Case Study 1. Hungary

Community care: an opportunity towards universal health coverage: Case study of Hungary form the field of primary care

1. Health system overview

Hungary is a CCE country with around 9.7 million of habitants. The average life expectancy at birth is one of the lowest in EU, and it is far beyond the economic position of the country. 72 ys old among men and 78 ys among women. The proportion of children below 20 is19,3%, the people over 65 is around 24%, as a result we can say about the ageing of the Hungarian population. The population is characterized modest birth rate $9{,}3_{0/00}$ high mortality rate, around $13{,}3_{0/00}$. The average years in health is around 55 years.

Hungary turn to the way of democracy after the transitional years 1989 and 1990. There is a strong central government power, the leading party has 2/3 in the Parliament since 2010. In Hungary there is centralized Compulsory Health Insurance system, a single purchaser of the health insurance services. The National Health Insurance Fund was found in 1992, it comprises the so-called basic package wide range of cash benefits (sick pay, maternity pay, invalidity pensions) and in-kind benefits (primary, secondary and tertiary care, as kidney dialysis, ambulance service, home skilled health, lab and imaging diagnostics).

In current years the main sources of the NHIF come from employee social security contribution (7% based on gross monthly salary, social contribution tax paid by the employers 4% based on gross monthly salary, tax reallocation by the Central State, special public health tax, claw-back of the pharmaceutical companies.)

The number of physicians per habitants is around the OECD average (330-350 per 100 thousands, however the number of nurses falls far short of the OECD average and hardly reach the 650 per th habitants, far from the ideal rate around 850-900. About the healthcare capacity we can tell that thanks to the successive reform steps the formerly high hospital capacities in international comparison it could reduce and was concentrated into fewer number of settles and institutions. We could see huge integrations, fusions form the mid 2000 years partly with the financial aid of the EU structural funds (the number of short-term care hospitals has fallen from around 150 to the current 100). In these years the average hospital capacity is around 430 short-term care beds / 10000 habitants and further 275 nursing homes-rehabilitation-hospice beds / 10000 habitants that is around the EU average. Also as a result of the strict performance volume limit (PVL) as a yearly financial cap of the hospitals reimbursement, the admission rate of

traditional hospitalization also has been decreased significantly during the last decade meanwhile the number and proportion of daily care, one-day surgery, curative treatment (like chemotherapy) have been increased a lot. Moreover, thanks to the HUN DRG reimbursement scheme the ALOS also has reduced to 5.3 days from the 9.2 in the mid 90's as an evidence for the improvement of technical efficiency.

It must be highlighted the biggest improvement in the field of ITC system that was embedded in the establishment of the so-called EESZT, national Electronic health service system to which all the healthcare service providers must be connecting including the pharmacies and all the GPs offices.

2. System enablers of community care

The Community care its own does not regulated in Hungary. There is separated regulation of primary healthcare and in another act sort of primary social care.

The complex primary health care is regulated in the Health Act 2015 CXXIII on Primary care. The most important services is listed in this Act are General Practitioner service, Primary Paediatric Care, School health service, Basic Dental Care, District Nurse services as a part of the basic package. Moreover Primary Occupation Health but it financed from private (company) sources.

Meanwhile the basic social services is regulated in the Social Care act III. in 1993. Among the community based services the Act define the home care, meals on wheels services, home electronic alarm system as primary social care, and the residential care for elderly and handicapped people as residential care. These services are mainly financed from Central State Budget with a certain rate of co-payment (15-20%).

In spite of both the primary health and primary social care it delegated to the level of local (municipality) governments, there is any pressure or advantage for the integration of these services. As a consequence the different services are organized different ways in different service providers. There are local governments (mainly the smaller villages) that directly employ 1-2 district nurses or a few home care workers. However, in bigger cities, there are special complex service provider but not integrated between social and healthcare but separated providers for primary social and another organization for primary healthcare.

