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How can the Swiss contribution improve Hungarian primary care?

Recent structure and problems of Hungarian primary care

There are 6,704 primary care physicians (GPs) in Hungary, covering the primary healthcare needs of a decreasing population of nearly 10 million. 1,560 are pediatricians, working mainly in urban areas, 1,519 GPs provide care for a mixed population and the others treat adults only. Recently, there were 227 empty practices, without practitioners.

Previously, patients were allocated strictly to local providers according to place of residence, and were allowed to visit only their official GP (panel doctor, district's physician), secondary care specialists and hospitals. Health care workers were employed by the state, municipalities or local hospitals. According to regulations issued in 1992, patients may choose their own doctors. GPs became free to form their own businesses, are financed per capita, directly from the National Health Insurance Fund (NHIF). Nowadays, this sum is about 3,000 EUR a month, covering the salaries of the doctor, practice nurse and other practice expenses.

General practitioners have two contracts; one with the local municipality for care, and the other with the NHIF for finance.

Some secondary care specialists can be reached directly by patients, others only by referral (neurology, rheumatology, radiology, laboratory and inpatient care), except in emergency cases. Secondary specialists are mostly civil servants, with fixed salaries, employed by the health services of the local municipalities or hospitals, financed by the NHIF, as fee for services.

All of the governments since 1990, have issued new regulations, implemented new initiatives and all of them planned health care reforms. There were changes in the ownership of providers; in the nineties, hospitals were shifted from state to the local/county municipalities and last year they were taken over again by the government.

The greatest challenges facing the Hungarian health care system:

- The financial crisis in the last years has deteriorated the stability of the whole Hungarian economy including the health care system.
- Besides low official salaries, the existing tipping system has a confusing influence on the rational and economic use of financial and human resources.
- The increased administrative workloads shorten the time available for consultations and curative procedures even more for prevention.
- There is a lack of young doctors, many young and middle-aged doctors want to move abroad, in the hope of finding better working conditions and salary.

Major anomalies of the Hungarian primary care system:

- There are no group practices; financial regulations do not support it. Cooperation in the form of a locum exists only between practices in the same office or area.
- There are no existing prevention programmes for expected lifestyle modification of patients; doctors are not motivated in prevention even in screening procedures.

- There is an ageing population of doctors (average age of GPs is 58 years) [1].
- Guidelines for PHC preventive services are generally lacking [2].
- Data collection at the primary level is often patchy, appropriate software is not available which would help to analyse data, necessary to manage health care efficiently.

Swiss contribution for the enlarged European Union

As a gesture of solidarity, Switzerland decided to help the EU enlargement to ensure equality and stability in Europe. The recipient countries include the ten new member states that joined the EU in 2004, also known as "EU-10": Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, and Slovenia. In September 2010, bilateral frameworks were also signed with Romania and Bulgaria, which joined the EU in 2007. Switzerland has pledged a total of 1,000 million CHF for them and an additional 257 million CHF for Bulgaria and Romania to help mitigate the economic and social disparities in the enlarged EU [3].

The Swiss contribution to Hungary

The Framework Agreement was signed between Switzerland and Hungary on 20 December 2007 in Bern. The tendering process started in 2008 and the selection period ended in spring 2012. Hungary was responsible for the selection of projects and the final decision was made by Switzerland. The pledged amount for Hungary is 131 million CHF. Due to the contribution, 39 projects and, through the block grants, more than a hundred small projects will be implemented by 2017, designed to reduce economic and social disparities in Hungary. For the "Public Health Focused Model Programme for Organising Primary Care Services" 13 million CHF were planned and 2.3 million CHF will be added as the Hungarian contribution [4].

Areas of support and activities

- Security, stability and support for reforms (education, social services and in the tourism sector)
- Environment and infrastructure (water supply, flood protection)
- Promotion of the private sector (employment creation)
- Human and social development (improved disease prevention, scholarships, promote joint research projects and exchange programmes [5].

Focus areas

While primary health care services have a traditionally strong curative focus, they pay little attention to prevention or health promotion aspects. In addition to the thematic focus, part of the enlargement contribution is also considered to be geographically concentrated. The regions "Northern Hungary" and "Northern Great Plain (Alföld)" are vested with priority. With a per capita gross domestic product of approximately 35% of the EU-25 average, these regions show the lowest development indicators in Hungary [3].

