcare level. Thus, the research should help answer three research questions:

1. ***What are the objectives of implementing patient-centered care in Ukrainian medical reform of primary health care management 2018-2020?***
2. ***What are the perceptions of patient-centered care among the primary care workers, and patients in Kiev and Case Ivano-Frankivsk?***
3. ***What are the policy implications for improving Ukrainian primary care reform in the future?***

The NHSU works for the benefit of the patient and informs the patient regarding the services in healthcare. All patients in Ukraine must choose a family doctor, sign a declaration with them, and receive primary health care services from them. If necessary, the primary care physician refers the patient to a specialized health care facility. In case the patients need specialised care, the family doctor acts like a gatekeeper here and issues referrals. The NHSU pays for patients, according to the contract with the facility. This is the way 'Money Follows the Patient' works in Ukraine on primary care. Thus, this also means that the more declarations, the doctor has, the more money he/she receives (EASO, 2021).

The research is based on the framework developed from the literature review on PCC and also based on the healthcare reform elements in Ukraine. The framework is based on the Donabedian framework of quality of care that has three categories - structure, process and outcomes. The Donabedian framework is considered to be the most comprehensive, flexible, and simple (Ghaffari, et al., 2014; Visnjic, et. al., 2012, WHO,

2007). The elements of the PCC were fitted into the categories. Additionally, the thesis builds on the literature related to healthcare management or client-orientedness to show how these are crucial in successful implementation of healthcare reform.

The main aim of this study is to compare and contrast two cities where healthcare reform was considered to be the most successful (81%) one or the least successful (65%) one - Ivano-Frankivsk and Kiev respectively (Health Index. Ukraine 2019).
The topic and the focus on Ukrainian healthcare reforms and PCC approach was chosen because of the limited literature availability. When the literature still exists on healthcare reform in Ukraine in general, there is nothing on the PCC approach/model. Therefore, the aim of the research is to fill the gap in the understanding of PCC on the primary level of healthcare in Ukraine. Thus, the topic is highly relevant because it has not been examined yet. The findings related to the cases in Ukraine may have broader applicability and can be used as lessons for other post-Soviet or third-world countries that are reforming healthcare.

To increase trustworthiness and achieve triangulation in findings, the researcher used different data collection methods. The researcher analyzed official national strategies, laws, websites, videos/webinars, conducted in-depth online interviews with different stakeholders from 9th March to 30th April. All qualitative data was processed by content analysis with the help of qualitative coding.

The thesis is divided into four chapters. The first chapter discusses the concept of patient-centredness in health care, barriers that can be during its implementation, and also the importance of the perceptions and why they should be studied. Moreover, the first chapter presents the theoretical framework of PCC. The second chapter gives the overview of healthcare reform and its critique. The third chapter discusses the research design and methodology. The last chapter presents findings that demonstrate how the PCC is perceived by different stakeholders, and whether the stakeholders' perceptions of PCC coincide with reform objectives. The final section of the thesis is devoted to discussing policy implications.

CHAPTER 1: PATIENT-CENTERED CARE AS A CONCEPT

This chapter presents the approaches to define the concept of patient-centred care (PCC) in general[1]. As there are many scholars so there are definitions of the PCC as a concept or approach, so there are different frameworks. In this chapter, the significance and definition of PCC as a concept will be presented and its framework that covers and reveals the elements of the concept. In addition, the barriers to implement the PCC approach will be identified from the previous research. The relevance of studying perceptions in reform implementation is explained.

1.1 Two models of healthcare: the appearance of patient-centred care as an approach/concept

The patient-centred approach or model was not always there for us as patients. There is a well-known model of healthcare, which is far from being the patient-centred one - biomedical model - that was an influential model for the communication between the doctor and the patient throughout history (Manning-Walsh et al., 2004). The biomedical model appeared in the late 1700s and was the dominant one until the 1940s. The model was also called doctor-centred and defined the doctor as the main person who takes the responsibility for the patient and makes the decisions concerning the patients' treatment or practices (Swenson et al., 2006). According to Engel (2008), the biomedical model is only focusing on the symptoms and strictly follows medical protocols for the treatment, no deviations are allowed; the patients' mind and body are disconnected and the person/patient is devalued (Engel et al., 2008).

The concept of person-centred care approach or related concepts such as patient-, family-, and client-care have a long history and first appeared in the 1950s as concepts in psychotherapy and medicine (Leplege et al., 2007). The necessity for the holistic approach in medicine where the patient's viewpoint was considered came from general practice and was promoted by psychoanalyst Balint (1969) and his co-workers. Balint's idea was to make a shift of the work of general practitioners towards patient-centred

[1] Person-centred care, patient- and family-centred care, are interchangeable concepts in this thesis (Leplege, et al., 2007; Mead & Bower, 2000; Stewart, 2001).

instead of illness-centred and see and understand the patient as a unique person, not as just a patient in order to form a more qualified diagnosis (Balint, 1969). Thus, Balint (1969) defines a patient-centred approach as the idea when a doctor understands the patient as a unique person; and in order to implement this approach, the doctor must be not only a physician but also a psychotherapist.

In the 1970s different notions of person-, client-, family- and person-centred care became well-known around the countries and started to be implemented. In the late 1970s, the new name of the model in healthcare appeared - biopsychosocial model - which attributed disease as a combination of three dimensions: psychological, biological and social (Engel, 1977). The creator and proposer of this model was the American psychiatrist George Engel, who argued for the need of the physicians to take into consideration the patient's emotional and social effects of illness (Engel, 1977; 1979; 1980). The biopsychosocial model of Engel triggered the necessity for patient-centred care (PCC) approach, as more and more research and scholars started to recognize the meaning of the patient or the person in the treating process and the quality of healthcare. (Beach et al., 2006).

There is no consensus about the definition of the PCC approach; however, examining the related studies, we may refer to it as a multidimensional approach, which puts the person/patient at the centre of the treating process and whose care can encompass different levels of care delivery: treatment, policy development, philosophy. These last dimensions refer to the study of Baas (2012), who talked about patient-centredness and explained that not only patients have to be included in decision making of their care, but all aspects of the policy, all stages of the treatment process, and institutional design have to be the part of the patient-centredness, too (Baas, 2012). Baas (2012) also considered patient-centered care as a philosophy or a mission that healthcare facilities must accomplish (Baas, 2012).

Most scholars also confirm that communication and feeling of empathy towards the patient are very important in this PCC model as these are beneficial for the patient and the doctor (Engle et al., 2008; Edvardsson et al., 2009; Swenson et al., 2006). Thus, the

common definition that exists among scholars regarding PCC is the shifting focus from the disease to the patient as a unique person that needs a unique approach (Steward, 2001; Ekman et al., 2011; Hobbs, 2009; Leplege et al., 2007; Mead et al., 2000)

1.2 Benefits and significance of PCC

A study by Swenson et al (2006) provided support for patient-centred care and discussed the benefits of this kind of approach in healthcare (Swenson et al., 2006). The authors conducted a survey in US clinics and interviewed around 300 patients of different ages and backgrounds, found that 69% of patients, which is the majority, were in favour of the patient-centred approach, whereas 31% still preferred a doctor-centred approach. Looking at these numbers, we may think that the PCC approach is still not for everybody (going back to this in the following section); however, a more preferable one.

There are other studies that confirm the preference of patient-centered approach by the patients as both parts - the caregivers and the patients - have the feeling of performing an important role in the treatment process (Levinson and Roter, 1993; Epstein, 2000; McKinstry, 2000).

Since there is such a high percentage of those in favour of patient-centred care, there should be then the reasons or benefits of this approach in healthcare, first of all, benefits for the patients. These benefits are studied well in the literature: the literature suggests that the PCC approach is associated with an increased degree of patient engagement, satisfaction and compliance and a lower degree of stress, cost and length of stay in the medical facility (Fredericks et al., 2010; Groene, 2011; Jin et al., 2008; Stewart, et al., 2000). Moreover, the studies which focus on primary healthcare level and on more specialized fields such as mental illnesses, showed that the PCC approach is a ‘must’ approach in order to receive the desired outcomes (Dobscha et al., 2009; WHO, 2008; Mead, & Bower, 2002). There is evidence that PCC has a positive outcome from depression recovery and also is positively associated with improved mental health (Dobscha et al., 2009; Stewart et al., 2000).

Patient-centred approach contributes to developing a good relationship between the doctor and the patient (which is beneficial for both equally) and reduces the concerns and emotional stress of the patient by being well informed (Epstein et al., 2007; Golin et al., 2008). A good relationship between the provider and a patient provides emotional benefits for the patient and improves patients' self-efficacy (Golin et al., 2008).

Epstein (2007) also argues that in order to make a good and right decision for the physicians regarding the patient, the doctor must take into account all the needs and preferences of the patient, deliver a sense of empathy and warmth. Thanks to the PCC approach, patients feel that they are enabled and have the ability to manage their own health.

The scholars also believe that only the PCC approach will lead to faster recovery and positive outcomes in healthcare. However, they also admit that willingness of the patient to participate is also essential as well as a receptive healthcare system, and a communicative doctor (Epstein et al., 2007). Only this tandem, according to Epstein (2007) leads to better outcomes in healthcare. Other research shows that when practitioners use a patient-centred approach in their agenda, patients experience higher satisfaction, are more compliant about the prescriptions, manage their attitude, and have generally better health outcomes (Williams et al., 2000). Patients who were treated according to the PCC model during visits on the primary level, were less likely to use specialty hospitals (Bertakis, et al., 2011). There is also evidence that when patients are encouraged and supported to care and manage their own health, visits to the emergency hospital services decrease (De Silva, 2011).

1.3 Barriers to patient-centred care implementation

One study conducted in Sweden, has shown that the facility structure had a tremendous influence on care delivery. The facilities and the healthcare system mechanism are built in a way to supervise and monitor patients rather than to support patients' individual preferences (Wolf, 2012). Although there were some PCC elements of care, however, PCC was not provided consistently throughout the whole process: there was not enough

time devoted to each patient, and the time provided was not necessarily spent focusing on the patient as a person; there was also 'labeling' of a patient, referring to them by the room or bed number. This idea is also supported by McCormack (2010), who with his colleagues argues that, yes, healthcare professionals' skills, competences and beliefs are essential regarding PCC implementation; however, the structure or context where this PCC is provided influences the healthcare professionals' previously mentioned elements (McCormack et al., 2010). Kitwood (1997) believes that labelling patients, disempowering them lead to depersonalization of the person, which does not contribute to the PCC implementation at all (Kitwood, 1997). Thus, it may be concluded from above that the design of the ward or facility together with social structure and its routines may serve as obstacles to patient-centered care implementation.

Another barrier that can stand in a way to the PCC implantation is the unwillingness of the patient to have this approach to be used towards her/him. A study by Swenson (2006), that was already mentioned in the previous subchapter, also showed that 31% of patients preferred a doctor-centered approach (Swenson et al., 2006). Swenson (2006) and his colleagues see this phenomenon as a barrier to the PCC implementation and lists presumptions why it is so: patients are not ready for the PCC approach; too much information is not desired by the patient; patients do not wish to have a choice, but wants to be strictly guided by the doctor. There are other studies that demonstrate the support of the preference of a doctor-centred approach (still the small percentage) or the so-called biomedical model (Dowsett, et al., 2000; Krupat, et al., 2000; Swenson, et al 2004).

One might think that users' involvement demonstrates more control, liberalization and empowerment; however, Cribb and Gewirtz (2012) do not agree about it. They say that the right given to users to be involved can be enforced and the users are empowered with the kind of the responsibility that they do not wish to be responsible for (Cribb et al., 2012). Moreover, Mayes (2009) and other scholars argued in their articles that patient/person-centered care introduces a new form of relationships between the caregiver and the patient that obscure the conflict (Cribb and Gewirtz, 2012; Cook and Brunton, 2015; Mayes, 2009). This is because of the different understanding of the PCC

as a concept from doctors' and patients' points of view. Thus, the idea that the patient or other user/client is empowered and they may rebalance power relations is false because the patients are still determined to act in a particular way - they are still not allowed to do whatever they wish.

However, the unwillingness of the patients to participate in the PCC approach should not be considered as an obstacle. If the patients do not wish to take part in the decision-making, and do not require a lot of information about their disease then it is their choice and the doctor needs to comply. By doing this, it is already a PCC approach, because the doctor accepted all the preferences of the patient even if these were labelled as doctor-centered approaches.

According to Scott (1987), another barrier that can occur in a way of successful implementation of PCC approach is caregivers' burnout (Scott, 1987). This may happen when the doctor experiences exhaustion, a feeling of unaccomplishment, and feels depersonalized. And because of these symptoms, they may distance themselves from the patients by developing cynic behaviour and dehumanizing patients.

1.4 Why do perceptions matter?

It is not an innovation to say that our perceptions are very important in all spheres of life, because our interpretation of actions or objects influence our everyday-life activities. According to Rober Efron, 'perception is man's primary form of cognitive contact with the world around him' (Efron, 1969: 137). And because our conceptual knowledge is based on this primary form of cognitive contact, studying perceptions is of great importance in science and philosophy (Efron, 1969).

Very often it happens that policies are failing or have poor implementation. There is evidence confirming that implementers do not always act as told to or they do not do anything at all in order to maximize policy goals. According to Lipsky (2010), teachers, health professionals, police officers, social workers, lawyers, and other 'street-level bureaucrats' (SLBs) are the main actors in implementing policies, because they directly

contact and communicate with citizens, thus are the frontline implementers of the policy (Lipsky, 2010). However, these SLBs are not always able to implement the government policies, because sometimes they have to deviate from rules and make decisions based on the individual case, which actually is a dilemma in the proper policy implementation (Lipsky, 2010). Hence, one of the reasons why the implementation process might go wrong pertains to the different perception of the policy by involved stakeholders (Cohen and Ball, 1990; Smit, 2005; Gross, et al., 1971). And this is the very moment when perceptions play their roles and the reason why policymakers' and implementers' expectations do not match.

Regarding educational reforms, there is evidence of different implementation depending on the teachers' perceptions. Vast amount of research confirms that regarding educational reforms implementation, teachers are the key to the success, because their perceptions and knowledge are essential in the effectiveness of reform implementation (Cohen, 1990; Fullan, 2007; Kirk & McDonald, 2001; McLaughlin, 1987). According to Little (1993), teachers do not accept the reforms in a way developers have intended to, because teachers form their own perceptions when reforms are introduced (Little, 1993). There are other studies that also provide evidence from the education field and how students' perceptions of the learning environment influence the learning outcomes (Hassall and Joyce, 2001; Prosser and Trigwell, 1997; Entwistle et al., 2002).

Perceptions in healthcare are also taken into account. For example, the process of treatment depends on the patients' perception of the illness. There are studies that showed how different perceptions of illness have different outcomes at the end (faster or slower recovery) (Cooper, 1998; Petrie and Weinman, 2006; Skotzko, 2009).

Research on nurse care also confirms that perceptions matter. Watson's theory states that carrying in healthcare can be efficient and effective only when it is demonstrated interpersonally (Watson, 1979). Thus, the relationship between nurse and the patient constitutes the caring outcome. Moreover, there should be mutual agreement between the nurses and patients on what is a nursing care attitude (Larson, 1981). In order to receive and deliver good care, nurses' and patients' perception of care must coincide

(Holroyd, et al., 1998; Christopher, et al., 2000; Widmark-Petersson, et al., 2000). As a result, the differences in perceptions of care between nurses and patients leads to dissatisfaction with received care. According to Stewart et al. (2000), the patients' perceivement of the visit of the physician as patient-centered is essential as it contributes to faster and better recovery (Stewart, et al., 2000).

The literature about people's perceptions of social policy also contributed to the importance of studying perceptions. The research was conducted in European countries and the authors argue in their book that to study perceptions of social policy is essential as it concerns improving the life standards of the population (Wendt, et al., 2011). Moreover, to assess the achievement of the policy, the scholars should not only take into account the benefit level provided, but no less important is people's subjective perception of security (Wendt, et al., 2011). Regarding social policy, other authors found that there is an interrelation between delivered by institutions welfare state programs and citizens' perceptions of those programs (Svallfors, 1997; Pfeifer, et al., 2009; Fraile and Ferrer, 2005).

In the world of information and communication technologies (ICTs), perceptions also matter. There are studies that focus on the digital divide term which claim that the term itself may mean different things depending on the audience and their perceptions (access or lack of skills) and because of this discrepancy, there may be different policy outcomes (Dijk, et al., 2003; Fisher et al., 1993; Grandy, 2002).

To conclude, it is crucial to say that perception of a certain concept or the policy is a very important and initial step in order to understand whether it is working the right way, whether it is implemented at all; moreover, the perception step can contribute to the further and improved implementation of the policy.

1.5 Patient-centered care framework

The scientific literature contains numerous definitions of Patient-Centered Care (PCC) as well as different frameworks to measure and understand this concept. The common

definition that most of the authors agree upon is that patient-centered care is care that is responsive to patients' needs and preferences (Duggan, et al., 2005; Laine, et al., 1996; McCormack, et al., 2010; Steward, 2001; Davis, 2020; Institute of Medicine, 2001; Barry et al., 2012). Regarding the frameworks of PCC, different approaches have been introduced, however, not many of them have developed frameworks that deal with perceptions, most of them contribute to implementation of PCC as a guideline (Ekman, et al., 2011; Lowrence et al., 2012; McCormack, et al., 2006; Mead, et al., 2000; Pelzang, 2010; Scholl, et al., 2014).

Thus, based on the literature review it is possible to say that patient-centered care as a concept is defined as an attempt to empower the patients by implementing 'money follows the patient' reform, by expanding their role in their healthcare, by making them more informed, being involved in decision-making, providing them with support, empathy, acceptance, comfort, and confidence, and the most important the feeling of being satisfied in healthcare services provision (from the patients' point of view), or the recovery process (from the caregivers' point of view) (Duggan, et al., 2005; Laine, et al., 1996; McCormack, et al., 2010; Steward, 2001; Davis, 2020; Institute of Medicine, 2001; Barry et al., 2012; WHO, 2007).

In this thesis, we are interested in studying the perceptions of PCC as a concept in Ukraine among the stakeholders. Since there is no perfect framework that would measure the PCC including all its elements, the combined models/frameworks will be used, where there are different elements of the PCC concept of different scholars. The elements were selected in a way that will help us to answer our research questions. They reflect the idea of the quality of care, interpersonal relationship between the doctor and the patient, perception of the PCC and also help to detect the barriers to a good quality of care implementation as well as implementation of the PCC approach. The Donabedian framework focuses on the domains that relate to the context (health care system) in which services (health care) is provided. This framework was used to classify the elements of PCC. The Donabedian framework will be used because of its simplicity and flexibility; it is also considered to be the most comprehensive framework *(cf Table 1.1)* (Ghaffari, et al., 2014; Visnjic, et. al., 2012, WHO, 2007).

Table 1.1: The combined framework of the concept of patient-centred care

Structure Health care system/organizational level	**Process** Patient-caregiver relationship	**Outcome** Quality of care
	⇓	
- Integrated health systems (WHO, 2008) - Money follows the patient (Eldridge, et al., 2009; Cashin, et al., 2014) - The principles of customer choice (Victoor, et al., 2012; Harris, 2003)	- Understanding patient as a whole (Hudon, et al., 2011) - The principle of customized care (Snyderman, 2012; Minviele, et al., 2014) - Patient engagement in managing their care and shared decision-making (WHO, 2008; Santana, et al., 2018)	-Perceptions of improved quality of care of different stakeholders - caregivers, patients and policymakers.

Source: Compiled by the author by drawing on the following sources, Donabedian, 1988; Eldridge, et al., 2009; Harris, 2003; Hudon, et al., 2011; Minviele, et al., 2014; Santana, et al., 2018; Snyderman, 2012; WHO, 2008; Victoor, et al., 2012.

The model says that the quality of care can be classified into three categories: 'Structure,' 'Process' and 'Outcome'. In this framework, structure includes PCC elements of the context in which care is delivered, the foundation of PCC; process includes elements of PCC which are important for understanding doctor-patient relationship; and outcome is associated with the quality of care and how PCC perception affects quality of care (Donabedian, 1988).

The category 'Structure' contains three domains of PCC:

Integrated health systems. Integrated health may be perceived differently depending on the person and the persons' needs. In general, it is supposed to be something 'right', in our case the 'right care' in the 'right' place. According to WHO (2008), integrated health systems is 'the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money' (WHO, 2008: 1). Based on the literature review integrated health systems may include different elements; facility infrastructure, performance monitoring, training programs, good healthcare governance, resources, health information system (Kemp, et al 2015; Pelzang, 2010; Santana et al, 2018; WHO, 2007; 2008).

Facility infrastructure is a part of integrated health systems. A properly accommodated facility is a crucial detail of PCC, because a professional, nice design ensures that patients feel comfortable, expected and welcomed (McCormack, 2008; Pelzang, 2010; WHO, 2007). The facility physical design contributes to the patients' safety, privacy and comfort (Kemp et al., 2015). Moreover, facility environments are supposed to provide services in the appropriate format - suitable visiting hours and language support (WHO, 2007).

WHO (2007) also refers to good governance in health systems integration (WHO, 2007). Good governance is possible only by the mutual accountability among policy-makers, providers and users when deciding about the patient-centered approach. Establishing a strong policy framework by the policy-makers and a clear vision of all stakeholders of how that framework will be implemented is an essential step to health systems integration (WHO, 2018).

Providing information about performance is also an important element of health care systems integration. Ideally, these structures should be created by policymakers, caregivers and the patients (Santana, et al., 2018; WHO, 2018). These measurements can include such approaches as surveys (patients' experience), patients' complaints or praises as well as lessons learned (Rathert, et al, 2013; Snyder, et al., 2012; Lohr, et al., 2009).

According to Santana (2018), there should be a balance among healthcare givers and the patients' preferences of issues (Santana, et al., 2018). In order to have a clear view of how the PCC approach will be implemented and will fit all facilities, improvement in the quality of healthcare is crucial (Pelzang, 2010).

Training programs as the way to a more integrated health care system. The lack of appropriate training and guidelines towards PCC is one of the barriers to its implementation (Pelzang, 2010, Santana, et al., 2018). Education, which should implement a biomedical model, is not the same depending on the facility and the content is not co-developed with the customers/patients and care providers (Shaller, 2007). With the widespread implementation of the patient-centered care approach, there is a necessity for innovative and adaptive education programs for the caregivers in order to change a cultural change and ensure successful implantation of the approach. PCC should be integrated into the educational curriculum and practice in a way that it continues to influence the culture and the improvement of the implementation (WHO, 2007; Pelzang, 2010).

Health information system is no less important. According to WHO, reliable and secure information is the base of making decisions in the health system, especially regarding policy development, implementation, health education, service delivery and health research (WHO, 2008). For caregivers and for patients, a reliable health information system is also the way of communication between two parts.

Money following the patient. Money following the patient belongs to the pay for performance schemes (P4P), which is also called performance-based financing, meaning that health workers or the facilities receive incentives for the achievement in health care services (Kovacs, et al., 2020). The P4P approach in health care can be dated back to the late 1990's. In 1999 in the USA, Institute of Medicine released a report, which demonstrated that the US healthcare critically deviated from hospital guidelines and best practices (IOM, 2001). Thus, the recommendation was issued that in order to

support the quality improvement, payment incentives need to be paid to providers (IOM, 2001).