The vast majority of GPs are self-employed or work in their own limited trust company in a contractual relationship with the Local government and also with the NHIF. The current home health service provider are private companies have direct contract with the NHIF, this contract includes the list of covered settlements. The home care or home skilled nursing is regulated in the 20/1996. (VII. 26.) NM order that include the basic skilled nursing activities, artificial nutrition, simple infusion therapy, change of ureter catheter, decubitus care,

wound care, home physiotherapy, home hospice. These activities is reimbursed by the NHIF by average visit fee tariff.

The social care is funded from general taxation, there is no dedicated source in the yearly state budget.

3. Service delivery: Toward into the group practices and praxis communities

In this part we are going to focus on the possible growth of group practice and praxis communities models. The need for improvement of primary care is clear: the number of unfilled GP posts has been increasing for years, and the gate-keeping function of primary care is weak. In Hungary the average number of registered habitants at one GP praxis is around 1500-1600 persons. There have been recent pilots for reorganisation, partly financed from the Swiss contribution (4 group communities each included 6 GP praxis) and then from the EU Human Resources Development Operational Programme (EFOP) (55 groups) and the EU Competitive Central Hungary Operational Programme (VEKOP) (6 groups).

Definitions: According to the Primary Care Act 2015. CXXIII. 2. § (1):

The praxis community (of GPs): a form of operation established for the performance of the tasks of general practitioners, home paediatricians, dentists providing primary care, and nursing services; The average size of these communities changed between 7500-13500 habitants.

The group practice (of GPs inviting specialist): a form of co-operation in the framework of which, in addition to the general care tasks of general practitioners and paediatricians, certain benefits belonging to the scope of outpatient specialist care is provided as defined by law.

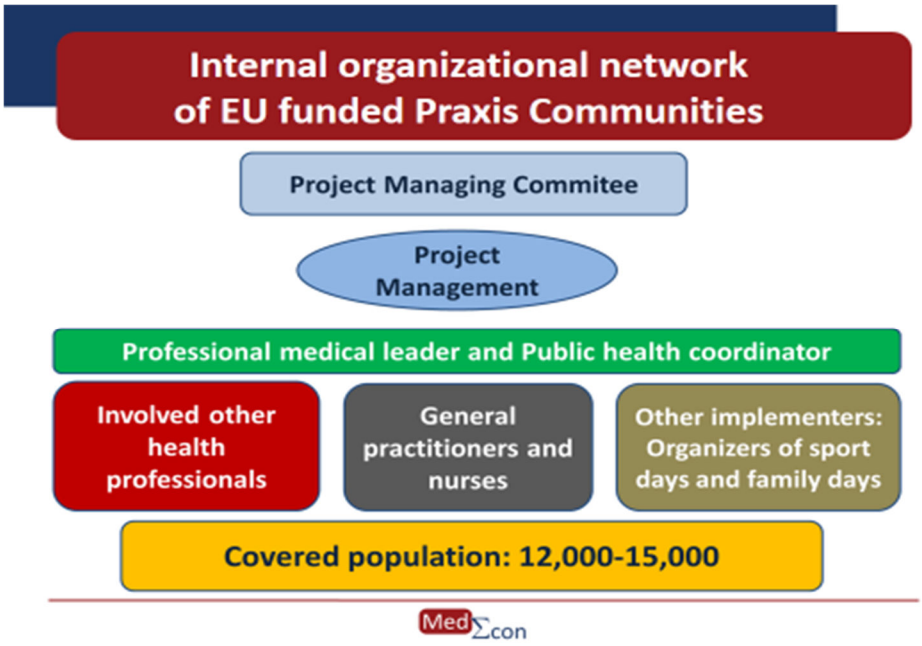
Apart of the short description in the Primary Care Act, there is no detailed description about the group practices at all, nor about the specific paediatrician group practices. Meanwhile about the praxis communities (hereinafter: PCs) a special white book or so-called HandBook developed by the Public Health Faculty of Debrecen University still was published at the beginning of the Swiss Contributed pilot model at 2012. In this framework the 4 praxis communities, all together 24 GP praxis could operate during 5 years.