Partnership in planning, in cooperation and in the execution

A consortium was established from governmental branches and medical universities, support is expected from NGOs and local municipalities and organisations based on ethnicity.

The "Cluster model"

Establishing general practitioner teams in North-East Hungary as a pilot

The target areas are located in the most disadvantaged regions, with many marginalised groups where four GPs' clusters were established that cover about 45,000 persons, 30% belong to Roma ethnicity, the most vulnerable minority population. The human resources of one cluster comprise six GPs and their practice nurses, in close vicinity to each other (in an area with a diameter of around 50 km as a maximum) [6].

In addition to the traditional curative services, these clusters can provide health-promotion and disease-preventive services by sharing the time and cost of employing new staff working in these areas [7].

One GP is designated to lead and to coordinate of the cluster (Head GP). All the other GPs report to the Head GP. The public health coordinator coordinates the work of the other health professionals and supervises the work of the health mediators and assistant health mediators, many of them were recruited from the lay local Roma population. The district health visitor collaborates with both the Public Health Coordinator and the Head GP, and the practice nurse, who reports exclusively to the GP employing her. The new services provided by the GPs' cluster are organised into the following units within the cluster as presented in figure 1 [8].

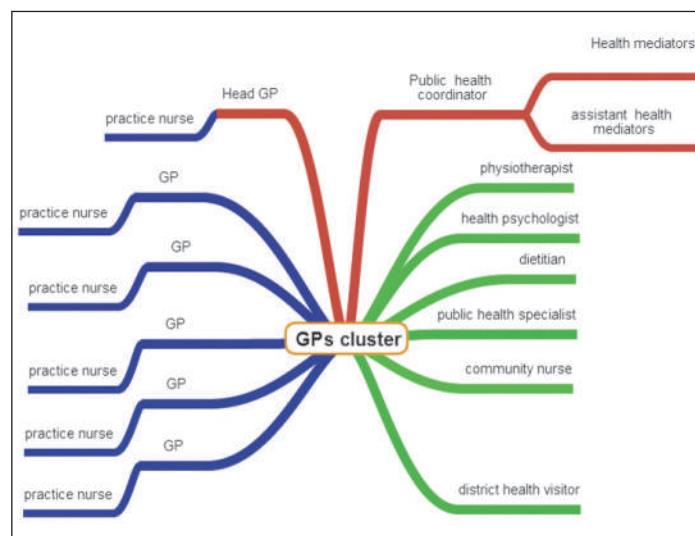


Figure 1
Professional structure of a "Cluster".

Education of the new staff members

University graduated staff members were recruited and employed, one for each cluster; public health professionals, community nurses, physiotherapists, dieticians, health psychologists. All the team members received further training in primary care and family medicine education, provided by the medical faculties of the universities.

Health mediators recruited from the local community were enrolled in vocational training to become nurse assistants or social care assistants subsequent to whom they were employed as full-time workers. They help health visitors in their field work, recruit

adults for health assessment and act as peer educators in their communities. Assistant health mediators received an ad hoc training to prepare them for assisting the planning and implementation of health promoting programmes, facilitating the participation of the Roma people in the preventive programmes and improving patient-adherence and persistence. Support workers were trained on the operation of the cluster by the public health coordinators [9].

Services of the "Cluster"

1. Health status assessments are performed by the public health specialist and the community nurse on adults over 18 years of age helped by the health visitor in the children's population.
2. Medical risk assessments appraised during a prior health status assessment. These procedures are performed by the GPs, providing medical advice/services to persons in the practice.
3. Lifestyle counseling and health education are aimed at increasing health literacy, to enhance the appropriate use of and adherence to medical and health advice, which are all necessary for improving health outcomes.
4. Chronic medical care with a focus on rehabilitation will be provided by the GPs and by the new staff members. The new feature of chronic care is its reorientation towards rehabilitation, i.e., helping people with disabilities to achieve optimal social integration.
- 5 Health promotion activities in community settings are initiated supported by the municipal/local governments, to improve the determinants of health and equity at local settings in the community. Schools and workplaces are the most frequent locations.

Public health expectations

A new system of primary care data reporting and processing will be developed, facilitating researches within the cluster. Based on pilot results, a health policy and health financing impact study is prepared as a basis for a country-wide introduction of the model in the future.

The expected net effect of GPs' cluster is a favourable cost-benefit ratio for the improvement of population's health status. In the era of economic crisis when the budget extension is not a realistic alternative to improve health status, this kind of opportunity is especially valuable [2].

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