This is one more important dimension that shows whether the primary healthcare workers have incentives. What does it mean 'money follows the patient' - more transparency, efficiency, better services, more patients, special care? Many nowadays payment systems in the primary healthcare level encourage doctors to increase the quantity of patients and at the same time reduce the visiting time for one patient (Appleby, et al., 2012). Many scholars suggest that policy makers must consider other ways to provide incentives/payment to reward caregivers practicing PCC (Appleby, ey al., 2012; Pelzang, 2010; Shaller, 2007).

A vast numbers of literature shows the effect of the P4P schemes; and it can be concluded that P4P schemes can have positive, negative or no effect at all depending on the settings in the healthcare (Eldridge, et al., 2009; Oxman, et al., 2009; Powell-Jackson, et al., 2015; Cashin, et al., 2014). Pay for performance programmes are to achieve the settled goals, from improving clinical quality or preventing diseases to reducing health disparities or improving the use of information technologies in health care (Cashin, et al., 2014). In Australia, for example, GP clinics are rewarded for investing in facilities (computerization, expansion of services such as providing care after office hours) (Cashin, et al., 2014). Another example is Medicare's Physician Group Practice Demonstration in the USA, which rewards physicians for achieving lower cost (Colla et al., 2012). Less popular, but also promising are P4P programmes that attempt to reward both quality and efficiency by better continuity of care. In France, Germany, UK and Estonia, the P4P programmes have this direction (Cashin, et al., 2014).

The principle of customer choice. In the past, patients were not allowed to choose their care provider. It has become only recently possible in the northwest European countries, such as the UK, the Netherlands and Sweden (Ranerup, et al., 2012). According to Victoor (2012), allowing the patient to choose their physicians would reduce waiting times and contribute to the competition between physicians and facilities (Victoor, et al.,

2012). Other scholars also support this idea saying that competition is important and would make healthcare more responsive to the customers, improve quality and efficiency of healthcare (Grytten and Sørensen, 2009; Dixon, et al., 2010). Another reason for implementing the patients' choice is to emphasize the patients' empowerment (Victoor, et al., 2012).

Thus, if taking into account the approach of 'money follows the patient' then this process of choosing the physician will encourage them to compete for their customers by improving quality of consultations, health services, decreasing costs and all these will help to ensure efficiency, quality and equity (Burge, et al., 2006).

The category 'Process' contains two domains, which actually have more components of PCC:

Understanding the patient as a whole. Nowadays modern medicine is moving away from the doctor-centered approach, which focuses only on diseases, symptoms, tests and other medical conditions of the patient. It is moving towards patient-centered now, where the patient is not only seen as a patient, but also as a person. This means understanding the patient as a whole, the kind of holistic approach to understand where the illness comes from, taking into consideration not only biological factors, but also psychological, social and individual health-related behaviour (Naughton, 2018; Roter, et al., 1987; Robinson, et al., 2008; Teutsch, 2003). Thus, caregivers must accept their patients as a unique person with their concerns, expectations, ideas, preferences, needs, feelings and dislikes and address those. This also means that treatment cannot be uniform for all patients with the same disease; it should be tailored to the patient' need, so that the patient feels he/she has a personalised care to their unique needs (Steward, 2001; Ekman et al., 2011; Hobbs, 2009; Leplege et al., 2007; Mead et al., 2000; Youssef, et al., 2020).

Caregivers must demonstrate respectful and compassionate care, which means being responsive to patients' values by acknowledging patients' religion, culture and showing empathy and understanding of patients' emotions (Mead, & Bower, 2002). Respectful

care towards the patient builds the relationship and promotes better results in the patient's treatment (Mead, & Bower, 2002). The literature shows that there is a lack of compassion recently and caregivers became less and less empathic listeners (Levinson, et al., 2010).

The principle of customized care. Earlier literature shows that customized care has always been an important element in healthcare (Minvielle, 2014; Snyderman, 2012). Every patient desires to be treated individually and feel that they receive the unique care, that the care is tailored to their preferences (Minvielle, 2014). As the doctor-centered approach is already the past, the new doctor-patient relationship refers to customisation as the essential element of care for health providers. The term customized care is relatively new in medicine; however, according to Davis (1987), this term is also known as 'the mass customization in industry', which has to be, and can be tailored in healthcare as well. Davis defined mass customization in industry as the production of consumer-tailored products in order to satisfy and meet consumers' different needs (Davis, 1987).

Minvielle (2014) argues that patient-centered care and personalized medicine are the first steps to the customization (Minvielle, 2014). However, in this paper, customized care is considered as an element of the PCC approach. In order for the PCC approach to work, customized care should be implemented. Thus, according to the literature, customised care is about using new approaches and techniques in the treatment process, which contributes to quality improvements, personal health planning, detecting early diagnosis, right treatment for the right person as well prediction of the side effects (Minvielle, 2014; Snyderman, 2012).

Patient engagement in managing their care of shared decision-making. Health-care provision can be improved by a positive engagement of patients with caregivers which leads to patients having a feeling of being respected and empowered. (WHO, 2008; Boivin, et al., 2010). There is evidence that shows when caregivers are engaged with patients, they are less likely to make mistakes (Santana, 2018). Thus, to improve patients' safety, health outcomes, quality of care, and help facility management,

co-developed care plans with support of a patient, which shows the engagement of both parts must be implemented (Coulter, 2012; Santana, 2018; Fix, et al., 2018).

Based on this principle, patients and doctors should be seen as equal partners in the treatment process and care. For the patient, as we have discussed above, that means empowerment and 'ownership' of health or a feeling of being involved; however, for the doctors it is a learning experience from patients, because in order to set goals, a caregiver must know the goals of a patient (Fix, et al, 2018). Thus, the key here is doing what the patient wants, even if that means going against the recommendations - 'Patients call the shots, while the doctors just help them to achieve their goals' (Fix, et al., 2018: 303).

Finally, to conclude the discussion of the theoretical framework, the 'Outcome' category will be the most important in this thesis, because patients' satisfaction of services will demonstrate to us how the PCC approach is implemented and understood from patients' point of view. Other stakeholders and their understanding of the PCC approach and its implementation are also involved - caregivers and policymakers. 'Outcome' will show us the value of patient-centered care and what improved quality of care will mean to different stakeholders. The responses from the patients about their health conditions and its treatment process are crucial at this stage of the research, because the link will be identified between health-care provision and outcomes (Lohr, 2009; Santana, 2018). Caregivers' and experts' perceptions of improved quality of care and the PCC approach are no less important than the patients as only the comparison of all three groups will give us the answer to move toward successful implementation of the concept.

CHAPTER 2. MEDICAL REFORM IN UKRAINE

The current chapter gives an overview of the medical reform in Ukraine from 2018 to 2020. Starting already in 2015, the Government of Ukraine initiated a transformational reform of the health care system in order to improve the health of the population and provide financial protection against excessive costs 'out of pocket' by increasing efficiency, modernizing the outdated service system and improving access to quality health care. The medical reform can be divided in three stages - the primary healthcare level (ambulatories, polyclinics), the secondary healthcare level (general hospitals), and the third level, that involves the specialized facilities, such as Institute of Cancer in Ukraine or Okhmatdyt Children's Hospital (EASO, 2021). The chapter also provides the statistics on the reform implementation and shows the currently examined/acknowledged challenges that prevent the reform from the successful implementation.

2.1 Primary health care prior to reform

During Soviet times, Ukraine inherited its centralized healthcare system, the Semashko one which in theory was free for all, or as they called it 'free medicine for everyone' (EASO, 2021). This Semashko system provided for the financing of health facilities themselves by the number of beds, the so-called 'pay-per-bed' system, which was not about service and quality (Semigina, et. al., 2019).

However, in practice it is different: every second patient in Ukraine refuses treatment or hospitalization, postpones it due to lack of resources (money), and more than 70% of Ukrainians resort to self-treatment, considering the fact that there is 'free' medicine in Ukraine (Topol, et. al., 2018). A 'Growth from Knowledge (GfK) Ukraine' study says that around 18 million Ukrainians visit the hospital every year, and almost 93% of them pay by themselves out of their pockets for the services provided (Ibid). Almost a quarter of Ukrainians report that it is unlikely that they could receive care from a state-run hospital or polyclinic if they needed it because of an inefficient health care system, particularly primary care (Cylus, et al., 2015). Studies demonstrate that up to recently

the Ukrainian system of primary health care was not efficient and effective (Semigina, et. al., 2019).

Despite the critical situation in the healthcare provision in Ukraine, it was not taken into account by any government and never meant to be reformed up to the 2015 year (WHO, 2019). During 25 years 21 drafts were developed just for one reason - to be developed only and there was no political desire for reforming. As a result, the health system in Ukraine was underfunded and relied on patients' money payments; medical staff were underpaid and not well-qualified (WHO, 2018).

Primarily care was not successful as patients tried to skip it appealing directly to the second level of healthcare - specialists. The whole system relied on hospitals which provided inappropriate non-emergency services (Yakovenko, 2018). Official statistics show that 24% of cases in Ukrainian hospitals were accompanied by surgery, compared to 70% in other countries. At least 20% of all inpatient cases could be treated on a primary health care level, and 57% of inpatient 'bed-days' could not be justified (WHO-WB, 2019).

The reason why Ukrainian patients do not rely on primary health care dates back to the legacy of Soviet times, where primary healthcare doctors/physicians played a role not as the people who treat diseases but as dispatchers who only provided referrals to the second level of healthcare (Sobol, et al., 2020). In primary healthcare there was no competition between doctors or primary facilities as there was no choice of physician or a facility due to the reason that patients were attached to certain territories and to the certain doctor (Ibid). Primary healthcare level was the most underfunded, because the funds were distributed at the local level. Facilities that belonged to the primary level were scarce of resources as often those got the budget what was left after the hospitals and emergency care (Yakovenko, 2018). The mentality among Ukrainians, especially in rural areas, was also that the physicians were perceived negatively as professionals as they did not fit in any hospitals in cities or towns and also most of them were old. The younger or better specialists usually refused to work in the rural areas as there were no incentives or accommodation to support them (Romaniuk, et al., 2018).

In conclusion, it would be relevant to see and compare what are the differences that the new medical reform is about to bring. Most of them concern the financial model; however, there is one more aspect that this research is interested in, and this concerns is the PCC approach *(cf Table 2.1)*.

Table 2.1: The main functions of the reform before and after

Functions	Before the reform	After the reform
Fundraising	Trough general taxes	Trough general taxes
Accumulation and pooling of funds	Distribution of funds at different levels of budgets (national, regional, district / city / united territorial community (UTC)	The only source of distribution of funds at the national level; Opportunities for additional funding from local budgets
Purchase of medical services	Passive ordering of services: financing of institutions on the basis of estimates. Funding is not based on the quantity and quality of assistance provided.	Strategic ordering of services: the decision to purchase services is made on the basis of data on the needs of patients and the ability of institutions to provide such services. estimate
The choice of the family doctor	The population of the city was divided into territories and each territory was attached to a certain doctor.	The free choice of the doctor, your registration is not taken into account; the patient may choose any doctor, from any town or village.
The focus	Doctor is the main and at the center of the process; the focus is on the disease.	Patient is at the center. Doctor and the patient are the team.

The relationship doctor-patient	Limited	Long-term personal
The main activity	Diagnosis and treatment of acute cases. Occasional medical care	Prevention, supervision and support of chronic diseases. Comprehensive, continuous assistance
The role of the patient	Passive consumers of medical services	Citizens are partners in addressing issues related to their own health and the health of the community in general
Patient's data	Paper-based	Creation of the E-health (health system).

Sources: researcher's design based on the WHO-WB joint report, strategies of MoH (2015 and 2018), Report of NHSU (2019).

2.2 The healthcare reform implementation

The concept paper, where the health financing plan was presented, was approved by the Cabinet of Ministers of Ukraine on 30 November 2016 (Decree No. 1013-r). In 2017 there was a law 'Government Financial Guarantees of Health Care Services' passed by Ukrainian parliament to finally reform the healthcare system in Ukraine (Law 2168). The law was initiated by the Ministry of Health of Ukraine headed by Dr. Ulana Suprun at that time, and who personally experienced 'the old medical system' in Ukraine and discovered a vast amount of disadvantages and problems. After interviewing doctors, patients and others, the team decided to launch the 'new' medical system and took the evidence-based and democratic approach to the implementing healthcare reform (MoH). There were also other laws that supported the health care system *(cf Table 2.2)*.

Table 2.2: Key legislation

Number of document	Name of document	Date of approval	Level of approval
1013-p	Cabinet of Ministers Decree on Approval of Health Financing Reform Concept	30 November 2016	Cabinet of Ministers
180	Affordable Medicines Programme	16 March 2017	Cabinet of Ministers
2168-VIII	Law of Ukraine on Government Financial Guarantees of Public Medical Services	19 October 2017	Parliament
2206-VIII	Law of Ukraine on Improving Affordability and Quality of Medical Services in Rural Areas	14 November 2017	Parliament
1101-2017	Establishment of the National Health Service of Ukraine	27 December 2017	Cabinet of Ministers
2246-VIII	State Budget Law of Ukraine 2018	7 December 2017	Parliament
503	Ministry of Health Order on open enrolment to PHC doctors and procedures of signing declarations	19 March 2018	Ministry of Health
504	Ministry of Health Order on PHC provision	19 March 2018	Ministry of Health
407	Cabinet of Ministers Order on PHC financing	25 April 2018	Cabinet of Ministers
2696-VIII	State Budget Law of Ukraine	28 February 2019	Parliament

Source: WHO and WB. Ukraine: Overview Of Healthcare Financing Reform 2016-2019.

The general elements of the reform were to strengthen primary medicine, change the financing mechanism, and to develop the modern system of storing the medical data (Yakovenko, 2018). According to the Ministry of Health of Ukraine (MoH) the key element of transforming the 'old' medicine is the focus on the patient and patient's needs (MoH). The next transformation according to the Ministry, is the 'money follows the patient' mechanism, which is characterized by the fact that the state will allocate the money according to the patients' needs, not as before, according to hospital beds (Ibid). No less important element of the reform is the introduction of family doctors. Now the patients have the right to choose the doctor they want based on their skills, regardless of the place of registration. Family doctors must constantly take good care of their patients and receive the salary and incentives for the number of contracted patients. Thus, physicians have to make sure that the patient stays with the doctor and is satisfied with the services provided. The new reform also guarantees the free services at the primary level. There are also recommendations for patients and doctors published by the Ministry of Health (MoH). They ask patients to be brave enough not to give bribes and in case it is required write a complaint. At the same time, the new reform promises doctors their long-awaited dreams - respect, appropriate qualification and financial compensation (Ministry of Health of Ukraine).

The healthcare reform was implemented in three stages. The first stage of the reform was initiated in 2018 and concerns the primary care level, specifically integration of the primary healthcare model with the family medicine style as exists in all countries of the European Union (MoH). The role of the European Union (EU) is crucial in health reforms implementation in Ukraine. Financed by the EU, and implemented by a consortium consisting of GFA Consulting Group GmbH, Hamburg, and the Finnish Institute for Health and Welfare, Helsinki, there are two huge projects that contribute to the health reform implementation - 'Moving Forward Together' and 'Public Health' (Center of Public Health of Ukraine (CPHU)). The main aim of these projects is supporting the modernization and development of a sustainable public health system in Ukraine for effective disease prevention and control in line with EU legislation, requirements and practices. Moreover, they strengthen national leadership and capacity in Public Health policy programming and implementation (CPHU).

On 1st April, 2018, the new institution was created in order to start applying reforms on the primary level - National Health Service of Ukraine (NHSU), which is the Central Public Authority, that operates state budget funds under coordination of the Ministry of Health (Decree No. 1101). Main functions of the NHSU are to make sure that the money is allocated accordingly - strategic purchasing, contracting and control for both, public and private providers (Ahiyevets, et al., 2020). Thus, starting from July 2018 primary healthcare facilities started to receive money based on the services they provide, which also because of the adoption of 'money follows the patient' mechanism , that replaces the mechanism of state-funded facilities (National Health Service of Ukraine). The only way to contact NHSU is through the national e-Health system, which was created already in 2017 (Ibid). Thus, to make a Declaration with the patient, to contact and to report is only possible via e-Health.

On primary healthcare level, the patients receive care from professionals - general practitioners or family physicians, therapists or paediatricians. They sign the so-called New Patient Declaration, which is a contract with the doctor (MoH). If the patient is not satisfied with the family doctor, there is always a chance of signing the new Declaration with the new care provider. According to MoH, the goal of family medicine is to ensure that every family in Ukraine has a family doctor who they can trust, rely on, and have confidence in, which is the part of the program - 'A Doctor for every Family' (Order No. 503). Moreover, the physicians should be motivated, and provide the highest quality services for the patient according to the patient's needs and preferences.

By looking at the survey data that was presented in 2020 by the national survey Health Index. Ukraine, it can be observed that the doctor's attitude was dramatically improved towards patients since the reform implementation *(cf Table 2.3)*.

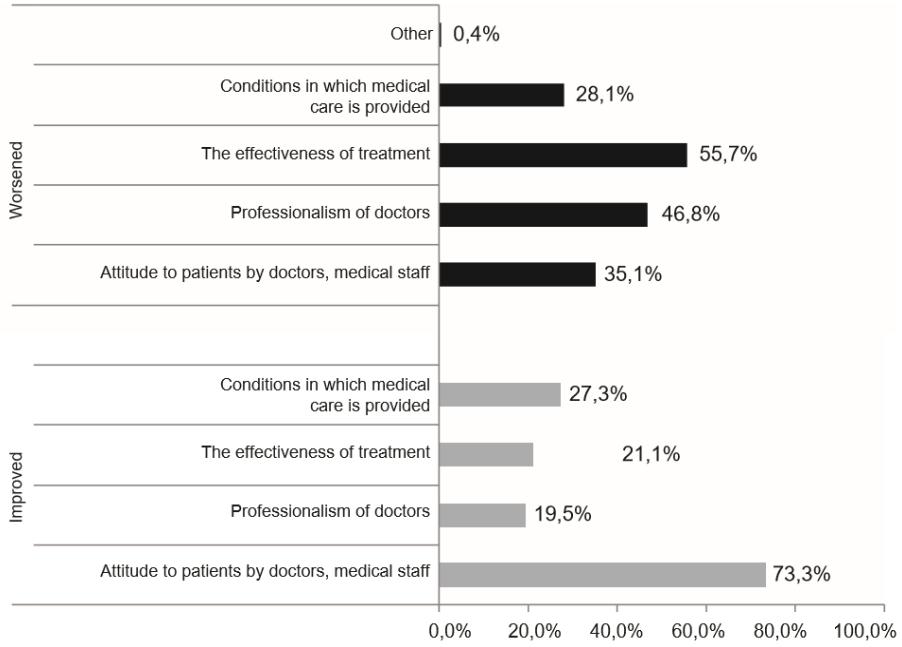

Table 2.3: What has improved and what has worsened?

Source: Health Index of Ukraine: the survey results 2018-2019.

The second stage of medical reform started on 1st April 2020 and concerned hospital care - the second level of medicine (EASO, 2021). The reform introduced free services and changes in specialized hospitals. It starts with the fact that in order to see the specialist, the patient will need a referral from the family doctor, so that the secondary level services can be free of charge.

The third stage of reform is not implemented yet and is planned to be implemented in 2021 (EASO, 2021). At this stage reform will touch upon specialized facilities, as for example, Okhmatdyt Children's Hospital in Kiev or the National Cancer Institute. There will be changes in medication procurement; however, due to the recent COVID-19 events, the third stage of the reform is delayed.

2.3 Challenges and criticism of the reform

The survey results of 'Health Index. Ukraine-2019' confirms that 87% of Ukrainian citizens are satisfied with primary healthcare and 73.1% are satisfied with the family doctor (HIU, 2020). 'Health Index. Ukraine-2019' started research in 2015 with the help

of the International Renaissance Foundation, School of Public Health of National University of Kyiv-Mohyla Academy and Kyiv International Institute of Sociology . In 2018, the questions on primary health care reform (choosing the primary health care provider, perception of e-health) were added to the research instrument of 'Health index. Ukraine' (Health Index. Ukraine, 2020). The World Health Organization also confirmed a relatively high satisfaction of the primary level transformation among Ukrainians in 2019 (WHO, 2019). According to the government website, by September 2020, 31 million of Ukrainian citizens made their choice with the family doctor, which is a bit more than 80% of the population (MoH https://en.moz.gov.ua/family-medicine.).

Experts from WHO hope for the optimistic outcome of the reform of the primary healthcare system as, according to them, it is a good foundation for the future implementation of the reform (WHO, 2019). However, there is a challenge in the medical reform implementation in the primary level, which has to do with the decentralization aspect (Ibid). It is believed that local authorities are not capable of taking the responsibility of decision making due to the fact that they have always received the orders from the top (central authorities). Starting with the 'money follows the patient program', primary healthcare level facilities will have to attract the customers by their own strengths; and considering the fact that this experience is new, it can create chaos (Public Health Center). Thus, the local government must learn how to make decisions independently, not waiting for the orders from the top.

Although the family doctors' salaries tripled since the reform, there is still a challenge for the doctor not to take bribes and for the patients not to give them (Semigina, et al., 2019). There are two reasons why this is so, according to experts, - patients do not understand the reform as nobody introduced or explained it to the public in their language; and the second reason is that the doctors themselves do not explain this new reform to their patients (EASO, 2021). The reform not only needs more time for the patients and the doctors to get used to it, but also there is a need for MoH to conduct information campaigns for patients/citizens to make them more literate regarding the new medical reform.

It is also argued that most of the secondary level of healthcare doctors opposed the reform because the official salaries are much lower compared to the old medical system Semigina, et al., 2019). Other evidence that is against the reform is the fact that there is not enough resources (funds) to sustain the reform and this will result in the health facilities closure. Thus, according to the experts. Funds would need to be increased from 3.2% up to 5% of Gross Domestic Product (GDP) (EASO, 2021). However, the amount of funds allocated to the hospitals will depend on how the facilities are performing, and if they are underperforming, they will eventually lose money (Ibid).

There is also evidence that the referrals do not always work, patients still come to the specialized hospitals, where they need already the second referral from the specialist from the general hospital and require consultation with the specialist without any referral (EASO, 2021). Unfortunately, the patients are sent back home or back to the family doctor, which causes the frustration of the patients; however, patients should remember that the aim of the medical reform is the strict referral system.

Another challenge in the primary healthcare level facilities was the start of the COVID-19 pandemic (Ahiyevets, et al., 2020). Since the primary healthcare functions properly, all patients with COVID symptoms or without visited first their family doctors. However, when the additional service package was added into the services list, the primary medicine was not included, and accordingly did not receive the appropriate test, equipment, costumes, etc (Ibid). The resources in fighting against the pandemic were allocated in the specialized facilities; however, most cases were first still detected on the primary level. According to the EASO report, this resulted in many staff getting the virus and quitting their jobs (EASO, 2021).