Later in the Application Guideline and its Appendixes included detailed description about the sense, the expected composition (e.g. minimum number of GPs, minimally provided additional services), the main tasks (type and list of additional services, preventive activities, health status assessment, life style consultations) and main indicators of the program (number of PCs meetings, % of scanned people from the covered population. Moreover during the last 7 years real operation in different frameworks the praxis community model has gained crucial experience. In general, the practical definition of praxis communities can be stated that the traditional - in a practice one GP and 1-2 nurses - type operating

model, expanded with public health professionals, implements a public health-focused, preventive approach.

In contrast, the so-called group practice would be a higher level organizational form of medical collaboration that would provide high-level primary care incorporating secondary care elements by integrating multiple disciplines to the population in a micro-region. The specialist (physician) who integrated into a group practice (eg. paediatrician, obstetrician-gynaecologist) does not provide the full spectrum of his profession that can be provided in outpatient care (in a formal secondary care polyclinic), he only performs routine care, and screenings (without having the special immobile medical equipment). In Hungary, currently group practice also has no legal basis yet, so it cannot be established in public funding. About the group practice there were not any consensus debate or published paper yet. In principle 4-6 medical specialists should be involved to create an effective group and to be able to provide appropriate volume and level of care. The involvement of at least equal number of nurses or assistants will be also needed.

Figure 1. Organizational network of EU funded Praxis Communities



Composition of PCs: As we can see the current collaboration of GPs in praxis communities (PCs) and future opportunities for working together, the ideal composition would be between 5-10 GPs including child and adult territories (areas). Apart from this basic group of GPs the involvement of GPs' nurses have to be a compulsory element of these programs (in reality, in the routine operation of PCs the GPs' nurses fulfil the vast majority of tasks). (See Table 1. below)

Respecting both the group practices and the praxis communities the administrative (organizational, financial, legal, IT etc.) support is also inevitable.

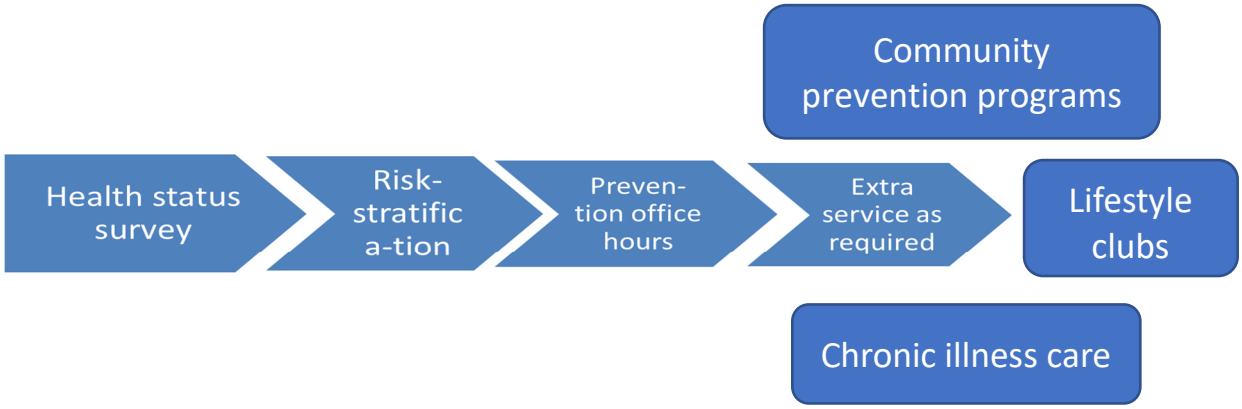
Table 1. Ideal professional and management team of Praxis Communities

1. Core staff of the Praxis Communities	
Professional leader as a GP **General practitioners** **General practitioner - pediatricians**	Public health coordinator (BSc or MSc degree) could work for more PCs
	Practice nurses (at least one person for each GP) Physiotherapists (FTE) Dietician (part time) District nurses (védőnő) (part time) Health or social voluntieers (part time)
2. Optionally involved professionals into Praxis Communities	
Dentist (part time) **School Doctor (part time)** **Phamasist (part time)**	Psychologists Mental health professionals Nursing assistants Social workers
3. Project Management (could serve for more PCs!)	
Project Manager **Project Economic or Financial manager**	Project assistant Contracted accountant (person or small company) Contracted lawyer

In the 2nd waive of this programme another 46 groups could begin their work, meanwhile the first 4 group could continue their activities. The patient pathway through this preventive focused programme is the following (Figure 2.)

