Hungarian health care in transition; studies on the improvement of the effectiveness of health care in Hungary by implementing quality assurance
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GENERAL INTRODUCTION

Abstract

The first part of this chapter describes the author’s background and experiences and some characteristic features of Hungary in the period between 1980 and 1997, in order to show that the demand for quality assurance emerged slowly and implicitly rather than rapidly and explicitly.

Furthermore, the ways in which quality assurance studies started in Hungary and the process of the institutionalisation of quality assurance are described briefly.

The second part describes the study objectives and research questions of this thesis and addresses the hypotheses, methodology and rationale of the study.
About the author; background and experience

The author of this study graduated at the Debrecen Medical University in Hungary in 1981, and worked as a researcher and lecturer at the Department of Social Medicine of the same university. He obtained his qualification in social medicine in 1986. Parallel to this he was a lecturer at the Department of Biophysics for a few years. Besides teaching undergraduates, his main responsibility was to analyse the Hungarian health care system and the health of the population with particular emphasis on chronic non-communicable diseases associated with the leading causes of death.

At that time these responsibilities resulted in a conflicting situation. The development of the Hungarian health care system in terms of number of hospital beds and of physicians was really spectacular. Hungary had reached a higher level of health care capacity than most Western countries. In contrast, the population's health status had decreased rapidly and steadily, with morbidity and mortality rates growing continuously since 1970. Showing a decreasing trend since 1970, life expectancy of the population reached the 1950s level of the western average.

From the early to mid 80s, Hungary was in the second decade of her experience with market socialism, which began to evolve in the 1960s. The basic aim was to improve the economy's efficiency through confronting state enterprises with simulated market conditions. But, as Kornai, a leading scholar on the socialist economies of Central and Eastern Europe concluded: “The basic idea of market socialism simply fizzled out. Yugoslavia, Hungary, China, the Soviet Union and Poland bear witness to its fiasco”. (Kornai 1990) Similar critical analyses were published concerning health care, education, art, and almost all parts of life, stirring heated discussions in the early 80s. The communist party itself initiated a nationwide dialogue about the ways socialism could be reformed in order to create what they termed a new, human-faced socialism.

In this situation it was quite understandable that the author’s students in social medicine started to ask obvious questions. ‘Why is the gap in the population’s health status increasing between the Western countries and Hungary? Why had life expectancy started to shorten after 1970? How is it possible that GPs offices, clinics and hospitals are more and more crowded (with patients laying on the floor in the hospitals), and that more and more under the counter payment (i.e. gratitude money, tip) has to be paid in order to have access to various types of examinations and treatments or even to be admitted to hospitals, while at the same time the health care system’s capacity is attractively growing? Why is health care becoming less and less human and increasingly reluctant to meet the needs of the public?’

At that time the writer of this thesis had no answers to these questions. In his quest for answers, the author first went to the library, where he found various books, which were used as background readings for public health professionals in Hungary. But reading these books was almost pointless. After pointing out that “socialism equals health”, the authors stated that Hungary’s main problems related to the health of the population would be solved by the pure existence of the socialism, and the likes. (Fülöp, 1973) Furthermore, the authors gave a rather negative view on prevention, and highlighted the primary importance of expanding curative care in hospitals. The author of this study felt that this was
not the answer that his students wanted to hear from him. To keep his credibility he decided not to present his library findings to them. Their open questions made him feel uncomfortable with his knowledge and urged him to begin studies in mathematical economics and sociology at the University of Economics, Budapest and mathematical programming at Kossuth University of Arts and Sciences, Debrecen. In those days during the last stage of planned economy, management, econometrics, epidemiology and sociology were labelled as capitalist manipulation and propaganda against real democracies. Real democracies were by definition: East Germany (DDR), the Soviet Union (SSR), Czechoslovakia, Romania, Bulgaria, Hungary, etc. Very often students would have classes in sociology and econometrics in the professor’s home.