The following challenge in the reform implementation was the change in the government. In March 2020, Ukraine received a new Minister of Health, Maksym Stepanov, and this fact could be a threat to the second stage of the reform as during the reform implementation there were four different Ministers, which in some way put the reform in the halt (Nadon, et al., 2020). Each Minister had a focus on different elements

of the reform and due to the change of Ministers it was not clear how the reform would proceed (Ibid). Thus, there was fear in the government that the second stage of the reform would not be implemented properly and even such things as procurement of medication by an agency - a mechanism that would save resources - would also not be accomplished (EASO, 2021).

With the implementation of new medical reform in Ukraine, there is a need for new guidelines, new protocols and new standards of practices as in other European countries. Starting from March 2020, Ukrainian facilities cannot use the old protocols which were not updated for more than ten years (EASO, 2021). All treatment should now be followed international guidelines.

By looking at the Health Index of Ukraine (HIU) survey results, it is still probably early to judge the changes, as the implementation has not reached its best results. The reform is not completed yet, thus we may not evaluate the overall results. The slight improvement can be seen; however not the dramatical one *(cf Table 2.4)*. The data collection for the round 2019 was collected by the Kiev International Institute of Sociology. The sample was over 10 thousand respondents, around 400 respondents in each region (HIU, 2020).

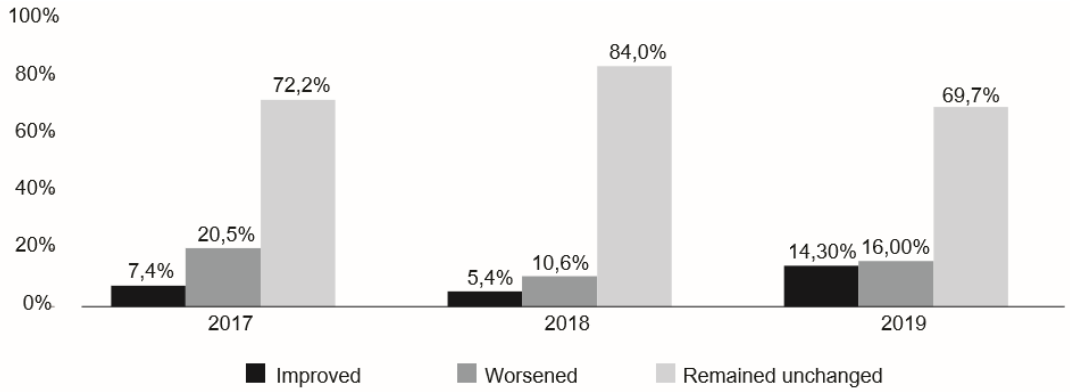

Table 2.4: Perception of the quality of care on the primary level

Source: Health Index of Ukraine: the survey results 2018-2019 (HIU, 2020).

Thus, by presenting the challenges of the health care reforms on the primary level and not only, it is essential to understand why these challenges occur. And studying the perception of patient-centered care will help the researcher to see whether there is a relation between PCC and the reform implementation on the primary level. Most of the challenges that were discussed have elements of PCC that are presented in the framework of the research - ‘money follows the patient’, the attraction of the customers, understanding between the doctor and the patient. It will be also possible to see whether these challenges still exist and what the stakeholders think about overcoming them. Will PCC play a role here?

CHAPTER 3. RESEARCH DESIGN AND METHODOLOGY

The chapter provides the details on how the research was conducted. It starts with a brief overview of the research problem and outlines the research questions. The research design, sampling procedure, research methods, reliability, validity, limitations and ethics of the conducted study will be presented under the current chapter. This chapter is pivotal in understanding the whole procedure of the research and can be useful for the repeated procedure in the future in other countries to study patient-centered care.

3.1 Research problem

The Ukrainian healthcare system is currently undergoing magnificent changes. Since late 2017, the Ministry of Health of Ukraine has begun to implement medical reforms, starting from the primary health care level. This is the first major step from the side of the government to reform the healthcare system in Ukraine since its independence. Regarding the new medical reform in Ukraine, the government says - 'Its goal is to provide all citizens of Ukraine with equal access to quality medical services and to reorganize the health care system so that the patient is at its center' (Government Portal). Thus the 'pay-per bed' system will be changed into 'money follows the patient' one.

Hence, this research intends to study the concept of patient-centered care (PCC) in Ukraine. This study is important in demonstrating how in the country from Soviet past, the concept of PCC is perceived at the primary level of healthcare as this is a completely new practice for Ukrainian citizens. This study will show what the objectives of implementing PCC are; what the barriers are towards its implementation; how it is understood by different stakeholders; whether there are any differences in perceptions; and finally, what can be done to improve the quality of care on the primary level which is closely related with the PCC approach. Therefore, the research conducted on the concept of PCC will answer the following research questions:

1. ***What are the objectives of implementing patient-centered care in Ukrainian medical reform of primary health care management 2018-2020?***
2. ***What are the perceptions of patient-centered care among the primary care workers, and patients in Kiev and Ivano-Frankivsk?***
3. ***What are the policy implications for improving Ukrainian primary care reform in the future?***

Thus, the aim of the current study is to explore how the PCC is perceived by different stakeholders and show how it influences the quality of care.

The thesis expects that there are discrepancies in perceptions of PCC among stakeholders (among different levels - policy makers(experts) - caregivers; caregivers - patients) and that is why there are cases of less successful medical reform performance on the primary level and more successful performance. The thesis also expects that in case the PCC is perceived the same by one group of different stakeholders (experts -caregivers), it can be still perceived differently by the third group - patients, which will also pose difficulties for successful implementation as the patient will not be satisfied with the PCC approach or do not desire it. It is also expected that although there is a good understanding of the new phenomena of PCC, there can be ignorance of implementing it from the family doctors' side because of the unexpected factors - lack of incentives, lack of time, etc.

The thesis assumes that in case of misunderstanding between the experts that were involved in developing the reform and caregivers, caregivers and patients regarding the medical reform and its main focus as the government stated above, can lead to the poor implementation of the reform and dissatisfaction among the patients. The aim of the thesis is to make these competing understandings explicit and to identify and examine these differences in stakeholder perceptions with the aim of facilitating future courses of action towards successful implementation of the PCC in the Ukrainian healthcare system.

3.2. Research design

The research problem will be analyzed within the context of Ukraine. It was carried out as a qualitative case study, using document analysis and in-depth/semi-structured online interviews on national and health facility level in Ukraine; thus the triangulation approach was used. Triangulation is a way to collect data from multiple sources. According to Tellis, 'triangulation increases the reliability of the data and the process of gathering it' (Tellis, 1997: 12). Why was the qualitative approach chosen for this case study? According to Yin (2003), qualitative case study helps the researcher to investigate individuals or organisations, directly through diverse approaches, interactions, cultures, or services and encourages the deconstruction and eventual reconstruction of various phenomena (Yin, 2003). We should apply a qualitative case study when:

(a) the research question is to answer "how" and "why" questions;

(b) one cannot manipulate the behaviour of the people involved in the study;

(d) the boundaries are not clear between the context and phenomenon (Yin, 2003). Since the study is about perceptions and understanding, there is no better research design than qualitative study.

Therefore, the study took place in Ukraine and can be perceived as the main context of the research. The selection of the research topic and its sole focus on Ukraine was chosen for various reasons. Firstly, the implementation of medical reform in Ukraine is constantly discussed in the state. Secondly, no similar studies had been carried out on the PCC concept before in Ukraine. All studies were focused on medical reform in general (Semigina, et al., 2019; Sobol, et al., 2020; Topol, et al., Yakovenko, 2018). Moreover, being a country of Soviet past and in Eastern Europe, Ukraine can demonstrate how the concept of PCC is perceived and implemented for other Soviet-past-like countries, which haven't changed their medical system on primary health care level. Thus, this research may be further used as a framework for exploring the concept of patient-centered care in similar contexts.

More specifically, the research was focused on two Ukrainian regions - Kiev and Ivano-Frankivsk, which would be our two embedded cases. According to preliminary

research conducted for this study, those are the regions where the medical reform on the primary level works the worst and the best respectively. Case selection was based on the national survey Health Index. Ukraine (2019), which is an annual survey organized by the International Renaissance Foundation to determine the actual level of satisfaction of Ukrainian citizens with medical care (primary care is one of the indicators, which was only taken into account) (Health Index. Ukraine 2019). The data was also collected with the help of the International Institute of Sociology in cooperation with Social Indicators Center. The results showed that the highest percentage of primary health care satisfaction is in Ivano-Frankivsk (81%); and the lowest percentage is in) and Kyiv (65%) (Health Index. Ukraine 2019). Thus, the chosen cases will help the researcher to see whether they differ in understanding of PCC; whether these percentages have something to do with the perceptions of PCC.

Thus, these regions can be seen as cases and the facilities can be taken as units of analysis. The research can be considered as multiple case one as it presents not only one region or facility. Yin (2003) argues that a multiple-case study design is more representative and robust than a single case study. Moreover, multiple-case study design also allows for replication in data collection, which is an advantage in understanding the issue under study (Yin, 2003). Based on the types of case study proposed by Yin, the type of our case study would be exploratory (Yin, 2003).

The study started in February 2021, when national strategic documents were first analysed, and ended in May 2021, when the last interview was conducted. The research was fully conducted in the Ukrainian language and materials were translated into English by the author of the thesis. All data from different sources was converted into digital text format for analysis. Audio recordings of interviews were transcribed before analysis.

3.3 Sampling

Due to the travelling restrictions, it was impossible to conduct face-to-face interviews, thus there were online interviews partially with video connection. According to

Salmons (2012), online interviews refer to in-depth interviews conducted with the help of computer-mediated communications (CMCs). As face-to-face interviews, scholarly online interviews are conducted in accordance with ethical research guidelines: handling sampling and recruiting, positioning the researcher, determining the e-interview style, selecting ICT and milieu, addressing ethical issues. Salmons call these guidelines a multidimensional framework (Salmons, 2012).

For the current study, the combination of purposeful, and convenience sampling was used (Patton, 2015). Purposeful sampling means that the participants or cases are selected purposefully because of their information richness and knowledge on the analysed problem (Patton, 2015). The research did not focus on all caregivers, but only those experts who work on the primary level - family doctors - as they are the main implementers of the medical reform, specifically PCC approach, when it comes to practice. Regarding the patients, the convenience sampling was used as the nature of the research does not require formulating any strict conditions based on which patients should have been selected. The only very broad criteria of the patients were those who have a signed declaration with a family doctor; and those who received primary health care in 2018-2021 were applied. Snowball sampling technique was used to interview family doctors and to interview patients as well. Snowball strategy starts with one or more rich-information interviewees who can provide us with additional relevant contacts (Patton, 2015). As the researcher was acquainted with a few physicians, she asked them to help introduce other physicians. Regarding doctors from Kiev, there is a platform ‘Helsi’, where all family doctors and polyclinics are registered. The doctors were chosen from there, contacted via Facebook.

Only public facilities were selected, as in the private ones even before the reform the services are usually better and they got used to the competition and know that they need to work on quality, have better facilities and care after patients in order to have patients. Since in Ivano-Frankivsk there are only five public polyclinics, the family doctor was selected from each and not only one as well as the patients. Regarding Kiev, it is a huge city, and there are 50 polyclinics. Polyclinics were chosen randomly, and where the researcher could contact the doctors. The reform is the same for all polyclinics, thus

during the first year all polyclinics had to be reorganized into the 'primary health care center' and equipped with all that was necessary. Thus, random sampling of choosing polyclinics helps the researcher to eliminate bias as all polyclinics have an equal chance to be chosen.

3.4 Data collection methods and research set-up

This subchapter tries to provide the readers with the information on what data collection methods were used in the research. Moreover, it will be highlighted how the study was conducted and how the data was collected in a real-world setting.

As it was stated in the previous section the triangulation technique was used, which is the collection of data through several methods. According to Bowen (2009), results or findings coming from different sources minimizes a potential negative bias (Bowen, 2009). Taking this rational idea into account, the thesis used a few data collection methods for the research - document analysis; semi-structured in-depth interviews. The following paragraph will discuss the mentioned above data collection methods and their implications in the carried out study.

3.4.1 Document analysis

According to scholars, document analysis is an essential step in the study of qualitative nature, as it helps the researcher to '[...] uncover meaning, develop understanding, and discover insights relevant to the research problem' (Merriam, 1988; cited in Bowen, 2009, p. 29). This method of data collection was used in the beginning of the research and was withdrawn from the official government websites. It was first important to see what was written in the documents regarding the concept of PCC, and only then the semi-structured interviews were conducted to see whether what was written was reflected in practice. Thus the main aim of the document analysis was to identify the main elements of the PCC and the understanding of how PCC should be applied.

The documents that have been analyzed are strategic documents/programs that discuss in more detail the health care reforms in Ukraine, and present different measures through which the reform can be improved. The first document that was studied was *The National strategy for reforming health care systems in Ukraine for the period 2015-2020,* which was initiated by the Ministry of Health of Ukraine (MoH) in August 2014. The main two aims of the strategy is '[...] first, to stimulate the right reforms, but at the same time to demonstrate to decision-makers that health and health care are powerful tools in politics'; second, to demonstrate the potential of various measures aimed at the effective development of health services. (The National Strategy, 2015; 4).

Another national strategy was *Operational management: How to Organize a System of Primary Health Care at the Local level* that was adopted in April 2018. It was developed by MoH with the technical support of international organizations working in the field of health care. The document is designed for united territorial communities (UTC), local governments, districts and cities responsible for providing primary health care (PHC), as well as for heads of health facilities that provide PHC, and is devoted to the practical aspects of the implementation of reforms.

Law was also analyzed, specifically Order 504 on primary health care provision which was adopted 19 March 2017 by the MoH (Order No. 504). Order 504 presents and defines the tasks, sets requirements for the organization and provision of primary health care in Ukraine. Law gives a list of services that are available on the primary health care, provides the guideline of providing them and also explains the role of the family doctor.

3.4.2 Semi-structured in-depth interviews

The current method of data collection reflects the conversation between two people. According to Leech (2002) this kind of interview gets respondents talking in a fairly focused way (Leech, 2002). Semi-structured in-depth interviews are flexible and they are characterized by a free-flowing communication between the interviewer and the interviewee. Moreover, semi structured in-depth interviews, which are built on

open-ended questions, allow the researcher to ask for more detailed answers and also ask the participant for further explanation if something remains unclear. This is essential in order to obtain more clarity on certain topics or issues (Morris, 2015).

The researcher conducted 27 interviews (cf Appendix 3 for an overview of the interviewees). All of them were online interviews via Messenger and Viber. The interview lasted from 14 minutes to 60 minutes. All participants can be divided into three broad groups depending on their affiliation - 1) experts in health care reform at the primary level; 2) family doctors; 3) patients. The date and time were always stated by the participants. All interviews were audio recorded and transcribed into a written form.

The researcher carried out eight interviews with family doctors from Ivano-Frankivsk region and nine interviews with family doctors from Kiev. This category was asked mostly questions about the relationship between the doctor and the patient and also regarding the quality of care on the primary level (cf Appendix 6). The interviews with this category were the longest regarding the time. The researcher tried to understand how the doctors perceive the PCC concept and whether they support it.

The next category was the experts, and there were four interviews conducted. The questions were mostly about the role and objectives of the concept of PCC in the context of the reform. The researcher tried to understand the purpose of implementing the PCC approach on the primary level of health care and also tried to identify the barriers to the PCC implantation and the quality of care (cf Appendix 5).

And the last category of interviewees was the patients. There were eight interviews conducted. The interviews were usually shorter regarding the time as the patients had a bit less questions as the other two groups. The aim of the patient group was to see whether patients support current changes, whether they are satisfied with the reform on the primary level and also what barriers they see in order to get good quality services on the primary level of healthcare (cf Appendix 7).

The sample size of the current research depended on the information saturation. The fact was taken into account when the participants were repetitive and no new information was given. Moreover, to make sure that we have all the data needed, it was transcribed, translated and analysed after each interview, and it helped us to determine the saturation point. Although the number of patients interviewed is small when dividing it between two cities, the saturation point was considered quickly reached.

3.5 Methods and techniques of analysis

The method of qualitative content analysis was used to analyse the qualitative data. It is argued that qualitative content analysis assists in grasping the meaning of the qualitative data in a systematic way (Schreier, 2012). Moreover, the content analysis is an option when your data requires interpretation and the researcher has to be involved in order to get the meaning of the data (Schreier, 2012). Qualitative coding was used as a specific technique for the analysis. Coding can be characterised as a procedure through which the information is organized into certain categories/elements (Schreier, 2012). The general categories/codes are determined in order to answer the research question. A code or a category in qualitative research most often is a sentence or a short phrase that symbolically assigns a meaning that is seen from the visual data (Saldana, 2013). An example of the coding procedure conducted can be seen in Appendix 8.

It is important to mention that codes or the coding frame can be either concept driven or data driven (open coding) (Gibbs, 2018). The researcher used a concept driven coding frame as codes came from the existing theoretical review and were already clear and pre-given before the act of coding. Theoretical literature, mentioned in the earlier chapter, has served as an initial platform for developing the framework of the research, and also contributed for the coding frame. During the coding procedure the author remained vigilant to any new themes and concepts emerging from the data.

3.6 Credibility and ethics

Credibility and trustworthiness are important steps to be ensured in qualitative study. Many authors refer to the validity of qualitative studies as trustworthiness that is confidence in the research findings (Lincoln and Guba, 1985; Mishler, 2000). It is argued that qualitative studies have lower credibility (reliability) than quantitative ones, due to the fact that it studies social phenomena that can be difficult to replicate. Thus, especially when doing qualitative research, the issues of trustworthiness arise. In order to ensure trustworthiness, credibility is the first step here that must be established. This is so because credibility ultimately requires the researcher to specifically connect the results of the research study to facts to show the validity of the findings of the research study. However, it is wrong to assume that qualitative studies are of the worst quality. Credibility can be established through triangulation and member-checking (Golafshani, 2003; Lincoln and Guba, 1985).

The credibility of the research was increased through interviewing as many physicians as possible in order to ensure the data; moreover, regarding triangulation, data from different sources were used meaning that participants of different categories were interviewed in different cities and at different points in time. Regarding member-checking, all data, interpretations, transcriptions and conclusions were shared with the participants in order to collaborate, as they could clarify their intentions, correct errors and if necessary provide more information that was not revealed.

Another nuance that undermines the validity is the fact that the language of the interviews and the language of presented results vary. Since the data will be translated from Ukrainian into English, the risk of distorting the data is involved. Qualitative study is considered to be valid when the distance between the meanings as perceived by the participants and the meanings as presented in the findings is as similar as possible (Polkinghorne, 2007). However, it is important to mention that translation is not only the translation but it also involves interpretation of the meaning. The message conveyed in the source language must be interpreted by the translator or by the researcher himself and translated to the target language in such a way that the recipient of the message

understands what it meant. According to Nes, et al. (2010), challenges in the interpretation and expression of meaning are more difficult when cultural contexts vary and the interlingual translation is needed (Nes, et al., 2010).

Since the researcher is Ukrainian and the research will be conducted with the Ukrainians, which means that our cultural context is the same, thus, this might bring fewer losses to the validity of the translation. Moreover, the researcher is a certified translator, which will contribute even more to the interpretation of findings.

Before the interview, the respondents were provided with the consent form (via email when it was possible, mostly orally) including the details of the study, which also ensured confidentiality, anonymity, and comfortable participation (cf Appendix 1; 2).

3.7 Limitations of the study

Author would like to acknowledge the limitations of the research. First, it is important to mention that the interviews were not face-to-face but online ones (video calls), which undermine and limit the sampling of interviewees. It is due to the fact that some important participants were probably dropped out because of not having access to the internet. Another important drawback of online interviews is the concentration of the participants. In face-to-face interviews, the researcher can clearly observe whether there is something that bothers or distracts the participant. Regarding the online version, the researcher cannot predict anything, and is not confident whether the participant is concentrated on the process or is doing some other things instead - reading emails, online news, etc.

Considering the setting of the interview, we are never sure what kind of setting the interviewee will choose - private or public. A public setting is considered the one with free access to the internet by anybody (Salmons, 2012). Because of the public setting, the researcher may hear a lot of noise, interruptions and experience bad connection. Salmons (2012) believes that we may have the possibility for problems with

connectivity, access, and software with any kind of computer-mediated communications (CMCs) (Salmons, 2012).

Second, the research cannot make any generalization with the current research or produce a theory, because the research is within the context of Ukrainian medical reform on the primary level of healthcare. The sample size will also not allow to make any generalizable inferences; thus the findings concern only perceptions of the interviewed people in a certain city. However, the lessons can be learned from the Ukrainian case and the developed framework can be used as a guideline to explore the patient-centred concept further. Third, only public polyclinics were taken into account; the private ones were not touched upon; for further research public and private polyclinics can be compared in the PCC approach implementation and the quality of care on the primary level of healthcare. Fourth, not all stakeholders were included, and for further research, the health facility managers and nurses could be also included for comparison with other stakeholders.

CHAPTER 4. STAKEHOLDER PERCEPTIONS: CASE ANALYSES

This chapter will demonstrate and discuss the findings of the research. First section of the chapter will outline the objectives of PCC in Ukrainian primary healthcare by relying on the analysis of reform documents and in-depth interviews conducted with the experts involved in policy-making. And after the researcher will demonstrate the findings from the family doctors' point of view. Last but not least will be presented the views of patients. In this systematic way, there is a possibility to follow the process from the experts, family doctors and consumers (patients).

4.1 Objectives of PCC in Ukrainian primary healthcare reform

When we open the government website of the Cabinets of Ministers of Ukraine, and search for medical reform, the very first sentence that we will see is:

'*The transformation of the health care system affects everyone. Its goal is to provide citizens of Ukraine with equal access to quality medical services, as a result of the changes the system needs to be oriented in a way so that the patient is at its center'* (Government Portal).

Thus, it can be said that the main goal of the healthcare reform in Ukraine is access and in order this goal to be achieved, the new model of healthcare must be patient-centered. PCC must be seriously taken into account.

The government also provides clear reasons why the changes needed to be done especially at the primary healthcare level. Among those reasons are: the fact that Ukrainians live 9 years less than EU citizens - 72 years and 81 years respectively; the fact that Ukraine ranks first in Europe in the prevalence of catastrophic health-related costs that impoverish the families of patients; the fact that 37.6% of hospitalizations in Ukraine are carried out without appropriate indications; and the last but not least fact is that Ukraine has one of the world's worst child vaccination rates, for example, the polio vaccine coverage rate in 2018 was only 69%. (Ibid.).

'...Citizens do not want to use a health care system that does not meet their equitable health care needs and aspirations. Preservation of the current system of management, financing, staffing of the system will only worsen the health of the population, exacerbate the problem of inefficient use of financial resources, increase inequality in access to health care for certain groups, further dissatisfaction with health care and public policy in general…' (The National Strategy, 2015; 16).