The starting point of the population based health development programme is the conduction of Health status survey. It is a questionnaire composed of several main blocks: questions about the current health status, about the personal and family anamnesis, health risk behaviour (smoking, alcohol or drug addiction, weekly exercise, etc.) This fulfilled questionnaires provide useful information for the GPs to plan further recommendations for the clients, direction them into additional primary care, lifestyle clubs, community prevention programs or directly to secondary care depending on the initial health status. (The detailed Job description of Public Health Coordinators is seen in Appendix 1.)

Figure 2. The preventive focused pathway of patient in the Praxis Communities programme



There is a further question about the improvement of gate-keeper function fulfilled by practice communities. As far as I know, there are no scientifically approved evidences about the improvement of the gate-keeper function from the EU funded projects, just early analysis form the Swiss contribution program. About gate-keeper functions we can highlight that the vast majority of PCs services means additional preventive activities and additional not medical – physician treatments. In short term these services, activities contribute to keep the people healthy, reduce the risk factors of future diseases, and in some of the cases to control the chronic diseases of ill people. As a whole these kind of preventive focused services in medium term and long term can contribute to the lower rate of referrals or directly turn to upper level of health care system, as secondary care consultation, or emergency wards.

To summarize the main lessons learnt from the 4 year Swiss Contributed pilot program the organizers of the program organized a conference in February of 2017, later the presenters published a special edition to the main lessons, experiences, practical views, insight of this program. There is a special publication of Népegészségügy journal dedicated to this topic to make conclusions about the Swiss Contributed pilot program done between 2012-2017. List of articles, studies: The conceptual framework of the primary health care development Programme; The daily life of the GP cluster, Experiences on health status assessment integrated into primary care; Operational experience of GP cluster from the viewpoint of the public health coordinator, physiotherapist, dietician, health psychologist, health visitors. Additionally, accessing vulnerable population groups. Finally the results of the PC development programme based on survey.

Main experiences of the first year operation of Praxis Communities:

- Generally was said the local population was quite open for getting additional services, to participate in this occasions.
- However, the utilization rate and the popularity highly fluctuated during the 4 year period.
- The non-medical services generally can offer extra services to the local population through which it can reduce the basic crowded GP's and specialists ' ordering times.
- The most successful program was the individual or group physiotherapy services for different age groups for healthy people or for ill people suffering from pain, orthopedic disorders, etc. (as later in the EU funded program too).
- The recruitment and hiring of the mental health specialist and health psychologists (and later to keep them in the program for years) in rural area has proved the most difficult task of the program managers. As a consequence this element was dropped from the obligatory parts and services of the EU funded program from 2018 in contrast to the high demand from the part of the local population.
- Another serious problem came from the lack of appropriate IT support, to make a special software that would have been served the complex work of praxis communities and the organization of their wide range of services.

Finally, it should be emphasized that the Swiss Contributed program was scientifically measured, monitored and finally analysed by a research team. From the beginning of the program with the significant help of the OEP (Health Insurance Fund Administration) carefully selecting about 100 control GP praxis to be able to control the effects on the behaviour and utilization of the target population. As a results they published reduced number of referrals in the study group compared to these control practices.

Table 2. Lessons learnt from pilot programmes on Praxis Communities

Positive attitudes	Negative attitudes
The bulk of the GPs would like to provide modern and high quality care	Burden of administration of project and applications, payment by performance
The local communities are open for receiving the new services	Financial risk, liquidity difficulties, failures of public procurement
The additional services are popular	These primary care projects are not planned stabile professional and economic host company
Improved equity, better access to care	In many times the rigid project framework hinder the flexible and practical solutions
Change of attitude both of the healthcare staff and the local population	Unmet expectations arise in the health professionals and local population
Strengthening the preventive approach	Adverse blurring of primary health care and community public health services
The vast majority of the former PCs members GPs would like to continue (67%-78%)	regulatory and financial uncertainty of sustainability task and period
Possibility of purchase new medical equipment	Usual changes in the health policy directions, and leadership.
Availability of new ICT solutions and platforms mainly for supporting patient pathways	Problems caused by local self-government and parliamentarian elections

The benefits of teamwork in the field of primary care	Distorted information and stereotype about the real sense and operation of praxis communities

About the final conclusion and Summary of the EU funded project (51 projects in EFOP and VEKOP between February of 2018 and December of 2020) any final documents had not been published yet. There are interim project papers, presentations. Main Experience of the Praxis Communities based on a nationwide survey conducted by the National Methodology Project 1.8.0/B component.