After the author graduated in these subjects at these universities, he started to analyse health care planning in Hungary. He arrived at a very surprising conclusion: between 1950 and 1986 nothing went according to the national five-year plans in the field of hospital, manpower, outpatient and primary care development. There were no relationships, evaluated by econometric methodology, between the central plan and what had really happened. (Gulácsi, Huszay, Dömösi et al. 1985/1-2) There were, however, many other plans produced by the Central Planning Office during the 1960s, to forecast e.g. the required amounts of eggs, tomatoes and other products, that would be needed to cater for patients in the Hungarian hospitals until the year 2000. (He has yet to analyse these forecasts.) He conducted comparative studies on standardised death rates, on equity, and hospital process measurement and patient flows. He put the official book of public health to the shelf and in his classes he discussed the results of his own studies with the students. In 1986 the communist party commission at the Medical University found his work to be meaningless, and declared that his teaching activity influenced undergraduate students in a rather negative way. The university’s secretary of the communist party decided that he had to leave the university.

The day following that verdict he became a general practitioner in a village, where he stayed for some years. Subsequently, he worked at a hospital’s medical respectively intensive care departments until the political changes of 1989. He saw several diagnostic, transportation and medication errors in primary care and in the hospitals which caused serious harm to patients and, either directly or indirectly, resulted in death. He had a patient who died because there was no night staff available to transfer the patient from the ward to the intensive care unit; another patient died next to him because the elevator stopped between two floors due to a power-cut; still another patient died because he was not able to open the door of the corridor, as it was obligatory to keep doors locked during nights. His peers, just like himself, started to work at intensive care departments with no previous experience, training or explanation, and no senior medical staff was available to help. Physicians were using equipment (ECG, ergometer, sphygmomanometer etc.), that had never been calibrated, and drugs with known and published lack of effectiveness and even efficacy (e.g. Strophanthin). Illustrative to the situation was that the hospital he worked at had the best video recorder available that was marketed internationally but had no functioning wheelchair to transport patients to the ICU. Later, these experiences helped him implement quality assurance programmes.
Quality assurance and health care reform in Hungary; how it started?

The political changes came just in time for him in 1989. Within a few weeks he was awarded a fellowship from the Dutch Government to study health care management in the Netherlands. One day in 1990, he heard a presentation on quality assurance by CBO (*) staff and he recognised that this was what he would like to do in Hungary. He asked for an appointment from the lecturer and some days later he entered CBO and met with Dr. Niek Klazinga; and later he got acquainted with the rest of the staff. In the meantime health care reforms started in almost all parts of the health care sector in Hungary.

After he had completed his studies in the Netherlands he set to work in Hungary to implement quality assurance programmes. He was invited to be the country co-ordinator and work together with the COMAC/HSR countries (Concerted Action Programme on Quality Assurance in Hospitals, European Community), by the CBO project leader (Dr. Niek Klazinga). (Rémond, 1995; Baert, 1995) At the same time he was appointed to be the Hungarian co-ordinator on quality assurance by the WHO Regional Office for Europe and Hungarian WHO Liaison Office. The elements of the European Union's COMAC/HSR project were the first quality assurance programme to be implemented in Hungary, with the financial help of the Dutch Ministry of Health, Welfare and Sport.

With the involvement of an increasing number of hospitals into the COMAC/HSR project, the need to create a legal body of quality assurance emerged. With the help of the CBO, WHO Regional Office for Europe, Hungarian WHO Liaison Office, the Hungarian Hospital Association, Hungarian Nursing Association, National Public Health Institutes and the Social and Health Insurance Funds, the Hungarian Society for Quality Assurance in Health Care (HSQA) was created. The author became the general secretary of the society. According to its constitution HSQA is responsible for implementing quality assurance programmes, and education and training. In order to attain its main goal, i.e. to assist and facilitate quality improvement, the Society applied for active membership in the International Society for Quality in Health Care (ISQua), and participated in various European projects. The author became responsible for implementing and running quality assurance projects, and also for publishing findings with colleagues. In the past years he published as the first author over 100 papers on Quality Assurance in various Hungarian medical and nursing journals. HSQA has become a successful organisation in quality assurance, and its multisite quality assurance projects have grown into nation-wide quality assurance development. His main objective was to see whether it would be possible to implement various quality assurance programmes in the Hungarian health care system during the transition period. Quality assurance in the early 1990s was a new concept in Hungary; even to discuss this topic was difficult because the Hungarian language lacks the appropriate words to describe the real meaning of some key elements of quality assurance such as: efficacy, effectiveness and efficiency, and benchmarking. It soon became clear, however, that not only was it possible to implement quality assurance programmes in Hungary, but there was great demand for them as well. Another fascinating question was how quality assurance would