Vladyslav Odrynsky, who is an expert of primary health care provision, Board Member of the Ukrainian Family Medicine Association, Head of Health Services, also mentioned the reason why there should be changes - the Soviet past and emphasized that doctors were not people-centered during those times:

'When you look in searching systems for the phrase patient-centered care, you will not find a lot, because during Soviet times nobody was people-centered. The doctors were oriented on the system itself' (Odrynskyj, 2020).

The Soviet past and other reasons for changes in health care which coincide with the documents also are explained by another expert:

'Our medicine is post-Soviet and exists in some kind of myth form that medical care in Ukraine is free. However, the real situation was out-of-pocket money from the patients. There was a concept conflict - free medicine+out of pocket money. [...]. Thus we lived in a big lie. This led to deaths and an unhealthy nation. Thus the reform's aim was to get back to the reality [...] and to allocate rationally those money that the country has [...]'(Interview 27).

The biggest barrier in primary healthcare as was identified is patient access. Therefore this aspect of the reform is one of the main objectives and is also demonstrated by the government on the website where it discusses what the reform will include:

'Ensuring financial protection of the population from excessive costs; effective functioning of the model of state guarantee of the health care package, which should be accessible to the whole population, regardless of gender, place of residence, level of wealth and other socio-demographic characteristics' (Government Portal).

'*New strategic approaches to improving the quality and access of care and reducing financial risks for people needed to give a new impetus to industry reform'* (The National Strategy, 2015; 4).

It can be observed that the dream of the Ukrainian people is meant to come true, as the main focus that each analyzed document has is the free access to medicine, and also what is even more important is the quality of care. There is even more evidence that demonstrates that finally Ukrainians are equal when it comes to medicine:

'*The strategy is based on the belief that health care reform is a powerful tool for reducing inequality in society, increasing social cohesion and stability'* (The National Strategy, 2015; 4).

However, currently, the problem of access also exists, because the new reform also brought new technology, which is beyond the power of people who do not have the Internet access or are not able to use it.

'A lot of patients cannot use the internet for example in order to see the doctor and appoint the consultation, in this case we cannot talk about the quality of care' (Odrynskyj 2020).

The main principles of primary care are also presented in law, it also mentions patient-centered care and also the discrimantion element:

'The principle of non-descrimination in the provision of primary care… the principle of person-centredness,...in a way that takes into account the individual need of the person…' (Order No. 504 I(5)).

The new medical reform in Ukraine is based on three main principles which are fundamental and should be applied not only to primary health care, but should be reflected in each subsequent stage of the reform. And in the very first principle, which is called people-centredness, it can be demonstrated how important it is and how serious the Ministry discusses it (the other two principles are the result-centredness and the implementation-centredness). In documents and law, there is also focus not only on physical health, but also on psychological and social aspects of health. In this way it can be concluded why PCC is needed - because health is not only physical one. Here is the evidence that demonstrate this:

'*People-centred care, which means that (i) the health care system must first and foremost listen to the needs of people (patients, workers); (ii) the quality and safety of services, their ability to adapt to ever-changing demands and challenges are the main tenets of the healthcare system that will emerge from the reforms; [...]. The prosperity of the system can be achieved only through the formation of trust, dialogue and mutual respect between the participants, and the effectiveness of the work will depend on the quality of such relations'* (The National Strategy, 2015; 6).

'*The comprehensive services on the primary level provides an assessment of not only physical but also psychological and social aspects of the patient's condition'* (MoH. Operational management, 2018; 50).

'The main goal is to provide the population with comprehensive and integrated services of continuous and patient-oriented primary care, aimed at meeting the needs of the population [....] '(Order No. 504 I(4)).

Thus, the main principles of PCC were discussed in documents, and they all focus on the needs of the patients, their different aspects that influence health, and mutual respect between the patient and the doctor.

Based on all experts' interviews and analized documents, the importance of the PCC is emphasized. The principles of the PCC that have to be implemented in the Ukrainian primary health care are very similar to those that are presented in the researcher's framework. Eight principles that are necessary for the PCC implementation were discussed in analized documents and expert interviews: respect for patients preferences, coordination and integration of care, communication, physical comfort, pain reducing, fear reducing, family and friends involvement, constant care, access:

'*All components of the system must act and cooperate in the interests of patients, always putting their interests above the interests of the institution, even if it requires the recognition of mistakes'* (The National Strategy, 2015; 17).

'*Providing a person-centered approach that takes into account the needs and expectations of people, in order to increase the effectiveness and efficiency of health services for the population'* (MoH. Operational management, 2018; 53).

'[...] because, when we see the word 'hospital' and we enter, and its walls are about to fall, this is not patient-centredness, [...] We always feel comfortable, when we enter the clean facility, where the furniture is new, where we can drink some water, where we have a clean toilet, where the receptionist will not be angry with you, where the doctors are polite. (Interview 23).

However, when the Order talks about the patient-centred approach and satisfying the individual needs of patients, at the same time it also mentions the principle of '*...effectiveness, which is manifested in achieving the best results through the provision of primary care services based on scientific knowledge and principles of evidence-based medicine'* (Order No. 504; I(5)).

Empathy is also mentioned, the element that must be present when we talk about the PCC approach, and this element was also discussed in the literature review; however, nothing was stated by the experts regarding this element:

'*Empathy is closely linked to respect and dignity. The health care system should not only provide medical care, but also alleviate pain, suffering, and help a person feel the value and significance of his or her personal problem'* (The National Strategy, 2015; 18).

The new financial model was also seen as the most important element of patient-centered care. According to some experts, this is so because the main problem was the 'out-of-pocket money' in health care and the person was concentrated too much on this aspect as having money in the pocket was the necessary tool to patients' health:

'It is very important to focus on the PCC approach from the financial point of view, because the money has to be allocated for the patient's needs, not for walls and nice decorations in the hospitals or electricity. Also it is important for the quality of treatment' (Interview 21).

'[...] the main aim was to rationally allocate those money that the country has and form the very necessary package of services for the patients on the primary care that the patients most need. And the money to follow the patient was also the point of the reform and how to help the patient' (Interview 27).

What was more important, that some experts of NHSU saw the new financial model 'Money Follow the Patient' as an element of patient-centred care, in contrast, the board member of Family Medicine differentiates it and does not consider it as a part of the PCC approach*:*

'When we talk about the reform that started to be implemented by Uljana Suprun, we cannot talk about patient-centred care but just about the changes in the financial system. We can talk about the patient-centered model only on the facility level, because it is about the quality' (Interview 26).

However, we cannot deny the fact that the new financial system is not about the patient, vise-versus, it is all about the patient, it is patient-centered because it allocates money to the facility according to the needs of the patient.

Very interesting explanation was given by the board member of Family Medicine regarding the objectives of the patient-centred care on the primary health care level:

'[...] it was decided that family medicine will be the base of this reform; it is when the person chooses the family doctor and this doctor is able to solve 80% of the problems of that person, for the rest 20% there are specialists...This is the patient-centred care, of course this is only the beginning [...]. The role of family medicine is the most important when we talk about patient-centredness, because the person chooses the doctor who she trusts and thus she trusts him with all her problems that are related to her health' (Interview 26).

As to the actors that have to implement the PCC approach, the evidence was not found in the law. However, strategies imply that the responsibility of the services that are provided on the PHC are on the team of the PHC. Order No. 504 defines the team of PHC as:

'[...] a group of medical workers operating within the PHC provider and consisting of at least one PHC doctor and at least one specialist (general practitioner - family medicine, midwife, paramedic, etc.) who works together with the PHC doctor or under his direction' (Order No. 504; I).

Experts' answers were not the same. The expert from Ivano-Frankivsk explained that the main actors who should provide the PCC model are the family doctors, while the expert from Kiev said it is the collective work of the facility and the state. Why the state, because it has to provide the facility with the equipment for the better services. There was nothing about the facility at all coming from the expert from the member of Family Medicine or something about the state:

'I will not say the doctor is the most important person who has to implement this approach. For example if I am the private doctor, ... then I am also responsible for implementing PCC. However, a lot of doctors work in state buildings and not everything depends on them… Thus the administration of the facility should be responsible for that. They hire the doctor, they decide who to send for the conferences' (Interview 23).

'The doctors and the managers have to implement the patient-centered model. They are expected to provide affordable service that is focused on the patient's needs, not on the system's needs; the quick one with the minimal cost' (Interview 26).

The documents and experts also mention how important it is for the patient to have a good relationship with the doctor and vice versa, mentioning also the principals of the health system in Ukraine in general:

'*The principle of mutual respect of patients and medical staff. Respect, dignity, compassion and care should be the number one principle in working with patients. Their safety, experience being in the new system, and health outcomes will improve as healthcare professionals feel valued, empowered and supported, and patients feel partnered rather than treated'* (The National Strategy, 2015; 17).

'*When I was studying at the university, I was taught that the relationship between the doctor and the patient is built on the paternalistic approach. The doctor is as a Father or a God, he is educated and knows more. And any patient was compared to the child that couldn't cope with any decisions and take any decision'* (Odrynsky, 2020).

'*And the concept of PCC looks at the patient as at the person who is empowered, engaged and has powers to cope with decisions and ask for less help from professionals'* (Odrynsky, 2020). The expert also mentioned that there was no word 'team' in the Soviet medicine, thus he specified that '*Only now it appeared in Order No. 504. This concept is also used by WHO'* (Odrynsky, 2020). It is important to mention that the researcher looked through Order 504 and unfortunately, the word team was only

mentioned in a way that the doctors need to work as a team, not that doctors and patients have to be a team.

There is also fear, when the patient is empowered and engaged, the doctors are usually not ready for this, and the patients are rejected. However, the time is the solution here an these kind of patients will be perceived better with the generation change:

'*But I believe it will change, because a lot of the countries went through these stages. I believe we will come to this, and instead of rejecting those patients , our doctors will learn how to work with them. Thus the doctor's task is to make the patient a member of his team'* (Odrynsky, 2020).

Another interesting aspect that the document provides is the freedom of choice and how crucial it is, which is positively welcomed by Ukrainian patients, family doctors and experts:

'Freedom of choice is the main driving force of free market competition in other areas, as well as one of the main European values...Patients should have the right to choose their own service providers based on geographical location, quality of care, professionalism of medical staff and availability of a wide range of services' (The National Strategy, 2015; 19).

All interviewed experts agree that the patient choice of the family doctor is important, because it empowers the patient; however, the importance of doctor's choice was also mentioned by the expert:

'There is no mechanism when the doctor can refuse from the patient. There are some situations when for example the patient can be a threat to the doctor's life and there is no mechanism how the doctor may get rid of him' (Interview 26).

A very interesting and crucial moment is seen in the documents where the connection between the PCC approach and the quality of the primary health care services is

demonstrated. Quality in healthcare is a multidimensional concept that has different approaches to its definition. The definition of WHO was found which says that quality of healthcare is a measure of how health services provided to individuals improve desired health outcomes. It also provides six dimensions that are necessary for the good quality of care in healthcare. And one of those dimensions is people-centredness:

'The health care must be human-centered: the provision of health services based on the individual preferences and expectations of patients and the culture of their community. (MoH. Operational management, 2018; 206).

Ukrainian law regarding the evaluation of the quality of care is a bit confusing, because it mostly focuses on the clinical component (clinical quality), on inpatient technologies and large medical facilities and less on the use in the primary health care level:

'Quality control of medical care is carried out on the following components: structure, process and results of medical care; organization of medical care; control over the implementation of management decisions; compliance with the qualification requirements of medical workers, including heads of health care facilities; study of patients' opinions on the provided medical care; ensuring the rights and safety of patients during the provision of medical care' (Order No. 752; (7)).

Thus, with the new reform, there should be new measures on how to evaluate the quality of care on the primary level, since this level of care now includes a wide range of services and changes. The proposed method that was analyzed in the documents was the systematic approach based on the principles of International Organization for Standardization (ISO). This is a sort of cycle that defines the quality of care - Plan-Do-Check-Act (PDCA) and it is implemented mostly by the management of the facility (MoH. Operational management, 2018). However, at the moment the facilities of primary health care are not using this approach.

Experts also see the importance of the quality of care; however, the quality of care is defined differently. They agree that this quality depends on the motivation for the

doctors, which should be provided by the management. Also, they see the quality of care as constantly upgrading the knowledge of the doctor. The quality of care is also seen as the patient engagement or being an active patient: Some of the excerpts that help to demonstrate this are included below:

'Patients have to be engaged when it comes to decision making. Without a patient's engagement, without satisfying their needs it is hard to talk about providing a quality medicine' (Odrynskyj, 2020).

'The factor that influences the quality is the knowledge of the doctor and his willingness to develop himself as a specialist' (Interview 23).

'Doctor has to be motivated, yes, to see the healthy patient and his results are no less important, but I am talking about the material motivation' (Interview 21).

The expert from Family Medicine also considers the incentives and motivation for family doctors as important factors, however he is not sure whether it will influence the quality or services. He also does not see the patient as the main contributor to the quality evaluation:

'But I would not say that it is up to the patients to decide, as for example let's take diabetes. Many patients come and want us to give them a dropper because this is an old-fashioned model to treat this disease. We refuse justifying it by saying it may have negative effects on your health. And of course the patient is not satisfied, but can we call that not quality, no!' (Interview 26).

A very new approach that was emphasized during the document analysis is the new terminology on primary level healthcare, or at least how this could be reflected in doctors' minds. The difference between the client and the patient has to be clear, and in the new primary healthcare the doctors must not see patients in front of them but first of all clients. And the doctor must understand that he exists only because there are clients and their needs:

'A client's needs are a set of emotional and physical states that a person refers to as "health" or "illness" and seeks medical attention' (MoH. Operational management, 2018; 214).

Service must be important not only for companies, but for the primary healthcare facilities, because it forms a unique culture that will attract not only customers/clients but also employees as there are few places in public institutions and establishments that have a culture of customer service.

Regarding the courses for the doctors, all experts said that it is provided by the NSHU annually and a few times a year and the family doctors who are interested may register when it is available. The experts also visit facilities from time to time for providing training. However, both experts admitted that it is not free and usually our doctors are passive when it comes to choosing the course unless the management will pay for them, which is unlikely in most cases:

'Doctors now have a huge opportunity to choose the course that they like or are interested in, but there is a big minus - the doctors usually do not want to spend money for that, because the training of a good quality is not free' (Interview 21).

Both experts assure that our doctors have access even to the international research websites, however, not all of them use it or even know about it. The only problem with the international protocols - not all of them are approved by the facility, thus the doctor cannot use them or there are no medicines in the Ukrainian market:

'Taking into account the fact that we started the health care reform the British Medical Journal gave us access to the information that we need, but I am not sure our doctors use that' (Interview 23).

And finally, beside the access barrier that was discussed earlier, there is also another barrier that the experts agree on - the connection of the primary level with the

secondary. This negatively influence the integration of health care and also the quality of services on PHC:

'Cooperation is one of the most important features of an integrated health care system' (MoH. Operational management, 2018; 60).

'[...] *the patient does not need to come back to the family doctor after having a consultation with the specialist, he can continue the treatment till the end with the specialist, but unfortunately, it doesn't work yet this way'* (Odrynskyj 2020).

Summary

To conclude, it is important to say that patient-centered care elements are present in the documents and law. The reason for the changes in the healthcare system was due to the Soviet Past and concerned not only the focus on the doctor, but also another financing system - the system where the money was allocated according to the beds in the facility. The aim of the reform is to improve the quality of care and also provide access to the services for all patients. Thus, the analysis shows that the PCC is a leading approach in achieving healthier nation results and reducing the cost.

Mostly, in documents PCC was defined as customized care, the satisfaction of the patients' needs, ephacazing also the 'team' element in the relationship between the doctor and the patient. However, according to the experts, the main element of the PCC in Ukraine is the new financing system - 'money follows the patient'. Experts also consider other, no less important elements of PCC. The physical comfort, doctor's attitude and family medicine that includes solving most of the problems on the primary level were also detected as important elements of PCC.

From the analyzed documents and interviews, the connection between PCC and the quality of care is seen. Ukrainian law is old and needs to have some changes as the quality of care and its evaluation concern only big hospitals; thus, there are no indicators to measure quality of care. If the indicators are absent, thus it is hard to define

what the quality of care on the primary level is. According to document analis, one fact is sure - that in order to have quality, the patient-centredness should be present, because this is one of the elements of the quality of care. Not all experts were aware of the fact that these measures are absent currently, but they saw the quality in different elements within PCC. Motivation for doctors, patients' engagement and professionalism of the doctor were also specified as the important factors that affect quality of care.

The barrier that affects the integration system of healthcare and the quality of care was the cooperation between all levels of health care according to the findings. When there is no cooperation between the primary and the secondary levels, neither the quality of care nor the satisfaction of the patient cannot be achieved.

Thus, the PCC is Ukrainian context is about the new financial model that is meant to reduce the money of the patients and contribute to the rational allocation of it by the state.

4.2. Primary health care reform in Ivano-Frankivsk. Integration of health care

Ivano-Frankivsk is a city in Western Ukraine and is the administrative city of Ivano-Frankivsk region, which has a population of around 240 thousand. There are seven centers of primary medical and consultative-diagnostic care (Mediks).

The first question that was asked to the doctors from Ivano-Frankivsk was about the integration of healthcare on the primary level. In general, the interviewed doctors were satisfied with the facilities and offices. The doctors, of course, would like to have more equipment, diagnostics and tests. Lack of computers was mentioned, because there is only one computer in the office - for the nurse and for the doctor, thus doctors need to bring their own in order to complete the reports or other documentation. There was also a case where the doctor complained about the uncomfortable table and a chair for the doctors. Here is the evidence from Ivano-Frankivsk:

'*But of course we would like to have more equipment that contributes to the biochemical tests. Regarding the office, the only minus is that I share it with another doctor. I really would like to have my one, but I am used to it already'* (Interview 4).

'*While the administration took good care of the patient, the doctors were, I guess, totally ignored, because, for example, nobody thought that I have 8-hours working day and I need to be provided with at least the good quality of care, not mentioning the working table. I started to have problems with my back and I think this is because of the uncomfortable chair'* (Interview 9).

While most of the interviewed doctors were satisfied with the facility and office, they also complained about the office that is shared with another doctor. It can also be interpreted that in case the patient needs more time for examination or conversation, the inconveniences will occur because the next doctor and his patients will need to wait then.

Another problem was discovered in the integration element and is seen also as a barrier to the integration health care is the IT area. The interviewed doctors do not trust it, they say it is not reliable, and it is more difficult for them because the system is not perfect. There were reported cases that the system could be out of order for the whole day and then the doctors are in despair, because if the patient needs the referral, it would be impossible to do.

There were also complaints regarding the system design as it does not allow the doctors to insert all the information about the patient's health. Thus they have more work, they have to duplicate the documentation, meaning that everything has to be electronically, and also on the paper. The doctors have to print out the electronic referrals, fill the patient card on paper and write different reports by hand. When the referral is printed out, how then it is called electronic. The doctors emphasized that if they do not do it, the patient will not be accepted by the specialist. It is inconvenient as the doctors reported that very often the paper referral is lost and the patient has to come back to the family doctor again. Some evidence on this issue:

'I always duplicate the documents because I am scared of some problems in the system. It is my personal fear, so I do everything that I can to keep the information secure' (Interview 4).

'When it concerns the referral, I also give one electronically, but also on paper. Because sometimes when the patient comes to the hospital, they may have some problems with systems and they require that the patient show this referral on the paper' (Interview 9).
'...but of course we duplicate everything, the patients have electronic cards and paper ones. But we do not need to duplicate electronic referrals' (Interview 15).

The interviewed doctors from Ivano-Frankivsk are not satisfied with the quantity of reports that they have to produce almost every day. The doctors do not understand why they need to write them and why there isn't a way that somehow these reports can be produced based on the system that the doctors used to fill the information. Some doctors even consider that it is not their job and there should be another person to do this.

'The reports! Oh, it takes a lot of time (smiling). It is probably the only thing that I do not like about my job' (Interview 4).

Thus, it can be said that the important barrier that was detected in the primary health care form the analyzed interviews of the doctors from Ivano-Frankivsk was the technical barrier - the doctors are not satisfied with the system and also they need to duplicate everything, because they do not trust the system. Moreover, they have to write endless reports daily. Thus, if the doctor is overwhelmed with his/her work taking into account the technical issues, how is it possible to contribute to the patient-centredness? Instead of coping with the technical issues, this time could have been contributed to the more visitors/patients or more time could be devoted for one visit.

Regarding the seminars or courses on the PCC, half of the interviewed doctors were not aware about it and they admitted that nobody told them something about the patient-centred care. However, it is all relative and depends on the doctors themselves.

There were doctors who participated in the courses or had a meeting with the management where PCC was emphasized and they also admitted that the courses the doctor may find themselves:

'Our management gathers every week for a planned meeting together with family doctors and there I heard about the new approach'(Interview 13).

'Yes, there were seminars by the Ministry of Health, where we were told about the new way of who the doctor is and what role he performs on the primary level. And yes, we were also told that we do not cure the disease, but the person first of all' (Interview 9).

Thus, we can say that perhaps, not all the doctors are aware of what PCC approach is. The crucial factor for the researcher was that two doctors from Ivano-Frankivsk argued that patient-centeredness is something that have been working already for a long time and it did not came to the with the reform:

'Regarding the patient-centredness, we always had worked like that - the patient was the center. Nobody specified anything specifically regarding patient-centredness on training courses' (Interview 8).

While the experts emphasized on the availability of the courses, specifically online due to the COVID-19 situation, the doctors from Ivano-Frankivsk say they never heard of it. The problem can lie in the management of the facility or in the doctor himself. It is difficult to imagine that the doctors will provide patient-centered care, not knowing what this concept connotes. Others state that they know what PCC is and have been working in this direction all their lives. Thus, PCC did not come with the reform specifically, it has been there for a while. The problem is whether it is suitable for all doctors or the doctors are not ready for this phenomenon!

4.2.1 Motivations for doctors. 'Money follows the patient' reform

As most interviewed doctors from Ivano-Frankivsk were not aware of the PCC courses, they were also not aware of how their salary is calculated and how much they should earn. 'Money follows the patient' is a new model of financing facilities which also affects the salary of the doctor. Ideally, it is when the more declarations (patients) you have, the bigger your salary is. The doctors consider it to be a good idea for patients, as the doctors are aware of the fee of charge services that the patients may have on the primary care; however, they are not sure how the money from NSHU allocates money that are meant to be the doctors' salary:

'And in our facility we have management; the money that is allocated by NSHU goes there and they distribute the money for me according to my declarations and also they see what is needed for the clinic. I hope I receive the majority of that money' (Interview 4).

When the experts were interviewed, they also confirmed that there shouldn't be the order from the top regarding how much the doctors should earn. The experts stated that health care is moving towards the market economy like all businesses and thus, it should not be regulated by any government institution. This explains the fact that the doctors do not know how the money is allocated, but what they should know is the conditions that they agreed to work on. They signed the contract with the facility where the salary facts were discussed and they agreed on them.