Richer municipality versus poorer rural areas: differences in the demand of and programs for the local population

In rural areas, the HR problem is bigger, also the involvement of professionals providing additional services in the work of the community of practice. There are more opportunities in settlements close to cities where there are universities with medical faculties, meanwhile, in disadvantaged small settlements it is more difficult to fill vacancies and thus provide additional services, even though they would be most in need here.

- It is also very important to reach out and address the population from GPs, as local people know their GP first and foremost, so they can help build trust when forming a community of practice. Building the trust of the population is a lengthy process, but it is easier in the countryside, as many people there know each other.

- In big cities, it is harder to reach and attract people. They can introduce professionals, screenings and community of practice services through larger lectures and presentations. But this method is also effective in smaller settlements.

- In small settlements, residents talk better, trust in services and new professionals is easier, they are more open for these new programmes and for each other.

- In small settlements, they go to the services provided by a psychologist and mental health professional as part of an individual session, because they are afraid of who is saying what. In large cities, small group sessions are also successful.

- Even the group services provided by Physiotherapists are visited by many habitants in both the countryside and big cities.

- The individual occupation of a dietician was attended by several people in big cities, in rural areas group occupations were preferred.

- There was no difference in participation in village days and stage events on health days depending on the territorial location of the community of practice.

4. Challenges and needed reforms

- *Community care services during the SARS CoV2 epidemic*

For both sectors the real long-term challenge would be the establishment of integrated service provision, or at least the creation of strong coordination between the different actors.

Another challenge comes from the wide range of ICT services, to integrate new services and to reorganize current ones to these platforms. For example the shift from personal visit to online visit led by the carers. To build smart home and smart personalized services for the elderly people. Accordingly the Praxis communities program should be expanded into this direction.

The intensive fight against the COVID-19 pandemic resulted a catalyst effects on the fast development and organization of ICT services, telecare, telemedicina, remote control of the chronically ill patients. In this respect these platforms do not make any difference between the social and healthcare, supposedly it might contribute to the higher coordination and integration of these services put the clients at the centre and organize around them these wide range of services.

5. Recommendations

In the continuation of Group Praxis and Praxis Communities programme some former program elements must be kept and it is recommended to add some new elements and new requirements to this program. (Also see Figure 2.)

According to the professional (medical) content of the future program: new element would be the initiation and organization of chronic disease management. In the frame of the EFOP 1.8.0/B methodology development a specific recommendation and guideline has been developed for this program element.

The integration or at least strong coordination with primary social care also should be a significant improvement of the community based services reflecting mainly to the complexity of needs of the elderly and disabled people. In the frame of the methodology development EFOP 1.8.0. B component a complex proposal and guideline was elaborated and prepared for the continuation and expansion of PCs program.

It is highly recommended to hire new nursing staff for providing preventive services in the GP praxis. The creation of new work places not only for 1.5 or 2 years would be very important but for 4-5 years.

It remains an important program element to purchase new medical devices up to 10% of the project budget. Small flexible digitalized devices both for diagnostics and for treatments, telecommunication, telemedicine devices, POCT equipment could serve the most effective GP’s work contributing to the increased competency level and improved gate-keeper role in general and as a

part of PCs program. In the call it is highly recommended to set up priorities and to give basic specification for these devices.

A further crucial question is the financing of constructions, building expansion by new (examination or consultation) rooms. One of the most important experience of these EU funded project that the size and other characteristics of existing buildings, GP offices (physically) became an important obstacle to effective operation of PCs. Just already intermediate term it is very important the PCs have its own administrative room and another room (or the same room in shared time can serve also) for individual examinations and consultations.