(*) Kwaliteitsinstituut voor de Gezondheidszorg, formerly Centraal Begeleidingsorgaan voor de Intercollegiale Toetsing, (Dutch Institute for Healthcare Improvement, Utrecht)
contribute to the population’s health status through the improved effectiveness of health care, to health care budgeting, and whether it would result in increased cost or cost-containment. (Kahan and Gulácsi, 2000) Better quality with increased cost could be difficult to manage in a middle-income country like Hungary. But to identify and implement quality assurance programmes that clearly contribute to cost-containment had reality. The author was in a very privileged position to have a fellowship from the Canadian Government. In Canada thanks to Professor Devidas Menon, he got acquainted with health technology assessment in the Canadian Co-ordinating Office for Health Technology Assessment. In addition to this in the mid 90s, thanks to Professor Anthony J. Culyer, he studied in the Department of Economics and Related Studies of the University of York where he received his master’s degree in health economics. These studies helped the author of this study to get closer to his research aims. The author will discuss these experiences in the following chapters.

**Study description**

The study consists of 10 chapters, with a reference section in each of them. The thesis starts with the ‘General introduction’ and ends with conclusions, to which recommendations for the future are added. Chapters 1-2 are descriptive and theoretical ones about the health care in Hungary: description of the population’s health status and the Hungarian health care system 1948-1999, delineation of health care system in transition. The series of quality assurance studies starts with a case study about a ‘patient with stomach-ache’. This case study gives a relevant description of the problems with quality in health care in Hungary. Chapter 3 consists of the study on the content area of quality assurance and key concept of the thesis. One of the research questions of the thesis is theoretically addressed by this chapter, namely: do quality assurance initiatives really improve the effectiveness and efficiency of health care, in what extent and under what conditions? Furthermore, in Chapter 4, the history and chronology of quality assurance, the impact of the quality assurance projects on health care in Hungary, changes of attitudes of consumers, providers, regulators and financing institutions are discussed. Chapters 5-9 contain descriptions of various quality assurance studies carried out by the author in Hungary between 1992-1998 such as: quality of hospital care, preoperative assessment in surgery, nosocomial infection surveillance, the quality of nursing care and quality of primary care. The ‘Conclusion and recommendations’ (Chapter 10) further discusses the quality assurance in Hungary, its influence and impact on health care. In this section the main results and the overall conclusion of earlier chapters will be summarised, and finally recommendations will be highlighted.

**The objectives of the study**

The intention of this study is to:
- demonstrate that quality assurance methods can be implemented in Hungary;
- analyse the ways quality assurance contributes to the implementation of the concepts of effectiveness in health care during the transition period;
- of the Hungarian health care system when the demand for health care increases, and resources are scarce; and
yields relevant and valid information for policy makers on the Hungarian health care system during the transition period and provide an insight into the 'black box' of the health care reform in general, and in the field of improving quality in particular.

**Research questions**

The general aim of this study is to acquire knowledge about the possible role of quality assurance in improving health care effectiveness and its relationship to the costs of health care services in the transition period of the Hungarian health care system. In particular, this study is designed to answer the following questions:

(i) Do quality assurance initiatives in Hungary improve the effectiveness of health care?
(ii) Do quality assurance initiatives in Hungary contribute to cost containment?

These two questions will be addressed in relation to the following topics:
- quality of hospital and primary care: patient satisfaction, and patient reports (Chapter 5 and 9);
- quality of preoperative assessment in surgery (Chapter 6);
- nosocomial infection surveillance: surgical site infections (Chapter 7); and
- the quality of nursing care: prevention and therapy of pressure sores (Chapter 8).