The evidence of this issue was also found in law regarding health care. According to law, it is the administration of the facility that decides the salary of the family doctor. On the official website of the Ministry of Health of Ukraine it is written *'Medical institutions that have signed contracts with the National Health Service have a flexible approach to salary formation. The decision on salary policy in each specific medical institution is made by the management together with the personale*' (MoH https://moz.gov.ua/article/reform-plan/jak-zbilshilis-zarplati-medikiv-u-zhovtni).

Thus, the salary may vary from facility to facility and from town to town. The doctors from Ivano-Frankivsk confirm that it is up to the administration to decide, and yes, they have contracts where all details are written; however, they admit that usually doctors agree to the menegers conditions. However, what the doctors complain about is that nobody can control among the doctors how much money the facility receives and what percentage of those are given to the doctors:

'I do not like the fact that the manager of the facility is like a seigneur and he decides. Yes, we can, we can complain collectively, but we know that it will not go further... thus the doctor usually agrees on the money that the manager pays...The doctor does not see it. For one patient the facility gets money, but how much goes for the doctor , manager decides' (Interview 9).

For the record, only one interview demonstrated that the doctor knows how much she should earn, and this information is usually written in the contract, thus she did not notice anything unusual with her salary calculation (Interview 14).

Another fact that is worth discussion is the motivations and incentives that the doctors must have in order to provide the quality services on the primary level. A few interviewed doctors from Ivano-Frankivsk except for the quantity of declarations that somehow affects their salary, they also have bonuses and additional mini salaries for their devoted jobs. Other examples also demonstrated the receiving of material motivations; however, the doctors are not aware of the process or mechanism that evaluates who is entitled for the material motivations:

'When we had the vaccination period and worked during weekends, we received bonuses. If the administration also sees you overwork, for example, you had to work from 8 to 16:00, but you worked two hours more, then again that month will be with bonuses for us. [...]. For the medical worker day we also have bonuses, nurses have less, doctors have more' (Interview 2).

'Yes, sometimes we have bonuses, but I do not know how they decide who and for what gets it. I only need to wear formal clothes when I come to receive them' (Interview 8).

It can be concluded that in Ivano-Frankivsk, not all doctors have incentives or are motivated somehow. Thus, it is obvious that besides the amount of declarations, the management should also somehow motivate the personnel as well. Because only the signed amount of declarations does not point to the quality of the services. In researcher's opinion the administration should provide clear and reasonable incentives for the doctors to be motivated. The incentives do not necessarily have to be material. In the researcher's opinion, when the family doctor receives a fixed rate or salary every month, this will not contribute to the quality services, and is not even considered as a motivation factor. Thus will only make a difference to the doctor whether he should stay or choose another facility where the fixed salary is initially higher.

What was clear from the interviews also, that the administration is not interested in motivating the doctor even when the patient stops the declaration with him. Because there is a chance that the patient will stay in the same facility but with another doctor:

'But, in general, when the patient leaves the doctor and chooses another one but within the same facility, the money still stays in the hospital' (Interview 8).

As we can see, the question of motivation is not how much to pay, but how to pay. A double increase of salary will not turn a bad doctor into a good one and will not interest him to improve his skills. Thus the managers should provide the strategy based on what they will consider the doctor's salary. First, clearly desired behavior of the specialist should be defined (adherement to treatment protocols or smiles to the patient) or the results of the doctor's activities (no complaints, the share of vaccinations among the target audience is very high). Also, make transparent the mechanisms for evaluating the activities of a specialist and determining the variable component that will influence the final salary.

The researcher found the similarity about the mentioned above strategies in one of the facilities in Ivano-Frankivsk:

'We have to report annually about our achievements, and show the quality of care that we provide. The doctors need to attend lectures, seminars, conferences, this gives us points and it helps to define the quality of care that we provide' (Interview 4).

'Money follows the patient' is a very important element of the PCC that was detected in experts' interviews. For the doctors it should be no less important. Although the interviewed doctors are not aware of the 'Money follows the patient' process regarding their salaries, they did not show the huge dissatisfaction of this aspect. It is suspected that the doctors from Ivano-Frankivsk would also not mind when there were no incentives or motivation. The participants did not emphasize it as something very crucial in their job, meaning that perhaps the services that they provide would not change whether they have incentives or not.

If the doctors are not aware of the system and how the incentives are provided, then how they will contribute to the quality of care, for example, if they do not know what must be taken into account.

4.2.2 Customer choice from doctor's perspective

Regarding the patients' choice of the doctor on the primary level, all doctors who were interviewed agreed that it is a good idea. The patients that usually choose the doctor who they want are satisfied, always listen to doctors and there are no conflicts in the relationship and the quality of the services are better because the patient tend to trust the doctor who they chose by themselves better:

'I am positive about it. From the patients I also heard that they like it to have a choice as they do not need to visit the doctors that they don't want to visit, especially when the doctor is impolite, careless' (Interview 2).

Choosing the family doctor is a good advantage for patients from the doctors' perspectives as they do not need to depend on the doctor that they were assigned to. Before the reform, all citizens were allocated to a certain doctor against their will. Thus, the doctors interviewed see very positive changes in this aspect and admit that it is an important one, because the patient is in charge. However, as we take into account the PCC approach, more time is needed, as the doctors may now have the patients they have never seen before, thus they need time to get used to the patient and to know his/her preferences in order to satisfy the patient's needs. Also, when talking about multidimensional aspects of the patient, it will not be so easy for the doctors to get them at first.

Another aspect, that can be added here, is that before the doctors knew where the patient lived and could come to their homes in case the patient is very sick or requires it. Moreover, the location was usually convenient for the doctor as all patients were from the same district/area of the city. Now, the new reform also allows people from villages to choose the doctor in the city or vice versa. Thus, the doctors say it is almost impossible to visit them or at least it is inconvenient as the patients can be from different parts of the city or even from the region:

'...for the doctors, maybe it is not good, because before I knew exactly where my patients were from, as I had the special territory where my patients lived. Now I have no idea; someone is from the village, others are from different streets. You do not know everyone' (Interview 8).

Additional issue that was discovered during the interviews is that while all doctors agree that the patient has a great opportunity by choosing the doctor at the same time, the doctors interviewed do not agree with the fact that they do not have this opportunity. While analyzing an expert interview, this issue was also present and one expert also confirmed that there is no mechanism designed for the doctor to reject the patient. A few interviewed doctors from Ivano-Frankivsk would like to have an opportunity to reject the patient in case it is needed:

'I would like the doctors also to have an opportunity to stop the declaration with the patient in case when the patient does not follow the doctor's recommendations' (Interview 14).

To conclude, it can be said that customer or patient choice is an important element of the PCC approach and usually the family doctors who were interviewed said that it is always a pleasure to work with the patients that chose you because it determines the success of the treatment process. However, the interviewed doctors also want to have the right to stop the decoration in certain cases. They want this procedure to be possible and less time consuming. When we talk about the quality of care, we cannot only be focused on the patient, because if the doctors are not satisfied or feel that the patient is not devoted to their recommendations, the doctor will not have any desire to have contact with that patients, thus the services perhaps are not going to be of a good quality.

4.2.3 The relationship between doctors and patients

Absolutely all interviewed doctors from Ivano-Frankivsk admitted that listening to the patient and trust are the most important elements that the patient needs and also are crucial for the good communication between the doctor and the patient. Thus, the ability to communicate and show that you care are the most important aspects the doctors think the patients want:

'When the patient comes, even before the examination the patient wants to hear some good words from the doctor, nice greetings, for example. This gives already a good start and the patient feels supported' (Interview 14).

The doctors also understand what attitude of the doctor the patients like, and they try to satisfy the patients' desire. The doctors stress the importance of the communication process, which has a huge influence on the patient. From the doctors' perspective in communication, the patient decides to trust or not to trust the doctor and from communication, the patient already receives a lot of help, sometimes:

'I never present myself as I am something huge and clever like the real treasure came to your hands (smiling). I speak simply like with a friend' (Interview 4).

For all interviewed doctors it was of great importance to know the multidimensional aspects of the patient. They justified it with the fact that it is important when they prescribe the medicines. The aspect that the doctors are most concerned about is the material status of the patient. It helps them to decide what medicine to prescribe - expensive, cheap or the cheapest:

'It is important to know also because you need to prescribe the medicine and you need to know whether the patient can afford them' (Interview 12).

When the researcher asked about the barriers in communication with the patients, the doctors from Ivano-Frankivsk pointed out the personal space requirements. In general, the doctors like the idea of the patients to have their personal cell phone number, because sometimes there are cases that the patient does not need to come and bring the analysis, for example. Thus, all doctors provide their patients with their personal contact details, because for the doctor and patient's convenience:

'It is convenient for me, because when one day the patient comes and we do certain blood tests and the result will be available later, the patient does not need to come again. He just needs to text me those results, and based on those I can even prescribe the medicines via Viber, for example' (Interview 9).

However, the doctors do not want the patients to cross the line and understand that the doctor is also a wife or a husband, a mother or a father and also just a regular man or woman. They say this usually creates a barrier between the doctor and the patient, because the patients do not understand that it is a day off or 12 at night and you usually do not answer the messages or calls. The doctors say that patients are getting frustrated and do not want to understand the doctor. With the new reform, only the family doctor may give a patient a referral if the patient wants to see the specialist doctor. The doctors

cannot log in into the system from home, only from work; thus, the patients do not understand this aspect and often require the referral immediately. Here is some evidence that demonstrate the mentioned above:

'[...] I am also a wife, mom, so I cannot devote myself to 24 hours patients' (Interview 2).

'[...] for example there is a situation when it is my day off and the patient needs a referral, he calls me but I say it is my day off and I cannot physically do it. But the patient insists, and then finds different ways, and if he doesn't succeed he blames me for that' (Interview 8).

It can be concluded from this section that the doctors want to be in good relationship with the patients. They understand what the patient wants and try to deliver that. The doctors focus on the communication element and say that the attitude of the doctor should be the one that respects the patient and does not place them above the patients. It was also identified that in Ivano-Frankivsk, interviewed doctors are very busy with the calls from patients regarding the referrals and also personal issues. All patients have their family doctors phone numbers, which is an advantage because the patient always knows that he can rely on the doctor's help. However, the interviewed doctors were not satisfied when the patient is demanding and requires something that is impossible to conduct because of the certain circumstances. Thus, the doctors see it as a barrier in the relationship with the patients. The doctors are willing to provide PCC; however, not during the time when the doctor has a day off.

4.2.4 Empowerment of the patients and customized care

Did the family doctors in Ivano-Frankivsk hear about the customized care and also are they mentally ready that the patient is the center and the doctor and the patient are a team? Well, not all of them. What was observed here when the doctors answered the

questions related to these issues is that not all of them are ready and have hard times to accept that. And those doctors who said that they were patient-centered even before the reform admitted that the doctor and the patient are a team and have to make the decisions together. Thus, some doctors are very excited when the patient is aware of lots of facts about the disease or have some knowledge in health care:

'We take decisions together with the patient' (Interview 2).

'I try to give the patient what he wants. For example, I did not see a huge problem with the patient's cough, but he required the X-ray, I usually say - 'OK, let's wait two more days and if the cough continues we will do an X-ray. When it concerns children, sometimes parents, thanks to their intuition, know their child's health better than I do'. (Interview 4).

However, regarding the treatment process and engagement of the patients, the interviewed doctors are still not ready to trust the patient or to trust his proposing way of treatment. They care for their reputation and say that sometimes when the doctor listens to the patient and does what the patient want in terms of treatment and diagnostics, they may be misunderstood by the others specialist:

'It is not pleasant whether a patient comes and he knows about the disease better than the doctor and there is a feeling that he checks you. And when the patient wants to show off it bothers me' (Interview 8).

'Another aspect is when the patient listening to somebody else thinks that he knows better what to do in his case. I sometimes react normally when I see some point, but when it is absolutely crazy, I can be angry… I do not like when patients make the decision. It sometimes disturbs, sometimes there are risks involved' (Interview 9).

Most of the interviewed doctors do not like when the patient is involved in the process, and not always the doctors see the patient's choice or decision as a patient-centered one. All doctors are using the international medical protocols that they have to comply with

and the doctor is responsible for the health of the patient. Yes, it is difficult to provide a customised care when there are protocols, nobody wants to take a risk among doctors. Thus, the doctors from Ivano-Frankivsk still allowed the patient to make a decision, provided a customized care, but at the same time they had to secure themselves as this customised care could cost them a lot:

'... we have protocols, and if there are problems and the patient dies, then the prosecutor will ask me whether I followed the protocol… if the patient refuses to take what I give, he must give me written consent' (Interview 8).

'...based on blood tests and other analysis he needed an operation, the patient refused because he was scared of corona.... Then I asked him to write a formal refusal and just worked on reducing the pain…' (Interview 9).

It was also evident from the interviews that the doctors try to satisfy the clients' needs as much as they could. Although they are not happy when the patient has some preferences, there are different kinds of measures that the doctor may take. However, these measures are considered to be illegal, but from the other side, the attempt to be patient-centred was accomplished:

'And I will tell you the big secret that some doctors write different things on paper when they make prescriptions and on the computer. Only this way you will satisfy the patient and also secure yourself' (Interview 9).

Empowerment of the patient is a new phenomenon in Ukrainian healthcare on primary level. While the doctors are willing to satisfy the patient in terms of the information, nice attitude or communication processes, they are not willing to allow the patient to take important decisions that concern their health. And if the doctors interviewed for this study were willing to do what the patient wanted, before doing that they also had to secure themselves by different kinds of consent forms. Thus, this element of PCC is not easy to implement as the doctors have protocols and must strictly follow them. And

from the doctor's point of view, the empowerment of the patient is not something very important because, as the researcher suspects, the doctor is still the main.

4.2.5. Perception by the doctors of improved quality of care

Regarding the perception of the quality of care, there are different suggestions and complaints at the same time from the interviewed doctors from Ivano-Frankivsk. Each doctor had something new to add to the factors that influence the quality of care; however, the research will still start with the pattern that the doctors mentioned. All interviewed respondents said that the connection with the secondary level of medicine is the biggest barrier that negatively contributes to the quality of care on the primary level. Therefore, the doctors would really like to see some changes on the secondary level of healthcare soon as they are frustrated and tired of the quantity of referrals they have to give every day.

Not only the doctors are tired but also the patients. When the patient is rejected from the specialist, he has to come back to the family doctor; thus, the family doctor is helpless in this situation. Another aspect is also when the patient has additional tests from the specialist, this specialist is not able to give a referral. And again, the patient must take it from the family doctor. Here is the examples of the data:

'I feel myself as a regulator now, because when I give a referral to a specialist and then that specialist sends the patient for additional tests, I need to give the referrals again. Thus the patient needs to go back to me and I have to do it. It takes time and this is not my job to do' (Interview 16).

'*...my patient had to do an X-ray, and they refused stating that there is not enough evidence. Then the patient comes frustrated and not happy, thus I think this connection must be somehow improved'* (Interview 9).

The doctors interviewed for the study also mentioned that the quality of care depends on the number of diagnostics that can be provided on the primary level. The doctors refer

to this issue as an important one as this is exactly an out-of-pocket money problem. Although the certain tests and analysis are free of charge, there are some that are not available, and the patients have to go to the private laboratories. This influences the dissatisfaction from the side of the patient as he/she has to pay themselves. There are also cases reported that there is time when a certain test are available in the facility; however, later it is not anymore:

'Very often it happens that we do not have reagents in our facility, because of that we need to send the patients to the private laboratories. It should not be like that, the patient must be able to complete all tests within our facility, which is actually huge' (Interview 16).

The respondents also saw the professionalism of the doctors as the factor that affects the quality of care. The doctors must always be aware of the new researches, upgraded information regarding protocols. The doctors must be active and participate in different seminars and lectures that are related to their field of interest:

'The doctors themselves have to improve first of all and constantly upgrade themselves. The doctor mustn't sit in his office and wait until someone will come and do it for him. Self improvement, self-study, these are the skills that our doctors lack, especially elder generation doctors, who still cannot work with the computer' (Interview 2).

There was also the case, when the doctor was very optimistic regarding the reform, and expressed that the reform is not a problem, and only positive changes are there; however, the problem is in the mentality of the people in general and also of the doctors. In order to provide PCC, the reform is not a panaceja here, it should come from the doctor and the personnel. The doctor must be open for changes, reorganizations and other regulations. The doctor also does not believe that the reform will change something dramatically when the doctors are resistant:

'The mentality is the only problem that influences the quality' (Interview 4).

Motivation was also defined by the doctors from Ivano-Frankivsk as the factor that influences the quality of care on the primary level. Motivation from the side of management would give an impetus for the doctor to work better and to take care of the patients bettre:

'Doctor's motivation to work, because they require from us quality and respect but instead do not provide us what they were promising at the beginning before implementing the reform'. (Interview 8).

Summary

To conclude, we may say that doctors from both cities identified some very important elements of patient-centered care that are connected with the improved quality of care. Training, communication, more convenient services. The biggest barrier here is the reform itself, which is not finished on the secondary level of medicine and it gives the doctors the feeling that they do not work for quality.

It was also detected that most factors that were mentioned by the doctors from Ivano-Frankivsk were mostly from the integrated section of the health care as an element of PCC. Doctors usually need more equipment, more beautiful facilities (rarely), others also mentioned special rooms for kids, where they would play. Does it mean that the doctors in Ukraine are still materialists and think this is the most important? However, the literature tells us much more than just integrated health care about the connection with the PCC approach and quality of care. From the other point we must understand what country the research is conducted in. And the doctors cannot be blamed because the truth is that Ukrainian hospitals or primary health care centers are always underfunded, thus this problem is so sensitive. When everything is there in the facility - equipment, diagnostics, then the doctors start talking more about communication aspects, engagement of the patient, joint decisions, customised care, ways of keeping the patients.

4.3 Primary health care reform in Kiev. Integration of the health care

Kiev is the capital of Ukraine which is situated in north-central Ukraine with the population of almost 3 million people. There are over 50 medical centers in Kiev that signed the contract with the National Service of Health of Ukraine (Helsi). According to the Health Index. Ukraine (HIU), Kiev is the least satisfied city with the reform (HIU, 2020).

The interview also started with the integration of health care. The interviewed doctors did not complain about the facilities much. They sounded like they were satisfied and also did not specify what they would like to improve or add concerning the facility aspect. Perhaps, the facility does not play the essential role in the doctor's understanding. They care more about the equipment they have:

'In general, our facility is not big, but we have everything we need. My office is also well designed, we have the equipment, even, dermatoscope' (Interview 11).

The interviewed doctors complained about the IT problems and the imperfection of the system, which does not allow the doctors to work properly and takes the valuable doctor's time. Not all doctors, however, duplicate the papers or the referrals. The interviewed doctors implied that they can do everything faster without the computer. Here is some evidence of the data:

'[...] but of course we duplicate everything, the patients have electronic cards and paper ones. But we do not need to duplicate electronic referrals' (Interview 15).

'*We have all the data electronically, but we also have it on papers. Thus, there is more work to do, and now it takes double time… I write the patient's card by hand three times faster than I type it, because the system gives you many options and you cannot find what you need anyway* (Interview 12).

In Kiev, the interviewed doctors did not complain about the daily reports that they have to write. This issue did not come out directly. The question was asked as an additional one based on the results from Ivano-Frankivsk. And only when the question about the reports was asked directly, some doctors complained about it. However, most of the interviewed doctors say that the system produces some reports automatically, and also some doctors found the solution - to have the nurse write the report instead of them:

'I do not understand why we need to write so many reports. Reports and then reports of reports. Common! What is it? But usually I do not do those; the nurse writes all of them, that was the condition when I came to work here' (Interview 15).

Regarding the training courses or seminars on PCC approach, the interviewed doctors in Kiev never attended one. They do not deny the fact that the courses are perhaps available, but as usually there is not enough time, they admit, because of the COVID-19 situation. There was also the case when the doctor completely ignored the courses, stating that there is no need to take those as they have a lot of working experience and know how to provide services to the patients. Another issue regarding this fact was that the doctors deliberately refused to take courses regarding the role of the family doctors, stating the same reason - big experience that they possess. Here is the evidence if the data:

'In general I think that there are a lot of different courses on the patient-centered care model, but with the situation regarding COVID, there is no time to take those' (Interview 20).

'We had an opportunity to take the course on how to become a family doctor, but taking into account that we have more than 20 years of experience, we refused' (Interview 12).

To the researcher's opinion, the doctors who refused to take courses on the family doctor issues missed the whole point of providing the patient-centred approach in their practices.

Two cases from Kiev demonstrated that the doctors, not being taking specifically any courses on the PCC issue, claimed that they have been working with the patient focus for a long time. However, later it was revealed that one doctor was familiar with this approach as before the reform, he worked in the private facility. And another case, where the PCC was used for a long time, was a relatively new doctor, who was trained already at the university during the internship on how to provide services using the PCC approach:

'I have been using the PCC approach for 11 years. Because before I worked in the private facility, and it was compulsory there to visit seminars on communication. There were conferences. That is why I cannot say that with the beginning of the reform I started to use the PCC approach' (Interview 15).

'Initially during the internship I was already explained about patient-centered care and what responsibilities the general practitioner has' (Interview 17).

To summarise this section, it can be said that the technical issues are the biggest barrier regarding the integration of the health system. However, what was analysed by the researcher, the biggest concern here is regarding the patient-centredness and its implementation. The doctors are so confident that they even refused to take the courses on the basics of the role of the family doctor. Thus, the facility does not play a role from the perspectives of the doctor; the courses are not necessary because they have been working already for a long time and know what they are doing. The only element that mattered was the equipment for the patient examination.

4.3.1 Motivations for doctors. 'Money follows the patient' reform

The interviewed doctors from Kiev admit that the change in the financial system is important not only for the patient, but also for the doctors, because the doctors salary must grow, when he/she has more patients. Although the doctors are aware of the

amount of salaries they have to receive, they still agree to work on the conditions that they initially agreed on. It seems that most of the interviewed doctors are aware of the changes, but they do nothing to change it by themselves. With this attitude of the doctors, the administration may also not be interested in the salary increase, as the doctors do not demand it and are ready to work for a smaller amount. Here is the evidence that show what should happen if you are not satisfied with the salary of a family doctor or have a feeling that you are manipulated:

'I left my previous job, because I had a lot of patients, but the salary did not change. I always do my best and everything that I can but for peanuts I am not going to do it. I know exactly how much I should earn….The manager assured me that the next month I would have it, but I did not, thus I left the facility' (Interview 11).

From the doctor's perspective, the only way out of here is to change the facility; however, they are not so much 'in a hurry' in doing so.

Regarding the motivation aspect, which is supposed to encourage doctors to provide services of a good quality was not found in the case of Kiev. Doctors in Kiev on the primary level do not have any incentives or motivation to work for quality:

'I personally, and also doctors that work here, do not have any additional money, we have fixed salary every month and we are not motivated at all, thank you my administration for this 'good' strategy' (Interview 18).

To conclude, it can be repeated that motivation and incentives that the management should provide for the doctors is a necessary step to the improvement in the quality of services on the primary level. This phenomenon was absent in the case of interviewed doctors from Kiev. The doctors admit that this is an important element and a tool for the quality of care; however, they are not experiencing that. Thus, 'the money follows the patient' is only about the patient in doctors' perspective.