Continuation of Central (national) methodological support: a few percent (4-5%) from the total EU fund dedicated to the development of GP cluster program should be allocated to the nationally organized methodological development, monitoring, trainings and special further education of the PCs' staff, IT support for the operating PCs.

Figure 2. Necessary further steps to disseminate the Praxis Communities programme in Hungary

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(Semmelweis Egyetem Egészségügyi Közszolgálati Kar Egészségügyi Menedzserképző Központ, IME szerkesztőség) **Interdiszciplináris Magyar Egészségügy (IME) Évfolyam:** *XVI. évfolyam,* **Lapszám:** *2017. / 6,* **pages** *17-23.*

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(12) 2015. évi CXXIII. Act on the Primary Care

(13) 1848/2020. Governmental Declaration on the development of Praxis Communities

Appendix 1.

Munkaköri leírás / *Job description*

Munkakör megnevezése: ***Népegészségügyi koordinátor***
Job position: Public Health Coordinator
Munkaideje: heti 20 óra/ ***Weekly woring hours: 20 h***
Munkavégzés helye / *Place of the Work*: municipality, other villages: ……

Munkakört betöltő neve / *Employee's name*	**A munkakör betöltésének kezdete /*Start***
…. the name ……..	**day/month/year**

Munkakör betöltéséhez szükséges képesítési előírás:	**Munkakört betöltő állami iskolai végzettsége:**
/ Minimum educational requirement:	***/ The highest degree of the employee:*** Okleveles népegészségügyi szakember, MSc Public Health Specialist, MSc, University of Debrecen
Felsőfokú egészségügyi diploma.	
High School or University diploma	**Szakképesítése / *Profession***
	Népegészségügyi szakember Public health expert
idegen nyelv ismeret:	***Foreign languages***
nyelv: szintje: -	*Level of knowledge A/B/C*
egyéb követelmények / *Other requirements*	**egyéb ismeretei / Other knowledge**

Függelmi kapcsolat / *Dependences – hierarchy in the workplace*	
Munkáltatói jogkörgyakorló: / *Her Employer:*	**Közvetlen felettes: / *Her (direct) boss:***
….. *name of the imployer ……*	*the name of the boss* *Professional (medical) leader of the project*

Detailed list of tasks of the Public Health Coordinator

During the performance of the work of the Commissioner of the Praxis Community, her tasks are managed by the professional leader, she performs the tasks of the public health coordinator of the Praxis Communities as follows.

1. Tasks to be performed in her managerial capacity:

 Organizes and coordinates the work of the professionals (like: dietician, physiotherapist, mental health specialist, praxis nurses, district nurses, health mentors) under its management within the project.

 Prepares a work plan related to the tasks of the professionals of the Praxis Community based on the instructions of the professional leader.

 Makes a proposal for the effective implementation of prevention services.

 Manages the organization of health status surveys (questionnairs), prepares a plan for calling (for inviting) for a health status survey from the local population.

 Organizes and manages the implementation of additional services, oversees the efficient execution of services, regular data recording, and communication related to risk assessment.

 Checks the preparation, professional and content adequacy of the reports of the employees of the Praxis Communities.

 Organizes and conducts Praxis Community meetings in collaboration with the professional leader.

 Monitoring, reporting obligations:

- *Fulfils its own reporting obligation on time, with appropriate content, to a high standard.*
- *It reports on the results and developments related to the implementation of additional services in the Praxis Community in its monthly report.*
- *Performs the tasks specified in the Data Processing Mandate Agreement.*

2. In the framework of her cooperative tasks:

 Participates in defining local guidelines for the implementation of additional services of Praxis Community.

 Regularly discuss with the professional leader about planned and ongoing activities in the Praxis Community.

 In co-operation with the professional leader, she liaises with local partner organizations (local governments, minority municipalities, health care institutions, non-governmental organizations, local businesses) in order to gain the widest possible access to additional Praxis Community services.

 If necessary, initiates the conclusion of a cooperation agreement with the project manager or the applicant.

All tasks undertaken in this assignment contract shall be performed by the Agent in the form of personal work.