**Hypotheses**

According to the literature quality assurance methods were implemented successfully under various circumstances in many countries through almost countless ways in order to achieve diverse quality improvement goals. (*) Evidence shows that quality improvement can be achieved through appropriate implementation of quality assurance methods. Literature on the effects of quality assurance on cost is relatively limited in number; however, the relation between cost and quality is an issue of universal interest. As Williamson (1978) and Reerink (1987) pointed out the focus of quality assurance is on increasing effectiveness and efficiency. Several difficulties can be encountered in this field. Cost elements, i.e. direct, indirect and intangible costs are difficult to account, and to find information about economic loss because of poor quality is not very easy. "Without any public consensus about what is meant by either quality or cost containment, it is difficult to evaluate their relation to each other fairly." (Carpenter and Bender, 1996) However, there is sufficient support for the hypothesis that "it is not too much quality, but rather too low quality that creates costs" (Crosby, 1979) and that quality assurance activities might contribute to cost containment. (**)

Based on international literature the following two hypotheses can be formulated.

(*) Fontaine, Vinceneux et al. 1997; Young, Charms and Barbour, 1997; Barber, 1993; Madhok, Thompson, Mordue et al. 1993
Hypothesis 1: Quality assurance can be implemented and used in Hungary in the transition period of the health care system.
Hypothesis 2: Once implemented, quality assurance activities can improve health care quality and contribute to cost containment.

Methodology

Descriptive and theoretical chapters (Chapter 1 and 2) are partly based on literature review of primary publications. Further analysis and the author’s conclusions are added concerning to the main focus of the study. Chapter 3 provides a systematic review of the literature on the content area of quality assurance and effectiveness and cost-effectiveness of various quality assurance activities. The methodology of the quality assurance studies varies, but the quality loop was followed and completed in all studies.

Further common feature of these methodologies, presented in Chapters 5-9, is that they allow for the creation of comparative (risk-adjusted) rates (i.e. hospital infection rates, pressure ulcer rates, 'standard patient population' and sample of 'prototype patients'). Comparative rates, on the one hand, enable the comparison of health care services, health care organisations or countries in the given field of health and medical care. On the other hand, comparative rates are also necessary to the investigation of effectiveness (benefit achieved or outcomes) and efficiency (cost relations) under specific real circumstances.

Rationale

These quality assurance projects were chosen for implementation in Hungary and will be presented as the core part of this study, in chapters 5-9, for of the following reasons:

a) they represent the two most important features of the outcome of health care:
   - patient satisfaction (Chapter 5 and 9)
   - clinical outcome (Chapter 7 and 8)

b) they represent various health care settings, e.g.:
   - primary care (Chapter 9); and
   - hospital care (Chapter 5, 6, 7 and 9);

c) they cover diverse medical activities such as:
   - diagnostics (Chapter 6);
   - medical care (Chapter 6 and 7);
   - nursing care (Chapter 8), and
   - patients satisfaction and patient reports (Chapter 5 and 9);

d) after the political changes in Hungary (1989) the public and the politicians became interested in learning more about the satisfaction of the population. In a hospital dominated health care system it was quite obvious to start with patient satisfaction surveys in hospitals.

e) other quality assurance studies were conducted in hospital settings because hospitals are still the basic institutions of the Hungarian health care system. In addition, doing quality assurance in hospitals is relatively easy as compared with e.g. primary care.

f) the chosen topics are in the focus of extensive international co-operation.
Format of this thesis

The thesis consists of two parts: a) health care in Hungary, and b) quality assurance studies. The main purpose of the descriptive and theoretical chapters is to analyse the most important problem areas and to describe the Hungarian health care system and the health status of the population. Furthermore, they aim to show the socio-economic environment in which the quality assurance studies were conducted. The objective of the second part of the thesis is to discuss the effectiveness and cost-effectiveness of the quality assurance activities to give an overview of the history and chronology of the introduction of quality assurance in Hungary and to present the results and impact of various quality assurance programmes in which the author of this thesis played the major role, such as:

- quality of hospital care; patient satisfaction and patients’ reports in hospitals,
- preoperative assessment in surgery,
- risk-adjusted surgical site infection surveillance in hospitals,
- the quality of nursing care: prevention and treatment of pressure sores in hospitals, and
- quality of primary health care; physician’s and patient’s reports on system performance.
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