4.3.2 Customer choice from doctor's perspective

Doctors who were interviewed for the study are not satisfied about the customer choice of the family doctor. The thoughts were divided, there were also those who are satisfied, but most interviewed doctors do not like the idea. They argue that there are different patients and sometimes it happens that the doctor does not want them, however they do not have the opportunity to choose the patient. Another reason was mentioned that sometimes the patient tries to escape from the legal actions and provides some fake documentation or evidence. Thus, in this case, the doctor cannot tolerate the patient and would like to stop the declaration. Here is the evidence of the data that reveal the positive and the negative aspects of the patient's choice of the family doctors:

'I like this idea, because when the person chooses the doctor that means there will be trust and respect, and we all know that the successful treatment depends on how the patient trusts the doctor. Because if the patient thinks I am a bad doctor, then whatever I would do would not help him' (Interview 12).

'I do not like it, because sometimes there are different patients, especially the new ones when they come from different doctor and they have their own weird preferences towards vaccination for example, or give me the certificate which is face about the fact that they are vaccinated' (Interview 15)

'I am not a fan of this. There are different patients, and the doctors do not want to cooperate with them, but we do not have a choice. This should be somehow maintained and better planned (Interview 18).

To conclude, the doctors agree upon the fact that the opportunity to choose a family doctor is an advantage for the patients, but not for the doctors. Thus, again as it was discussed in the section of Ivano-Frankivsk (cf section 4.3.3), the PCC approach is more than just a focus on the patient. The relationship should be balanced, otherwise, the doctor will not be able to provide the patient-centred care. The important aspect was found regarding the patient's choice, which is trust. Choosing freely the family doctor

generates trust, and trust is the most important element in the relationship between the doctor and the patient.

4.3.3 The relationship between doctors and patients

Interviewed family doctors from Kiev agreed that the most important element in the doctor-patient relation is trust, as if there is no trust, there is no compliance; if there is no trust, there is no desired outcome. The doctors also mentioned that communication is very important for the patient, because the patient wants to be heard and also receive the recommendations from the doctor:

'Sometimes it happens that I already know the diagnoses of the patient. I do not need to even ask him what bothers him. I can immediately prescribe the medicines, but it will not make the patient happy. The patient came, he wants the communication, he needs to be heard' (Interview 12).

Regarding the knowledge of multidimensional aspects of the patient, it played a huge role. The doctors saw it as a tool to prevent diseases and a better care for the patient, because if the doctor is aware of the different aspects, he may prevent or at least warn the patient of the consequences. Another reason why the element of multidimensional knowledge of the patient is important concerns the material factor, because sometimes the patients do not have enough money to purchase the necessary medicines, thus the alternative can be found. Here are the examples of the reasons mentioned above:

'It is important for me to know multidimensional aspects of the patients, especially when the family has a few kids and I need to know whether the diseases are the same' (Interview 15).

'When I choose medicines, it is important for me to know whether a patient can afford them; thus, yes, I need to know more than just the patient's name!' (Interview 20).

The barriers that stand between the successful doctor-patient relation were also detected in the analyzed interview of family doctors from Kiev. The doctors are not satisfied with the patients disturbing them 24/7. They complain that the patient is not completely aware of who the family doctor is and what his/her role is. Some doctors confessed that they do not pick up the phone when they see the patient is calling during not working hours. Some pick up and explain that they cannot help the currently:

'There is a certain group of people that think that doctors owe them something. The doctors are slaves and they must do everything when the patient desires. I had an accident when it was Sunday morning and I was on my morning run and suddenly the patient calls and explains that he has problems with going to the toilet' (Interview 11).

Thus, friendly relations between the doctor and the patients are crucial. Trust determines this relation. Communication is also essential. The patient wants to be informed and heard. Multidimensional aspects affect the treatment process and its outcome. These are the elements that also define the PCC concept according to the doctors who were interviewed for the study. However, the communication aspect is not perfect since the problem of calling the doctors 24/7 exists. The patients somehow are not informed what to do when they have health problems, and they are also not informed that the doctor cannot be available 24/7.

4.3.4 Empowerment of the patients and customized care

The doctors from Kiev who participated in the study do not consider empowerment of the patient as an important element of the patient-centred care. They still believe that the doctors are the main actors in health care provisions and when the patient appeals to the doctor, it means that he/she needs professional help. The doctors argued that if the patient wants to make decisions then, he can do it by himself and the doctor is not needed. However, when the patient comes for a consultation, that means something is not helping what he has tried and he needs a professional approach. And this approach, according to doctors, is the doctors' decision:

'*Well, the patient has the right to his own opinion, but I think when the patient comes for help then he must listen to the doctor. If he wants other treatment and he knows best, then what is the point of visiting the doctor'* (Interview 12).

What concerns the customized care, the doctors understand it as providing the right information for the patient and communication attitude, but not as the tailored approach for the patient. The polite attitude, the information access and explanation are the elements that characterize the customized care. Customised care is not seen as the making wishes of the patient. Customized care, according to the interviewed doctors cannot be something that is deviated from evidence-based medicine. The doctors emphasized on the importance of the protocols they have to follow and consider those as patient-centered:

'I respect my patient and I would never prescribe them something that is not evidence-based or something that is not written in the protocols, because protocols are patient-centered. The patient may drink even holy water, I don't really care, but I never prescribe it.' (Interview 11).

To conclude, the interviewed doctors from Kiev are not willing to satisfy the patient's needs in terms of non-medicine approach. They try to convince the patient, they emphasize on communication, that it is a very important part; they also say that usually these kinds of issues occur when the patient does not trust the doctor or when the relationship between the doctor and the patient are fresh. And they do not agree that patient-centered care is something that can harm the patient; and they see other medicines that are not in protocol exactly the ones that can harm the patient.

However, can we talk about the PCC when the patient strictly follows the doctor's recommendations? It is possible, but only when the patient agreed to this and understood the risks of his disease. Thus, the doctors argued that the patient must listen to the doctor's recommendations because the doctor is already patient-centered and is aimed to help him/her. Physical health is the most important one for the doctors, and the focus is still on the deseas, not on the patient himself.

4.3.5. Perception by the doctors of improved quality of care

The doctors listed numbers of factors that influence the quality of care. The main argument was regarding the healthcare system in general, and continuity of the reforms for the further integration. Among the factors that contributed to the quality of care on the primary level were satisfaction of the patient, professionalism of the doctors, concentration on the important parts of the job of the doctor, visiting time, improvement of the quality on all levels of healthcare. Here is the evidence:

'When we talk about the quality of services on the primary level it is first of all the satisfaction of the patient. When the patient is satisfied it is the quality it is that we do a good job' (Interview 15).

'The next thing that needs to be improved is that we have a cohort of doctors that are sitting and waiting for somebody to come and explain and teach them; however they do not understand that nobody will' (Interview 11).

Regarding the secondary level of health care, the doctors in Kiev see it as the problem, however, they do not emphasize on it and say that it is a temporary issue. Due to pandemic, the health reforms are in halt, thus only more time is needed to improve everything. Doctor's distraction must be also minimized, according to interviewees. The reports and the administrative work that the doctors are required to do not contribute to the quality of care:

'It seems that we do most of the administrative jobs, thus we are distracted, and do non-doctor's jobs' (Interview 18).

And the last case, which was a deviant one, rejected the reform. The doctor from Kiev is not satisfied with the new model of the reform because it lowers the quality of the health care services. She was the only doctor among all interviewed who had such an opinion

'I think we do not have quality now, and we cannot talk about the improved quality at all. I think this reform is a step back. We need to go back to how it was before. Before the reform, the patient was able to get the help from the specialist, it was quicker and professional, now he needs to go back and forth. The level now is lower than before… We delay the process… Sometimes two-three days mean a lot... It is not right, not professional, it is bad' (Interview 12).

To conclude, the participants mostly agree that in order to improve the quality of care, the reform must continue to be implemented on other levels of healthcare. There was no unanimous element that was considered to be the best regarding the equity of care; however, more time for the visits were repeatedly mentioned, professionalism of the doctor who must improve the skills often and satisfaction of the patient.The case of the dissatisfaction of the reform was also mentioned, where the argument was made regarding the impossible achievements the quality of care if to continue implementing the reform.

4.4 Comparison of the primary health care reform in Kiev and Ivano-Frankivsk.

Regarding the integrated health system, the interviewed doctors from Ivano Frankivsk are more satisfied; however, would like to have more equipment, tests, separate computers in order not share it with the nurse and also better office design for a doctor. Only interviewed doctors from Ivano-Frankivsk mentioned the issue that they share the office with another doctor, thus, would like to have their own office. According to them, when the patient needs more time for the examination, they cannot provide it, because the office should be used by another doctor. There was no such an issue in Kiev, the doctors usually have separated offices and are in charge of it.

Thus, the facility issue played a more important role as the element of PCC in Ivano-Frankivsk than in Kiev.

All interviewed doctors from both cities have problems with the IT aspect which affects their daily work in terms of time consuming. The doctors do not trust it and very often spend a lot of time filling in the information about the patient's health. The difference was noticed regarding the electronic referral between two cities. For interviewed doctors from Ivan-Frankivsk, it was a huge problem, because the referral had to be printed out and it often happened that the patient was frustrated, as he first needed to take this referral, and then come to the specialist. If the patient for some reasons forgot the paper at home, he will not be accepted. In Kiev, the interviewed doctors did not complain about the referrals as according to them, they do not need to print it out, it is always electronic.

It may be concluded that there are different information systems or software that the facilities use in both cities. Thus, the technology can affect the lives of patients. If the patient waits for a long time because the doctor cannot find certain symptoms in the system or is sent back from the secondary level to the primary again because of some administrative work, it will not make the patient satisfied.

Complaints regarding the report writing were also identified in both cities; however, the doctors in Kiev were not so frustrated about them. Some doctors are directly using the computer system to produce the report, some have their nurses to write those. The interviewed doctors from both cities also agreed that the time for some administrative work could be devoted to patients, either to serve more during the day, or to provide more time for the visit. Thus, the occupied doctors with other duties affect the patient-centered care, because of the lack of time.

Regarding the courses or training programs, there is a huge difference between the cities. In Ivano-Frankivsk, interviewed doctors heard about the PCC approach and some of them were provided with the course. Interviewed doctors in Kiev, did not consider those courses as important ones, because of the experience they have. However, in Kiev and in Ivano-Frankivsk there were cases when the doctors admitted that PCC is not a new phenomenon for them as they have been always using it in practice.

Motivation aspects also differ. Doctors in Ivano-Frankivsk receive incentives and are more motivated by the management in contrast to interviewed doctors from Kiev. In Kiev the interviewed doctors work on a fixed salary, and claim that it almost never changes. According to the literature review, motivation is an important factor that contributes to the competition between the doctors, thus it affects the quality of care. The doctor cannot provide the PCC approach if his efforts are not appreciated. Thus, it can be presumed that doctors in Ivano-Frankivsk are more likely to provide better services on the primary level.

Regarding the patient's choice of the family doctors, the interviewed doctors from both cities considered it as a good idea for patients, because they chose the doctor they like. However, as from the doctor's perspective, participants from both cities agreed that sometimes it affects the PCC approach, because the doctor will not be able to visit the patient in terms of the distance, or the case when patients do not follow the recommendations. According to the doctors, when the doctor is not happy with the patient or his behaviour, he/she will not be able to provide PCC.

There was no difference between the interviewed doctors from both cities regarding the doctor-patient relation. They all considered trust and communication as the main elements of the relationship between doctor and the patient. For all interviewed doctors it was important to know the multidimensional aspects of the patient. They justified it with the fact that it is important when they prescribe the medicines. The aspect that the doctors are most concerned about is the material status of the patient. It helps them to decide what medicine to prescribe - expensive, cheap or the cheapest.

Regarding the barriers that can come in between the doctor and the patient, all interviewed doctors from both cities mentioned personal space that causes misunderstanding between the doctor-patient relations. The doctors are tired of issuing referrals and do not understand the patients that are asking for them in non-working time. The doctors are ready to provide all the patients required, but only during the working hours.

Neither the interviewed doctors from Ivano-Frankivsk, nor the interviewed doctors from Kiev are ready to accept the fact that patients can make decisions. The doctors consider themselves as professionals and patient-centered because they prescribe only what is best for the patient's health. The doctors rely on the protocols, and consider them patient-centered ones. However, in Ivano-Frankivsk, the doctors do not only care for physical health, but also take into consideration customized care and try to satisfy patients preferences, by illegal actions (prescribing one medicine for the patient, and not the same for the computer system). In Ivano-Frankivsk, the interviewed doctors may accept the patients preferences or decisions, however, they also need to find the ways to secure themselves from prosecution and ask the patients to give a written consent on the refusal of the treatment.

Considering the patient-centered care, the literature says that not only physical health can be taken into account, but also the patient as a whole. Thus, completely ignoring the patient's preferences does not provide a quality of care, and is not considered a PCC approach, according to the literature. However, from the interviewed doctors' perspective, patient-centredness is when the professional takes care of your health, using the procedures that are determined by protocols.

Quality of care and what factors or elements contribute to its improvement was the most diverse issue among interviewed doctors. Interviewed doctors from both cities said that connection of the primary care and the other levels of health care is essential and the same principles must work on each level of healthcare. Only interviewed doctors from Ivano-Frankivsk mentioned integrated health care as an crucial element that influences quality of care, meaning that professionalism of the doctors, new equipment and physical comfort must be addressed first. In Kiev, there was the case that did not believe in the new reform and claimed that in order to have quality, the previous Semashko medical system should be returned in order to provide patient-centredness and the quality of care.

To conclude the whole section, we can observe some differences in the perceptions of PCC; however, it is considered that there are more similarities between two cases of

analysis. Patient-centered care for interviewed doctors from Ivano-Frankivsk is providing the necessary help and services that the patient needs, only in some cases, the services that the patient wants and good relationship with the patient. Patient-centredness for interviewed doctors in Kiev is strictly following the protocols, good relationship with the patient and devoting more time for the patient during the visit.

4.5 Perception of the patient-centered care by the patients from Ivano-Frankivsk and Kiev

Thich section will demonstrate what the patients want on the primary health care level and what the patient-centred care is for them. Two cities will be compared, where we can see whether the patient's demands are the same or differ. Moreover, it can also be demonstrated what the improved quality of care is for patients. Thus, by analyzing this section, it would be possible to establish the link between the Ministry, doctors and patients and to see whether there is a deviation from what was written, implemented and desired. The section is not divided according to the cities, because as for patients, the findings did not differ depending on the city, thus the findings are presented by the combination of the data from both cities.

4.5.1 Integrated health care from the patients' point of view

The biggest difference that mattered regarding the integrated health system was the physical comfort. Patients from Ivano-Frankivsk did not complain about the facility and were satisfied with them. Interviewed patients in Kiev complained about the old-fashioned design and lack of diagnostics. Interviewed patients from Ivano-Frankivsk only complained about the issue of having sometimes more than one doctor in the office. Here is some evidence:

'*Nothing has changed! Everything is old and old-fashioned'* (Interview 19, Kiev).

‘*...what I noticed when I came there were three doctors. When I entered they went away, but still I had the feeling that they could enter any time. It is not really a bad thing, but still I would not like to have many staff inside when I come’* (Interview 7, Ivano-Frankivsk).

The literature review defines physical comfort as an important element of PCC, because a professional, nice design ensures that patients feel comfortable, expected and welcomed (McCormack, 2008; Pelzang, 2010; WHO, 2007). Moreover, it contributes to the patient’s safety and privacy (Kemp et al., 2015). However, what we can observe from the interview is not a very crucial element from the patient's perspectives.

Regarding the issue of the convenience in the appointment of the consultation, the interviewed patients from Kiev found it as a very important element that contributes to the comfort of the patients. The patients are satisfied with the new system of appointing the consultation, the online one, because they do not need to wait for a long toe as it was before the reform. The interviewed patients from Ivano-Frankivsk do not use the registration online, they call the doctor directly or write the message and then the doctors give them time, no matter of the patient’s age. The patients in Ivano-Frankivsk perceived this new format of the consultation appointment as an additional burden, and they believe that it does not contribute to the shorter queues, because, still not all of the patients use it. Here is the evidence of the explained above:

‘What is the point of using online appointments if you will still come and wait in line like those patients who did not make it online’ (Interview 6, Ivano-Frankivsk).

‘*I always do it online, it is very convenient, but of course I can also call if it is an emergency’* (Interview 22, Ivano-Frankivsk).

To conclude, it was not really clear how the appointment process was conducted in Ivano-Frankivsk. Even when the patient calls or texts regarding the consultation, the doctor or the nurse still have to somehow insert the time into the system in order to avoid the huge lines. Thus, the doctor may not be bothered while examining the patient

by calls from the other patients about the consultation time. It is the third year since the implementation of reform on the primary healthcare level started, and the patients are still not used to using the online appointment of consultation. Considering the PCC approach and the little time that is given for consultation, there is no additional time for appointing the consultation via phone, otherwise the PCC approach is violated and does not contribute to the patient's satisfaction.

4.5.2 Satisfaction with the services the patients received during the visit

All interviewed patients from both cities are satisfied with the lists of services that they can get on the primary level. They admitted this list includes much more free of charge services, than before. Most of the respondents mentioned the cardiogram that they can get in the family doctor' office, also they can check the sugar level immediately. Some mentioned ultrasound service as free of charge one, others were surprised by the massage services. Thus, 'The money follows the patient' financial model was very crucial for the interviewed patients from both cities. The fact that they do not need to use the out-of-pocket money is an important aspect in the patient's satisfaction. Analyzing the interviews, the suprisiness of the patients was too evident, because finally they can get the necessary and important for their health services on the primary level now. The data that contributes to the mentioned above:

'Yes, we always have free blood tests, cardiograms, consultation of course. I can come now to the doctors, I do not worry that I need to buy chocolate or pay' (Interview 9, Ivano-Frankivsk).

'My family doctor, having heard my problem, immediately recommended a message course inside the facility for two weeks. It was a very positive experience (Interview 25, Kiev).

It was also interesting to know how aware the patients are of the reform and what services are provided on the primary healthcare level. All interviewed patients know very well what services they may have on primary health care. Almost all of them

understand even what ‘Money follows the patient’ means. They know exactly that they are the main source of how the facility receives the money. The changes in the financial system are the long-waited positive changes that the patients were waiting for. The material aspect matters when we talk about the PCC approach from the patients' point of view.

4.5.3 The option to choose the family doctor

The interviewed patients from both cities considered the opportunity to choose the family doctor as an advantage. They have a chance to choose the doctor they trust and they are comfortable with. It is a very important option for the patients because, according to them, the professionalism of the doctors is not the best quality that the health system can be proud of, thus the patients want to choose themselves not be assigned by somebody to the doctor that they do not know or do not trust. As soon as the option of choosing the doctor became available, the patients also changed the family doctor. The very important reason for this was also the fact that before, if the patients wanted to visit a doctor who is not the one he/she is assigned to, they had to pay an informal fee just for the new doctor to accept them. Now, since the declaration is signed with the new doctor, the patients do not need to give bribes or pay for the informal visit. Here is the evidence that demonstrate mentioned above:

‘This is cool. Especially taking into account the level of the medicine in Ukraine, it is important for me to choose the doctor that I am confident in and I know he is a professional, when I trust him or when I see positive feedback about him’ (Interview 5, Ivano-Frankivsk).

‘When I was about to choose the doctor for my child I knew exactly who I wanted and I was very happy I had that option’ (Interview 19).

Another aspect that was pointed out only by the interviewed patients from Kiev was that there is not enough information about the family doctors. Thus this choice by patients is not always easy and available when they do not know what doctors they need. The

patients want to see the years of experience, the short overview of the doctor's profile and also the feedback of the patients about the doctor. However, the only information that the patient can find now is only the stars of satisfaction (where 1 is not satisfied at all and 5 is very satisfied). The patients from Kiev also mentioned that this choice is not always free, because if they chose from what is left this does not mean that he/she chose the doctor that they wanted:

'It is a good idea. But there is also a negative moment regarding this; because when the patient made a choice of what was left, it is still not considered a free choice, it was not the patient desire to choose the doctor, but he had to make this choice and just chose from the doctors that were available' (Interview 10, Kiev).

To conclude, it can be said that the patients are very satisfied with the opportunity to choose the family doctor. According to literature review, the patients' choice is to emphasize the patients' empowerment (Victoor, et al., 2012). This is exactly what the interviewed patients from both cities feel. They feel empowered and say that this opportunity will contribute to the better quality of services.

4.5.4 Patient-doctor relationship

The interviewed patients from both cities were satisfied with the family doctors they had signed declarations with. For the patients, trust is a very important element in the patient-doctor relation. The patients also do not tolerate the bad attitude of the doctor or when they see the doctor is trying to be superior. Patients want support and proper treatment. Patient wants to be heard and informed of all details that concerns his/her health. For interviewed patients it was very important that the doctor is available 24/7 and replies all their messages or answers calls:

'Good relationship. She is always available for me, and supports me; immediately replies to messages; she never ignores the messages, I trust her, this is the most important. And I like the way she treats the patients, because I don't have repetitive diseases' (Interview 3, Ivano-Frankivsk).

'I like my doctor. She is responsible and a real professional. She always calls me back when sees the missed call, she is very careful in the diagnostics and prescribes only necessary and effective medicine' (Interview 19, Kiev).

The interviewed patients also are very concerned about their health and would like the doctors to sometimes remind them about the important tests, vaccinations, or other diagnostics. The patients say that since the doctors receive money for the patient, and taking into account that some patients do not so often visit the doctor because there is no need, the doctors, in turn, must contact the patients and show that they care. The patients are convinced that this is one of the duties of the doctor's job:

'I would like the doctor to call me from time to time (once in 6 month), just for the reason to connect together […]' (Interview 6, Ivano-Frankivsk).

'I would like the doctor to show that he cares, to call sometimes, to remind me about something, maybe I need a check up or maybe there is a vaccine.' (Interview 10, Kiev).

The patients from Ivano-Frankivsk who were interviewed for the study are not really willing to tell the doctor a lot about their families or other aspects, and think that this is not the competence of the doctor. In contrast, the patients from Kiev were not so radical about it and did not mind to have very close relationship with the doctor and emphasised that the doctors knew about them enough information:

'I do not think the doctor must know about my other aspects of life other than health. I came to him for specific help, thus three is no necessity to open up. For mental support we have psychiatrists, not family doctors' (Interview 6, Ivano-Frankivsk).

'I think my family doctor knows a lot. She is aware of my child's health, my husband's business, she knows my ups and downs' (Interview 22, Kiev).

To summarise this section, the patient-doctor relation plays an important role in the patient's life. Providing care and showing care, this is what is the most important for the patients. The patients want their doctors to always be available and provide 24/7 support. Patients feel dependent on their family doctors and would also like that doctors contact them from time to time. Thus, care24/7 is another important element that the patients want. The interviewed patients from Ivano-Frankivsk are not ready to share other aspects of their life with the doctor than health. According to the literature review, PCC is not only about physical health, but also other aspects of health. Thus, the only focus on the patient's disease does not contribute to the PCC.

4.5.5 Customized care; empowerment of the patient

Beside the fact that all interviewed patients from both cities would like the doctor to show them care constantly by calling, asking how things are and reminding them about vaccinations, the patients also want some other no less important attitude from the doctor. They want to be heard, they want to be respected, they want the doctor admit the mistake when there was one, they want to know more information about the medicines the doctor prescribe or about the disease they have, some of them only want evidence-based medicine, some want the doctor take their preferences into account, others like when the doctor is rational and does not prescribe expensive medicine:

'I do not think medication is important in all cases. The support is more important sometimes' (Interview 7, Ivano-Frankivsk).

'Our doctor always advises us what medicines are best and gives us the option of choosing the cheapest' (Interview 22, Kiev).

To sum up, what the researcher can analyse from all interviews is that patients like to be involved in the treatment process, like to know a lot of information about the situation, and have the alternatives of what medicines they may choose. The interviewed patients from Ivano-Frankivsk were more concerned with the prescription medicine and the

information about it and to know whether it is the best option. However, the patients from Kiev tend to trust doctors more when it comes to the comparison of two groups of patients and consider the doctor as professional and the person who has the right to prescribe what they consider best. Thus this also shows that in Kiev patients are more doctor-centered and strictly follow the doctor's recommendations. Customized care as an important element of patient-centredness is more evident in Ivano-Frankivsk. And by customized care, the interviewed patients usually mean the proper prescribed medicine and to be informed of all the necessary aspects. Customized care and empowerment of the interviewed patients in Kiev was less evident as they consider the patient has to follow doctor's recommendation and not interfire.

4.5.6 Quality of care from patients point of view

When it comes to quality all interviewed patients from Kiev and Ivano-Frankivsk want different things; however most of them emphasize on the qualifications of the doctor and the attitude to the patients. Almost no patients mentioned the facility interior or some other conveniences. Physical health was still the most important for them or everything that is related to health - equipment, diagnostics. When the patient answered regarding the quality it coincided with the previous questions when they answered about the relationship or the customized choice. Most patients from Kiev see the quality in the doctor - doctor's qualifications, doctor's attitude and also the recovery result. Here is the data that proves the mentioned above:

'The quality is when the doctor is a professional' (Interview 22, Kiev).

'The quality is when the doctor helped me with my problem and of course nice and polite communication with the patient' (Interview 25, Kiev)

'The quality must be in the doctor and when for you it absolutely doesn't matter which doctor to choose because they are all good' (Interview 10, Kiev).

The patients from Ivano-Frankivsk, in general, also pointed to the same problems - attitude of the doctor; however, there were also different factors/aspects that were associated with the quality - more analysis on the primary care level; queues:

'I see the quality improvement as first with the nice attitude of the doctor to the patient. The positive energy that the doctor must produce, I understand that the doctor absorbs a lot of negativity, but nevertheless, he must learn how to cope with that' (Interview 6, Ivano-Frankivsk).

'I would like to have a fully electronic queue, because you can plan your day' (Interview 3, Ivano-Frankivsk).

In general, the patients from Ivano-Frankivsk emphasised on the more services on the primary care, so that they would not have to go to the private labs and also long queues at the doctor's office; while the patients from Kiev emphasized more on the doctor's attitude. This is due to the fact that in Ivano-Frankivsk, there is still a problem with electronic doctor's appointments and also the doctors complained about the lack of tests on the primary level. Regarding the quality of care, the patient's perception is the professionalism of the doctor and the doctor's attitude to the patient. Thus, shared decision-making or the empowerment of the patients are not important elements regarding the PCC approach. The patients themselves are not ready for the PCC approach, the one that the previous literature describes. They rely on the doctor too much and are dependent on them.

Summary

To sum up the whole subchapter about the patient's viewpoint on the reform in general and patient-doctor relationship would be relevant with the facts and recommendations from the consultant for communications with patient communities, who works in the organization Patients of Ukraine. The respondent, being one of the members as the patient representative in the Ministry when the reform was developed revealed also the very important objective of the reform that concerns primary care. Regarding family

doctors, the consultant responded that the idea was to create a 'friendly doctor' who will be always responsive and care about the patient:

'I do not think that the attitude of the patients changed significantly towards the family doctor and they still now do not understand how important the doctor is in the patient's health…. the plan was to create a friendly doctor for the patients, who is always there, who always responds. I do not think that the doctors changed as professionals, but the attitude towards the patient changed definitely. These changes in the reform make the patient grow up and prevent patients from appealing to the specialist when it is not a serious problem. Thus, the reform is focused on the patient and makes him more responsible' (Interview 27)

The objective of the reform regarding the patient was to make the patient realize that he must be responsible for his own health. The patients must know how and when they need to visit the doctors, they also need to be very active patients and be aware of the details of their diseases or other problems they have. The responsibility of the patient is also the aim of the reform and patients need to take care of it in advance and thus the problems with the appointment will disappear because the patient will not need the urgent visit in case there is no time available.

CONCLUDING REMARKS

The thesis aimed to analyze the perceptions of patient-centered care on the primary health care level in Ukraine among the policy-relevant stakeholders (2018-2020). Two cases more specifically were analyzed - Kiev and Ivano-Frankivsk. It was important to understand the perceptions of patient-centered care by different stakeholders. The perceptions are important, when we talk about reform implementation, in our case the patient-centred care on the primary level; because of different perceptions, the reform cannot be implemented or can be implemented in a different way as it was planned. The aim of the research was also to compare and contrast how the patient-centered care is perceived in two cities, by doctors, patients and also by the experts. The aim was also to find out how patient-centred care influences the quality of care and also what were the initial objectives of this PCC approach in the reform.

To study the phenomenon of PCC in Ukraine, the researcher used different data collection methods. Two national strategic documents, information from the official website of MoH, and a law (order) related to the health reforms and patient-centredness were analyzed by the researcher. In addition, the researcher conducted 27 in-depth interviews. The data were analysed using qualitative content analysis. Based on the findings the thesis argues that the perception of patient-centered care on the primary level of healthcare is perceived differently by different stakeholders, even comparing two cities these perceptions vary. The pattern that we see in doctors from Ivano-Frankivsk is similar among doctors from this city; however, it is a bit different from the doctors from Kiev.

Doctors

Two cities according to the previous research had different percentages of the reform satisfaction on the primary care; however the findings did not show the dramatic difference in perceptions of PCC. To compare and contrast, it is observed that doctors and patients who participated in the study from Ivano-Frankivsk are more satisfied because of the motivation issues from the management and nice facilities. It was also

detected that the interviewed doctors from Ivano-Frankivsk are more patient-centered than in Kiev, because they still try to satisfy the needs of the patients based on the patient's preferences. Doctors in Kiev are more radical, and see the patient centredness in the protocols and strictly defined rules.

Another factor that could lead to the previous results where the reform performs better in Ivano-Frankivsk is the fact that interviewed doctors were more responsive towards patients, although still complaining about the violating personal space, regarding the patient's calls or messages during non-working hours.

However, there were also contradicting findings to the ones that showed the previous satisfaction. The interviewed patients in Kiev were satisfied with the online registration for the doctor's appointment while in Ivano-Frankivsk, it was completely opposite. Another contradicting factor is that the doctors in Kiev do not write a lot of reports and usually have other ways of completing those. In contrast, in Ivano-Frankivsk, doctors are more overwhelmed. One more aspect is that, in Ivano-Frankivsk there is a problem with referrals and this issue makes the patient more frustrated while in Kiev, the referrals are only electronical, thus no issues were detected.

The strategic documents and law have the information regarding patient-centered care; there are different programmes conducted by MoH and NSHU during the year, however this is not enough and most of the doctors are not willing to take those, considering them as not of the priority choice. The main objectives of the PCC approach is the access of the patients and satisfaction of the patients needs, these are the aspects the strategic documents emphasize.

However not all of these facts the experts consider to be patient-centered. The financial model that was implemented was not patient-centred according to the expert from Academia of Family Medicine, while other stakeholders see it exactly as patient-centered.

It was also emphasized by the experts that the medical system of the Soviet Union was not patient-centered, thus the changes were needed.
From the documents, and experts interviews analysis it may be concluded that the main objectives of the PCC are equal access to primary care, improved quality of services, mutual respect between the doctor and the patient, to increase the effectiveness and efficiency of health services and the improved culture of communication.

The more we move further the more discrepancy there is. Based on the family doctors' interviews, we may say that the doctors are working as there were no changes at all. Most of them were not provided with the proper training, most of them are not satisfied with the salary, most of them do not have any incentives or motivation to work and it is suspected that most of them do not know what is there about PCC and how related it is to the quality of care.

Regarding the integration on the primary level, all interviewed doctors pointed out technical problems. This is time consuming for them because they have to duplicate everything on paper as well and also the system is not perfect. What was noticed: the doctors did not emphasize on facility design, it seemed it did not play the role for them at all. All they wanted was more equipment and tests that could be available in the labs. A few of them complained about the visiting time, that it is not enough, and when the doctors talked about the facility, they talked specifically about their offices. It can be observed that the focus is mostly on the disease and the sick patient, this is still the priority for the Ukarinian doctors. To be more specific the focus is close to the one that has been working in Ukraine for more than 20 years.

The second problem or barrier that was discovered was writing reports. The doctors see the solution for this - hiring a specialist who can do it as they do not consider it as their job.

Regarding the 'money follows the patient' principle, all doctors understand what it is, however they do not really like to specify or ask about it from the administration. The doctors from Kiev, compared to the doctors from Ivano-Frankivsk do not have any

incentives or motivation. The expert of the Academy of Family Medicine of Ukraine does not support nor understand why the doctors accept the working conditions if they do not like it taking into account the fact that there is always demand for family doctors in Ukraine. The doctors do not understand their rights and are used to working for small salaries in Ukraine, thus the administration does not provide the necessary incentives or motivation packages for doctors.

Having interviews with the doctors the researcher could feel this overwhelmingness from the doctors' point of view regarding the PCC approach. The doctors feel that everything should be for the patient but nobody thinks about the doctors at the same time. The doctors are scared to lose their jobs, scared to lose the patients, scared to be prosecuted, because they are not protected by law, scared of patients' calls which are as they say 24/7, scared they will not be able to provide the referral when the patient needs it. Thus, when the focus is only on one side, here cannot be mutual comprehensiveness of two parts. The administration should value the workers and be not only patient-centered but also person-centered which involves not only patients but all stakeholders involved.

All doctors admit that communication is important and consider this element the one of PCC. The doctors seem to know what the patient wants - to be heard, to be informed, to have quick recovery, minimal cost, support and 24/7 access. However, not all of the doctors can provide that for patients because of the existing barriers as lack of time.

Regarding the improved quality of care, most doctors consider the amount of signed declarations with the patients or the satisfaction of the patient. Taking into account the interview of the member of the Academia of Family Medicine in Ukraine, it is difficult to evaluate quality in Ukraine because there are no indicators yet. Therefore, the doctors themselves are not sure what quality is and how to evaluate it. Most of the doctors, especially from Ivano-Frankivsk see improved quality of care on the primary level when the quality on the secondary level is improved also as often there is misunderstanding between two levels of medicine. Also, improved quality was mentioned by the doctors

of both cities - the improved knowledge of the doctor. The doctors must study and obtain new knowledge regarding their profession.

Patients

While the doctors in Ukraine are still hesitating with their answers regarding PCC or quality of care, the patients of Ukraine know exactly what they want and perceive the quality and the patient-centredness in their own way.

The patients who were interviewed from both cities are not afraid to ask any questions they want. However, they still tend to strictly follow doctor's recommendations, because they trust the doctors. Thus, the patients are considered to be passive participants in their health. This is an important fact because in order to receive patient-centred care, the patients also have to be active and participative in their health. The expert from the Patient of Ukraine made it clear that the objective of the reform was also to create active patients who would be responsible for their health. Thus, this phenomenon was not evident in both cases.

Regarding the integrated system, the patients also did not focus much on the facility, they were satisfied in general with the facility; however this satisfaction dominated in Ivano-Frankivsk. Patients from Kiev complained about the old design, the one that was from Sovit times. The documents did not specify this issue at all. Thus, the element of the physical comfort as a patient-centered was almost absent among the patients. According to the experts, it is important when the patient is satisfied with the physical comfort because it reduces the general fear and makes the patient feel comfortable.

Patients in Ivano-Frankivsk do not use online registration/appointment as they do not believe it will be faster or convenient. In contrast all patients in Kiev use online mode. All patients to whom the researcher talked to felt empowered and satisfied with the given opportunity to choose the family doctor unlike the doctors. From their conversations it was clear that they have been waiting for this for a long time. Most of the patients from Ivano-Frankivsk changed the doctor as soon as this option started to

be available, they also said that even when they did not have this choice they did not use the services from the doctor they have been assigned to territorially only in case they needed an official document. Another pattern was observed in Kiev - all patients chose the same doctor who they were assigned before. Thus, a huge advantage is observed in favour of patients with this new reform because now they are in charge of choosing the doctor they like, and they trust. Most of the patients would like the family doctors to call them and ask how they feel, also remind them about the important check ups or vaccinations.

The interviewed patients from Ivano-Frankivsk are not willing to open up for the doctor as they consider him not a psychologist or specialist who can solve mental problems. Thus this contradicts the perception of family doctors and the primary medicine as a whole. The document analysis showed that this is a very important part of the reform on the primary health care level and the National Strategy document emphasizes on it (The National strategy, 2015:18). However, the patients want exactly what the doctors pointed out - to be heard, to be informed, not to see that the doctor is in a hurry, and have cheap medicines prescribed.

The unexpected fact was also the one that the patients do not perceive the family doctor as not serious or unprofessional one as it was stated in the literature review on the reform (Romaniuk, et al, 2018; Yakovenko, 2018; Sobol, et al, 2020). They perceive it as a first person to contact and as someone who must know everything. According to the expert from the Patients of Ukraine organization, this is an opposite statement. And she believes that a long time is needed in order for patients to understand who the family doctor is.

Regarding the quality of care, the material wishes prevail. The patients want to have more free of charge services, cheaper medicines and professional doctors with a nice attitude.

To conclude regarding the perceptions from different stakeholders, there are differences, and each group perceives it differently. The documents revealed all the elements that

were present in the framework of the research, except for the facility design. The document focused on the relation between the patient and the doctor, satisfying the patients needs and preferences. The document analysis also determined that 'money follows the patient' financial model is the most important element of the PCC approach on primary care. In contrast, some experts agreed and disagreed. By the Board Member at Academy of Family Medicine of Ukraine it was not seen as the main element, but family medicine was seen as the main element of PCC. Literature review and the document analysis together with experts consider empowerment of the patients and becoming a team with the doctor as also no less important elements. In contrast, the interviewed doctors from Kiev and Ivano-Frankivsk and the patients from both cities did not consider those as essential elements or not even PCC elements.

Financial model of health care, improvement of the quality on all levels of health, communication and information providing, access to the primary health care services are the most important elements of patient-centered care, according to the findings from both cities.

Together with other findings on PCC, we can also say that this study does not argue that only PCC is the most important element that affects healthcare reform implementation. During the research and findings, other problems were also detected that may be connected to the reform implementation - change of government and unwillingness of government to promote the reform. Thus, other issues that influence reform implementation should be studied.

POLICY IMPLICATIONS

From the findings of this study on perceptions of the PCC approach and its influence on the quality of care, it can be concluded that perceptions matter. PCC was the main element of changes on the primary health care level according to the document analysis. However, interviewed doctors in Kiev and Ivano-Frankivsk had different issues regarding the PCC approach. Some issues were addressed in one city better than in another. Some problems were only identified only in one city, while in another one, they were absent. Thus, in order to have consistency and coherence in the implementation of the reform across cities, the reform must be interpreted in broadly similar terms. Based on the findings, there is some misunderstanding and unwillingness regarding PCC. Perhaps, because of it, there is a difference in two cases regarding the satisfaction of the reform in general. As a result, the implication should be given in order to eliminate these misunderstandings.

Integrated health system. Based on the findings regarding the integrated health system, the biggest discomfort that did not contribute to the PCC approach was the technical issue that was evident more in Ivano-Frankivsk than in Kiev from both points of view, patients' and doctors'. The system did not provide a list of the symptoms to choose from; sometimes the records disappeared; electronic referrals were not available. As a result, the doctors have more administrative work and devote less time for the patient. Thus, in order to provide PCC approach and make both, the patients and the doctors to save time the following should be considered:

- There should be less administrative work for family doctors, or software should be developed that when the doctor inserts the information, the system automatically produces the report. Perhaps, when the software is better, it will eliminate dissatisfaction or time consuming. The software should also be better designed and then suggested to all regions. This will eliminate the discrepancies regarding the issue with the electronic health system.

The problem with registering online for consultation was found in Ivano-Frankivsk among interviewed patients. While in Kiev, there is no other way to register for the consultation, in Ivano-Frankivsk, patients call directly the doctor. As a result, long queues are an issue and additional burden for the doctor. Long queues and answering the calls regarding consultations are not the priorities of the patients and doctors respectively. Thus:

- Family doctors must encourage the patients to use online registration, thus, in case there is no access to the internet, the doctor must find a way by registering the patient via phone, still insert it into the system to avoid having few patients at the same time.

The different perception of PCC in two cases was also due to the unwillingness to participate in the programmes regarding the PCC approach in the case of Kiev. Thus:

- First of all, there should be designed compulsory courses on the PCC for all levels of the health care and personnel. When the same information will be provided to the facilities, a more unified perception of the PCC can be developed across the primary medical system in the country.

Money follows the patient. This element concerned the experts and the interviewed doctors. In order to receive the competition and work for quality, the incentives or motivation should be provided for the family doctors on the primary level. The findings demonstrated that this was an issue in Kiev and some interviewed doctors worked for the fixed salary despite the numbers of declarations. When the doctor is not encouraged, the PCC approach will suffer. Thus:

- The managers should provide the evaluation system for the family doctors (because currently there is none) in order to provide different incentives that would encourage the doctor to work for quality.

The principle of customer choice. Both groups of doctors who participated in the study saw the opportunity to choose a family doctor by the patients as an empowerment of the patient. However, the doctors were not satisfied with the fact that they do not have the right to stop the declaration with the patient that does not follow the recommendations. Since PCC approach is not only focused on the patient, but seen as a team of a doctor and a patient, this issue should be addressed:

- The National Servise of Health of Ukraine, the Ministry Of Health of Ukraine or the management of the facility must provide a possible procedure for the doctors in cases where it is needed to stop the declaration.

Understanding a person as a whole. The constant calls from the patients to their personal doctor's number beyond working hours was an issue in Ivano-Frankivsk. As a result, the patient's needs were not addressed because of certain circumstances, for example, a doctor was busy and didn't reply. Thus:

- The communication must be better established between two groups, patients and doctors. The guidelines should be provided to the patients on what to do in case of emergencies. Regarding the doctors, the personal number is not suggested to be given; however, the office number or the number of the nurse, who is in the office could address the issues that patients require. As an additional suggestion, the groups are encouraged to be created by patients of the same family doctors where patients can exchange experiences and provide help to each other when it is not a serious case.

Patient engagement and decision-making. The difficulties were found in both cases among interviewed doctors and patients regarding the perceptions of the shared decision-making. Neither patients, nor doctors are ready to accept this change. So far, a doctor and a patient are not a team. This issue implies the doctor-centered approach and contradicts the PCC one. Thus:

- The doctor has to take into account the patient's preferences. In case, the patient insists on the choice the doctor does not approve, the doctor should provide as much as possible evidence or information to convince the patient. From the other side, the patients need to be active ones, they need to make decisions and ask the doctor to provide the certain information; also they can propose the choices for the doctors, too. This will contribute to the quality of care and make the doctors be more careful in their job, because he/she must inform the patient and see that the patient also cares.

Quality of care. Addressing the issue of quality of care and its improvement, many factors must be taken into consideration. The findings showed that the connection with all levels of health care is important; the qualification of the doctors, providing necessary information for the patients and having as many diagnostics as possible are important factors for patients and doctors. Thus, the first suggestion would be:

- The connection between the primary care and the secondary one must be established as soon as possible as it affects the primary services quality. The secondary level of healthcare is currently not motivated and does not want to accept the patients with referrals.

- Doctors on the primary level must make sure that they follow the latest standards in medicine and their managers should provide all the necessary information for that.

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Appendix 1: Consent form

CONSENT FORM

'IMPLEMENTATION OF PATIENT-CENTERED CARE IN PRIMARY MEDICAL CARE REFORM IN UKRAINE 2018-2020: AN EXPLORATORY STUDY OF STAKEHOLDER PERCEPTIONS IN KIEV AND IVANO-FRANKIVSK'

Dear Sir or Madam,

You are being invited to participate in the research project 'Implementation of patient-centered care in primary medical care reform in Ukraine 2018-2020: an exploratory study of stakeholder perceptions in Kiev and Ivano-Frankivsk', which is carried out by a second year master degree student Olga Riznychuk from the University of Tartu's Johan Skytte Institute of Political Studies as a part of her Master's Thesis. You have been selected to participate in this study because you are involved in the medical reform implementation and possess knowledge about the topic of this study that may significantly contribute to the research findings. The information provided in this form is to help you decide whether you would like to take part in this study. If you have any questions, please, contact the researcher at olgariznychuk@gmail.com or by phone (Viber) +380664653172.

Aims and implications of the research: The main aim of this research is to explore how the different stakeholders understand the concept of patient-centered care (PCC) on the primary health care level. Very often it happens that the implementation of the reform is not successful because different stakeholders understand the concepts or processes in different ways, or ignore the guidelines that were presented with the changes. The research wants to explore what is the case in Ukraine. PCC is closely connected with the improved quality of care, thus is essential for the study. The research

questions that the research will try to answer are: ***What are the objectives of implementing patient-centered care in Ukrainian medical reform of primary health care management 2018-2020?***
What are the perceptions of patient-centered care among the primary care managers, workers, and patients in Case 1 and Case 2?
What are the policy implications for improving Ukrainian primary care reform in the future?

Procedures of the research: Should you agree to participate, it will take approximately 60minutes of your time to be interviewed by the researcher from the University of Tartu. During the interview you will be asked to answer questions about your perceptions related to the implementation of the PCC approach in primary healthcare and the improved quality of care. The interview will be audio-recorded to ensure that the researcher has an accurate record of the discussion. If you prefer not to be audio-recorded, please, let the researcher know. Audio recording will be destroyed after the interview has been transcribed into a written form. The researcher will ensure protection of personal data and secure processing and storage of the gathered empirical material as outlined below.

Possible risks and benefits for participants: For the participants, this research entails minimal risk. All measures will be taken into account to protect participants' confidentiality and privacy. Participants may remain anonymous and their responses will not be linked to their identity should they wish so. Participants are free to leave the interview at any time and may skip a question which they feel uncomfortable about. You are not supposed to benefit directly from engaging in this research except for information which you can obtain by answering questions about the interviews. In case you are interested in obtaining a summary of the findings of the research, please let the researcher be aware of that.

Anonymity and confidentiality of personal data: All measures will be taken to protect your privacy and confidentiality. Assigning numbers to each interviewee will anonymise the data and will be only used for the purpose of the Master's Thesis. The

participants' identifiers (name, email address, telephone number, etc.) will not be maintained in association with the research data, and will only be known to the researcher. The only person who will have the access to the audio file and the transcription of the interview is the principal researcher from the University of Tartu and any other person or agency required by law. Confidentiality will also be strictly observed in presentation of findings: the interviewees will remain anonymous and their answers will not directly be tied to their identifiers, thus rendering them unidentifiable. Audio recordings and transcripts will be destroyed after the completion of the analysis. The information from this study may be published and publicly presented, but your identity will be kept confidential. You will remain anonymous and will not be identifiable from the data.

Rights of research participants: You can choose not to participate in this study or withdraw your participation at any time during or after the research begins. Refusing to be in this research or deciding to discontinue participation will not affect your relationship with the researcher or the University of Tartu. Should you encounter problems as a direct result of being in this research, please, contact the researcher listed at the end of this consent form.

Informed consent: You are freely making a decision whether to participate in this research study. Agreeing to the interview means that you have read and understood this consent form, you have had your questions answered, and you have decided to be a part of the research study.

If you have any other questions before or during the study, you are free to talk to or contact the researcher. You will be given a copy of this document for your own records.

Researcher: Olga Riznychuk	**Respondent:**
Signature:	**Signature:**
Place and Date:	**Place and Date:**

Appendix 2: Consent form in Ukrainian

Бланк згоди

‘ВПРОВАДЖЕННЯ ПАЦІЄНТО ОРІЄНТОВАНОЇ МОДЕЛІ В РЕФОРМІ ПЕРВИННОЇ МЕДИЧНОЇ ДОПОМОГИ В УКРАЇНІ 2018-2020: ДОСЛІДЖЕННЯ СПРИЙНЯТТЯ ЗАЦІКАВЛЕНИХ СТОРІН В КИЄВІ ТА ІВАНО-ФРАНКІВСЬКУ’

Шановний (а)...,

Вас запрошують взяти участь у дослідницькому проекті ‘Впровадження пацієнто орієнтованої моделі в реформі первинної медичної допомоги в Україні 2018-2020: дослідження сприйняття зацікавлених сторін в Києві та Івано-Франківську’ який проводить студентка другого курсу магістратури Ольга Різничук з Тартуського університету Інституту політичних досліджень імені Йогана Шутта. Вас обрали для участі у цьому дослідженні, оскільки ви берете участь у впровадженні медичної реформи та володієте знаннями на тему цього дослідження, які можуть суттєво сприяти результатам дослідження. Інформація, надана у цій формі, допомагає вирішити, чи хотіли б ви взяти участь у цьому дослідженні. Якщо у вас виникли запитання, будь ласка, зв’яжіться з дослідником за адресою olgariznychuk@gmail.com або за телефоном (Viber) +380664653172.

Цілі та наслідки дослідження: Основна мета цього дослідження - дослідити, як різні зацікавлені сторони розуміють концепцію орієнтованої на пацієнта моделі на рівні первинної медико-санітарної допомоги. Дуже часто трапляється так, що реалізація реформи не є успішною, оскільки різні зацікавлені сторони по-різному розуміють концепції або процеси або ігнорують рекомендації, представлені зі реформами. Дослідження хоче дослідити, що відбувається в Україні щодо

пацієнто орієнтованої моделі (ПОМ) на первинній ланці медицини. ПОМ тісно пов’язаний із поліпшенням якості медичної допомоги, тому і є важливою для дослідження. Питання проєкту, на які намагатиметься відповісти дослідження, такі: Які цілі впровадження орієнтованої на пацієнта моделі в українській медичній реформі на первинній ланці 2018-2020 рр.?

Яке сприйняття орієнтованої на пацієнта моделі серед керівників первинної ланки, робітників та пацієнтів у випадках 1 та 2?

Які подальші дії для вдосконалення української реформи первинної медичної моделі в майбутньому?

Процедура дослідження: Якщо ви погодитесь взяти участь, вам знадобиться приблизно 60 хвилин вашого часу, щоб пройти співбесіду у дослідника з Університету Тарту. Під час співбесіди вам буде запропоновано відповісти на запитання щодо вашого сприйняття, пов'язаного із впровадженням підходу ПОМ на первинній ланці медицини та покращенням якості медичної допомоги. Інтерв’ю буде записано, щоб забезпечити точний запис дискусії дослідника. Якщо ви вважаєте за краще не записувати аудіо, повідомте про це досліднику. Аудіозапис буде знищено після того, як інтерв’ю буде записано в письмовій формі. Дослідник забезпечить захист персональних даних, безпечну обробку та зберігання зібраного емпіричного матеріалу, як зазначено нижче.

Можливі ризики та вигоди для учасників: Для учасників це дослідження передбачає мінімальний ризик. Усі заходи будуть враховані для захисту конфіденційності та анонімності учасників. Учасники можуть залишатися анонімними, і їх відповіді не будуть пов’язані з їхньою особою, якщо вони цього забажають. Учасники можуть вільно залишити співбесіду в будь-який час і можуть не відповідати на питання, яке їм здається незручним. Ви не повинні отримувати безпосередню користь від участі у цьому дослідженні, за винятком інформації, яку ви можете отримати, відповідаючи на запитання. Якщо ви зацікавлені отримати короткий висновок результатів дослідження, повідомте про це дослідникові.

Анонімність та конфіденційність персональних даних: Будуть вжиті всі заходи для захисту Вашої приватності та конфіденційності. Присвоєння номерів кожному інтерв'юйованому анонімізує дані та використовуватиметься лише для цілей магістерської роботи. Ідентифікатори учасників (ім’я, електронна адреса, номер телефону тощо) не зберігатимуться у зв’язку з даними дослідження та будуть відомі лише досліднику. Єдиною особою, яка отримає доступ до аудіофайлу та транскрипції інтерв’ю, є головний науковий керівник Університету Тарту та будь-яка інша особа чи установа, передбачені законом. Конфіденційність також суворо дотримуватиметься при презентації висновків: співбесіди залишатимуться анонімними, а їх відповіді не будуть безпосередньо прив’язані до їх ідентифікаторів, що робить їх неможливими для ідентифікації. Аудіозаписи та стенограми будуть знищені після завершення аналізу. Інформація з цього дослідження може бути опублікована та публічно представлена, але ваша особистість зберігатиметься в таємниці. Ви залишатиметеся анонімним і буде зовсім неможливо ідентифікувати вас за допомогою даних.

Права учасників дослідження: Ви можете не брати участь у цьому дослідженні або відмовитись від участі в будь-який час під час або після початку дослідження. Відмова брати участь у цьому дослідженні або рішення про припинення участі не вплине на ваші стосунки з дослідником або Університетом Тарту. Якщо у вас виникають проблеми як безпосередній результат участі у цьому дослідженні, будь ласка, зв’яжіться з дослідником, переліченим в кінці цієї форми згоди.

Інформована згода: Ви вільно приймаєте рішення про участь у цьому дослідженні. Згода на співбесіду означає, що ви прочитали та зрозуміли цю форму згоди, отримали відповіді на свої запитання та вирішили взяти участь у дослідженні. Якщо у вас є будь-які інші питання до або під час дослідження, ви можете поговорити з дослідником або зв'язатися з ним. Ви отримаєте копію цього документа для власних записів.

Дослідник: Ольга Різничук
Підпис:
Місце та дата:

Респондент:
Підпис:
Місце та дата:

Appendix 3: List of interviews

Number	Respondent	Type	Date	Duration
Interview 1	Family doctor (Kiev)	Video call	09.03.21	24 min
Interview 2	Family doctor (Ivano-Frankivsk)	Video call	02.04.21	42 min
Interview 3	Patient (Ivano-Frankivsk)	Video call	03.04.21	16 min
Interview 4	Family doctor (Ivano-Frankivsk)	Viber call	04.04.21	1 h
Interview 5	Patient (Ivano-Frankivsk)	Viber call	06.04.21	36 min
Interview 6	Patient (Ivano-Frankivsk)	Video call	06.04.21	21 min
Interview 7	Patient (Ivano-Frankivsk)	Messenger call	07.04.21	14 min
Interview 8	Family doctor (Ivano-Frankivsk	Viber call	08.04.21	38 min
Interview 9	Family doctor (Ivano-Frankivsk)	Messenger call	10.04.21	51min
Interview 10	Patient (Kiev)	Viber call	10.04.21	23 min
Interview 11	Family doctor (Kiev)	Messenger call	13.04.21	46 min
Interview 12	Family doctor (Kiev)	Messenger call	14.04.21	40 min
Interview 13	Family doctor (Ivano-Frankivsk)	Messenger call	17.04.21	24 min
Interview 14	Family doctor (Ivano-Frankivsk)	Messenger call	17.04.21	24 min
Interview 15	Family doctor (Kiev)	Viber call	18.04.21	19 min
Interview 16	Family doctor (Ivano-Frankivsk)	Viber call	19.04.21	25 min
Interview 17	Family doctor (Kiev)	Messenger call	19.04.21	23 min
Interview 18	Family doctor (Kiev)	Messenger	20.04.21	17 min
Interview 19	Patient (Kiev)	Viber call	21.04.21	17 min
Interview 20	Family doctor (Kiev)	Messenger	22.04.21	25 min

		call		
Interview 21	Family doctor/ Regional coach ICPC-2, NSHU expert (Ivano-Frankivsk)	Viber call	22.04.21	42 min
Interview 22	Patient (Kiev)	Viber call	22.04.21	13 min
Interview 23	Expert NSHU/family doctor	Messenger call	23.04.21	47 min
Interview 24	Family doctor (Kiev)	Messenger call	24.04.21	18 min
Interview 25	Patient (Kiev)	Messenger call	25.04.21	21 min
Interview 26	Board Member at Academy of Family Medicine of Ukraine	Messenger call	26.04.21	22 min
Interview 27	Consultant of communications with patient communities (Patients of Ukraine)	Messenger call	30.04.21	51 min

Appendix 4: Participants that were not reached

The person contacted	Date	Position
1. M.V.	Apr 02.	The director of the National Health Service of Ukraine the Western Branch
2. T.M.	Apr 03.	the patient in Kiev
3. D.D.	Apr 04	The family doctor in Kiev, the member of the 'Medical Leaders' organization
4. K.A.	Apr 09	The family doctor in Kiev.
5. Ch. K.	Apr 09	The family doctor in Kiev, the member of the Association of Family Medicine in Ukraine.
6. Dr.G.	Apr 09	The family doctor in Kiev.
7. I.I.	Apr 09	The family doctor in Kiev.
8. O.T.	Apr 09	The family doctor in Kiev.
9. M.T.	Apr 09	The family doctor in Kiev.
10. I.B.	Apr 09	The family doctor in Kiev.
11. A.K.	Apr 09	The family doctor in Kiev.
12. H.K.	Apr 09	The family doctor in Kiev.
13. D.B.	Apr 09	The family doctor in Kiev.
14. T.C.	Apr 09	The family doctor in Kiev.
15. O. K.	Apr 10	The family doctor in Kiev was contacted; however she is on maternity leave.
16. A.B	Apr 11	The family doctor in Kiev
17. I.D.	Apr 11	The family doctor in Kiev
18. T.K.	Apr 11	The family doctor in Kiev
19. S.T.	Apr 11	The family doctor in Kiev
20. L.M.	Apr 11	The family doctor in Kiev
21. I.L	Apr 14	The family doctor in Kiev
22. J.K.	Apr 14	The family doctor in Kiev
23. O.D.	Apr 15	The family doctor in Kiev
24. T.K	Apr 15	The family doctor in Kiev
25. D.K.	Apr 15	The family doctor in Kiev

26. V.S	Apr 15	The family doctor in Kiev
27. The messenger group "Doctors of Kiev"	Apr 15	accepted, nobody answered rom there
28. The Ministry of Health of Ukraine	Mar 23	
29. Ukrainian Association of Family Medicine	Apr 16	
30. The messenger group "Doctors of Kiev"	Apr 17	
31. A.H.	Apr18	The family doctor in Kiev
32. M.B.	Apr 03	The family doctor in Ivano-Frankivsk
33. H.I.	Apr 18	The family doctor in Kiev
34. V.R.	Apr 18	The family doctor in Kiev
35. A.S.	Apr 18	The family doctor in Kiev
36. O.Y.	Apr 18	The family doctor in Kiev
37. M.P	Apr 18	The family doctor in Kiev
38. J.Ch.	Apr 18	The family doctor in Kiev
39. L.V.	Apr 18	The family doctor in Kiev
40. M.T.	Apr 19	The family doctor in Kiev
41. O.D.	Apr 19	The family doctor in Kiev
42. V.N.	Apr 19	The family doctor in Kiev
43. R.D.	Apr 22	Expert NSHU

Appendix 5: Interview guidelines for experts/policy-makers

Research questions	**Concepts**	**Interview question**	**Idea behind the question**
1. What are the objectives of implementing patient-centered care in Ukrainian medical reform of primary health care management 2018-2020?	***PCC in the medical reform of Ukraine***	1. Could you tell me about the role of PCC in the medical reform in Ukraine? Why is PCC important for the reform in Ukraine? How will PCC change/reorganize primary health care in Ukraine? 2. What key areas should a PCC intervention focus on in Ukrainian medical reform? 3. Who will be implementing the PCC reform? What is expected from them? How will their jobs change as the result of implementing PCC? What resources would be needed? 4. How is it supposed to be evaluated?	The understanding of the PCC approach in Ukrainian medical reform context. What is expected from the PCC approach ? The idea about the PCC from the point of view of experts who were involved in the reform development.
2. What are the perceptions of patient-centered care among the primary care workers, and patients in Case 1 and Case 2?	***Integrated health system***	1. What can you say about the current facility? Is there everything that the doctor needs to examine the patient? 2. What training programs do you provide in order for better implementation of the PCC approach?	It is important to discover how healthcare experts perceive the integrated health system. What the main barriers are to the integrated health system from

		4. What can you say about the health data records? 4. What barriers do you see from preventing health system integration?	experts' point of view.
	Money follows the patient	1. How will the reform change the funding of primary health care in Ukraine? 2. What kind of incentives do the doctors have in order to keep competition?	Understanding of how the reform 'money follows the patient' works at the primary healthcare level in Ukraine.
	The principle of customer choice	1. What do you think about the idea that patients choose their doctors? 2. What are the advantages and disadvantages of introducing customer choice in primary health care in Ukraine?	Understanding the mechanism or the idea of how the patients choose the facility and the family doctor from the experts point of view.
	Understanding person as a whole	1. How should the doctor establish communication with the patient, earn trust, and understanding? 2. How important do you think it is to have knowledge of the multi-dimensional aspects of the patient and their family? What is the proper way of doing it?	The core component of the PCC approach. Does the doctor treat the disease only or a patient? What are the main barriers preventing a good doctor-patient relationship from

		3. What do you think is the most important aspect of the patient-physician relationship? Why?	experts' point of view? Understanding on what basis should the doctor prescribe treatment; how should they communicate with patients and build relationships.
	The principle of customized care	1. How does the doctor make sure that he/she gives the patients what they need?	Understanding of how the doctors should treat patients: as unique people and provide everything that is needed only for this person; or work with everyone by provided uniform/guidelines
	Patient engagement in managing their care of shared decision-making	1. What do you think about the idea that the patient is the main actor and it is up to him/her to agree or disagree about the treatment?	Understanding how empowered the patients should be and whether they should participate in the treatment process and discussions about the health issues.

3. What are the policy implications for improving Ukrainian primary care reform in the future?	**Improved quality of care**	1. What do you think about the current quality of primary health care services in the facilities in the region? 2. What are the factors that determine the quality of care offered? waiting time, opening hours, access….? 3. How is the quality of care evaluated? 4. What needs to be done for improved quality of care on the primary level?	Understanding the perceptions of patient-centered care and how different perceptions influence the quality of care in the cases provided.

Appendix 6: Interview guide for family doctors

Research questions	Concepts	Interview question	Idea behind the question
2. What are the perceptions of patient-centered care among the primary care workers, and patients in Case 1 and Case 2?	***Integrated health system***	1. What can you say about the current facility? Is there everything that is needed to examine the patient? 2. What training programs have you had in order to implement the PCC approach? 3. How do you keep records for your patients? Are you satisfied with the way it works now? 4. What barriers do you see from preventing health system integration?	Understanding the important elements of an integrated health system by caregivers. Detecting the barriers. How aware the doctors are of the PCC training programs.
	Money follows the patient	1. How do you understand 'Money follows the patient' reform? 2. Do you have any kind of incentives? How does it work?	Understanding of the system or mechanism how the doctors are motivated.

	The principle of customer choice	1. What do you think about the idea that patients choose their doctors? 2.What are their main preferences when choosing the doctors?	Opinion of the doctors regarding the patients' right to choose the family doctor. Do the doctors support the idea?
	Understanding person as a whole	1. How do you establish communication with your patient, earn trust, and understanding? 2. Do you think it's important to have knowledge of the multi-dimensional aspects of the patient and their family? How do you get this information during consultations? 3. What do you think is the most important aspect of the patient-physician relationship? Why? 4. What barriers prevent you from communicating with your patient effectively?	What is important for the doctor to know about the patient and why? What may cause difficulties in the relationship between the doctor and the patient?

	The principle of customized care	1. How do you make sure that you give the patient what he/she needs?	Does the doctor know that the patient is satisfied after the visit?
	Patient engagement in managing their care of shared decision-making	How important is it that the patient is involved in the treatment plan?	What is the doctor's attitude regarding the shared decision-making?
3. What are the policy implications for improving Ukrainian primary care reform in the future?	***Improved quality of care***	1. What do you think about the current quality of primary health care services in your facility? 2. What are the factors that determine the quality of care offered? waiting time, opening hours, access….? 3. What is important for you in providing healthcare services on the primary level? 4. What challenges have you faced in providing quality care at this facility 5. What needs to be done for improved quality of care on the primary level?	What is quality for family doctors? What factors are important for improved quality in primary care?

Appendix 7: Interview guidelines for patients

Research questions	Concepts	Interview question	Idea behind the question
1. What are the perceptions of patient-centered care among the primary care workers, and patients in Case 1 and Case 2?	***Integrated health system***	1. What can you say about the doctor's office? Is it comfortable? What would you like there to be in order you feel more comfortable? How convenient is it to appoint the consultation with the doctor? 2. What else is there that you do not like in the facility?	The general satisfaction of the patient regarding the facility or services; detecting barriers for patients.
	Money follows the patient	1. Have you ever heard the phrase "money follows the patient"? What do you think it means? 2. What services can you get in the polyclinic?	Are the patients aware about the services they can get on primary health care? Are they free for them?
	The principle of customer choice	1. What do you think about the fact that now you can choose your doctor?	What does the patient think about the idea of choosing the doctor?

		2. When you have health problems where do you go?	
	Understanding person as a whole	1. What relationship do you have with your current family doctor? 2. How do you want the doctor to communicate with you? 3. How aware is your doctor about your family conditions?	What does the patient expect from the doctor? What doctor's attitude is acceptable for the patient?
	The principle of customized care	1. How do you want the doctor to treat you? Is it important for you that your preferences are taken into account? 2. What do you think is the most important for patients?	Does the patient consider the doctor the God, or can propose his/her preferences?
	Patient engagement in managing their care of shared decision-making	1. How involved are you in your treatment process? 2.What are your thoughts on patients participating in the treatment process? Do you think it is a good idea to let	Is the patient active? Does he/she rely only on the doctor?

		patients decide their course of treatment?”	
2. ***What are the policy implications for improving Ukrainian primary care reform in the future?***	**Quality of care**	1. What is important for you in receiving healthcare services on the primary level? 2. What do you think about the current quality of primary health care services in the facility you visited. 3. What would you like to be improved in receiving healthcare on the primary level?	What is important for the patient in receiving the services in primary care? What would they like to be improved?

Appendix 8: An example of coding procedure (8 interviews)

Code	Sub-Code Label	Description	Quote example	No.of Coded Segments
Integrated Health System	Training programs	Refers to the opportunity to have coursers, lectures or seminars regarding PCC approach	*'We have a new institution called NSHU and they provide us with different kinds of seminars and training programs. They have special training programs on client-centredness, patient-centredness and how to cope with difficult patients'*	12
	Facility	Refers to the importance of the physical comfort	*'I work in one of the best clinics in the region, I am satisfied with the facility conditions'*	8
	Technology	Refers to the IT support and the convenience of use of new software	*'I am satisfied with the electronic system, however it is not ideal, I always duplicate the documents because I am scared of some problems in the system'*	7
	Barriers	Refers to the barriers that exist regarding integrated health system	*'The compliance with the department of the health in Ukraine is very difficult. The doctors have to write a lot of reports about vaccination. This all took a lot of time that we could have done for the patient instead'*	12
Money Follows the Patient	Motivation/incentives	Refers to the incentives or other motivation factors that doctors receive on the primary healthcare level	*Except for the doctors day, we do not receive any other bonuses. It absolutely doesn't matter how many patients I served 5 or like last Monday 67'*	15
The Principle of Customer Choice		Refers to advantages or disadvantages of the idea that the patient can choose the	*'I am positive about it. From the patients I also heard that they like it to have a choice as they do not need to visit the doctors that they don't want to*	10

		family doctor	*visit, especially when the doctor is impolite, careless'*	
Understanding Person as Whole	Communication	Refers to the importance of communication and the attitude during the communication	*'I am always honest with my patient and tell them what I am going to do. I try to use simple language and explain their disease, what may happen and what the treatment will be'*	12
	Most important aspect	Refers to the most important element in the doctor-patient relations	'*Trust and respect [...]'*	6
	Multidimensional aspect	Refers to the importance of the knowledge of the multidimensional aspects of the patient	*'It is important for me to know multidimensional aspects of the patients, especially when the family has a few kids and I need to know whether the diseases are the same'*	10
	Barriers in communication	Refers to the barriers that can be in the doctor-patient relations	*'It is very difficult for me when I see that the patient doesn't trust me. This is the biggest barrier for the doctor'*	14
The Principle of Customized Care		Refers to the importance of the satisfaction patient's needs	*'But for me it is important to show the patient that he is important for me and I can help him even if it is beyond my abilities, but I have to make sure that I do it. And this is what I think the patient wants'*	13
Shared Decision-Making		Refers to the empowerment of the patient and the idea of the 'active patient' who makes the decisions together with the family doctor on the primary health care	*'From one side I also understand that patients are not experts when it comes to medicine. And sometimes patients are scared when they hear the word Antibiotic or Hormone. So I need to explain that these are not always bad'*	9
Improved Quality of Care	Current quality	Refers to the satisfaction of the services on the primary health care	*'Nothing needs to be improved'*	10
	Factors	Refers to the factors that influence the improved quality of	*'The mentality is the only problem that influences the quality'*	8

		care on the primary level		
	Barriers	Refers to the elements that can be improved in the future because they affect the quality of care	*'The only barrier that I see in treatment of my patient and which is the bad quality when I give referral to the second level and they refuse to work'*	9

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