Is the glass half full or half empty?

The Association of the Hungarian Primary Care Paediatricians celebrated its 15th anniversary in 2010. On this occasion we interviewed dr. András Huszár, president of the Association, who was one of the founders.

Why did you decide to establish the Association?

Although it has never been clearly verbalized nor published in print, but from the beginning of the 1990s paediatric primary care was pushed more and more in to the background. No minister, secretary of state, party politician, professional leader or head of institution would openly declare that there is no need for paediatricians in primary care, but manifestations, measures - or rather the lack of measures - let us anticipate nothing favourable. Former communist countries that by then had achieved some kind of paediatric primary care network, one after the other decided to do away with the system. From the Baltic states to Poland, Romania and Bulgaria primary care paediatricians and GPs had been ordered to take a family physician exam all of them were forced to carry out the primary care of all the patients belonging to them – from newborn babies to the elderly.

The most important step for health care reform at that time was the modernization of primary care, but the focus of the Dutch experts playing an important role then as well as that of the heads of the newly formed family physician departments was nowhere around paediatric primary care. We were only mentioned when we started a loud protest about not being mentioned. All our complaints were done away with the reply that the term family physician includes primary care paediatrician too.

It has been well-known since the 1950s that paediatrics is a discipline of its own, still due to the fact that working conditions of a family physician and a primary care paediatrician are similar (both work in a consulting room, both do primary care, the work of both are regulated by health insurance and local governmental regulations and contracts) the system of family physician was declared to be able to handle our problems too. But in fact, it was not able to deal with our problems and we became a „subsidiary branch". This is best illustrated by the fact that we never got into proportional representation, notwithstanding the fact that we comprise(d) more than two fifth of workers in primary care and are responsible for the care of one fifth of the population (and the most sensitive one fifth from the aspect of the future).
We never received proportional representation in the ministry or in the professional bodies, or in scientific, academic or lobby groups. Paediatric professional bodies focused on to the problems of hospitals and university clinics. Contracts with the local authorities were formulated to serve family physicians and the Medical Chamber was busy dealing with the unsettled general position of about 30-40 000 doctors. Paediatric conferences were trying to find answers to problems of clinical paediatricians and primary care paediatricians found themselves fully alone.

By the summer of 1995 it became obvious that primary care paediatricians might completely get lost in between family physician and clinical paediatricians. It was clear that no one but ourselves would stand up for our own needs – and for the needs of a better primary care of

children. In November 1995 at a meeting of about 300 colleagues we announced the establishment of the Association of Primary Care Paediatricians.

Weren't you, the founders, accused of disrupting the unity of paediatric care?

Of course, we were. But on the one hand such unity had never existed, on the other hand we were trying hard to explain wherever we could that the organization of primary care does not work against paediatrics. We kept explaining our status, goals and objectives at the ministry, at university faculties, at clinics and local hospitals. I am convinced that within the 15 years of our existence we never did anything that would have compromised the general interests of paediatrics, on the contrary: we contributed to it.

We have been fighting independently only and exclusively for the special questions in our field; in case of general questions of doctors we have always worked in unity with the medical Chamber.

How long did you have to work before results came?

Our consistent representation, our non-political attitude resulted in respect and acknowledgement among our partners. We are counted on, being asked for an opinion, are invited to forums and discussions. However, I would not dare to say that we have been included in the mainstream representation: professional politics tends to ignore our problems even today. At the same time, it is our association that deals most comprehensively and most deeply with the challenges of paediatric primary care in Hungary today.

Can you detail these challenges?

There has been an unbelievable development in the field of genetics, molecular biology, information technology, medical technology, vaccinology and social paediatrics. Morbidity structure has changed and the number of children under care with chronic diseases has increased, the economic gap and cultural distance between families has widened. There are more and more professional trainings still I do not feel that on a larger scale we are ready for the care of these new tasks.

Besides professional challenges we have been carrying the structural problems of primary care for years. The geographical distribution of paediatricians in primary care is unequal, there are territories where the health care provider of all the children are paediatricians and other territories where none of them are. Moreover, territories with the fewest paediatricians are the ones populated by people in the lowest economic situation, these are the ones where the morbidity rate of the population between the age of 1-14 is the highest, where the number of years spent in good health is the lowest. I do not want to detail again the huge differences in the paediatric education of a primary care paediatrician and a doctor running mixed praxis, all I want to refer to is that paediatricians receive a long training, whereas family physician get their paediatric knowledge only through experience in practices.

We consider it a major step that last year the Paediatric Professional Board finally accepted that equal opportunity has to be provided in the access of paediatric primary care for every child in the whole territory of Hungary in and outside working hours. I am glad that it has

been recorded that childhood lasts until he age of 18. But my question is: have we moved anything forward? Can these declarations be enforced? However obvious these issues are if one board refuses to speak with the other, if there is no cooperation between local governments, if boards of family physician refuse to speak about these declarations. We do not really feel support from the leaders of the sector either. It seems that parents tend to formulate their need for us, but as a whole they are the „lamb", they are still in silence.

Would real political intention solve the problems?

Partly it would. But should decision-makers be ready to accept our proposals, they would not necessarily want to invest money in the implementation. We cannot want anything at the expense of the body of family physician: they are ready to hand over their child patients but only if this does not mean the decrease of their income.

A similarly serious problem is that some of our own colleagues receive our intentions with great incomprehension. We have explained it in our paper as well as in conferences, but we do not always have an understanding audience. It is not evident for everybody that a well built-up paediatric primary care system does not necessarily require a school doctor, that the decisive scene of paediatric primary care is the primary care paediatrician's office, that it is possible to distribute tasks more efficiently among actors in health care, and that the time of atomized surgeries are over. We are not used to modernization by breaking through the boundaries of routine easily. I was shocked to hear on the radio the other day a renown sociologist specialized in children condemning paediatricians for not even visiting a child with high temperature in the home. He does not even think of how ineffective and outdated it is in 2010 to visit every high temperature. Today our task is not to take knowledge to the homes but to concentrate care instead.

Is the rigid belief in the non-changeability of practice related to the age of the colleagues?

Obviously, it plays a role. Anyway, how could this population of 60 on average believe in a near happy future after so many decades of bad experience? At the age of 60, 70 or 75? They say that by the time future becomes present, it will have been all over for them. We in fact, work for the future of paediatric primary care, for the youth of today… the only problem is that we do not really see them…

Are there young people at all in paediatric care?

Yes, there are, but fewer and fewer of them. And the ones that come tend to prefer clinics and hospitals as well as sub-specialities. Or they simply want to work in other European countries that guarantee a higher status quo and income, which is just understandable: they look out to the best possibilities in their career. Territorial paediatric care is not too much respected. And the reason is not that our income is behind that of the possibilities of a family physician but mainly because young people find transplantation or intensive therapy more interesting than mass prevention.

But how could residents be charmed by the beauty of territorial work when they do not really have a chance to experience it? In the last 15 years in paediatric training it was impossible to implement an accredited training practice network, similarly to the one organized on a family physician level. Ironically, paediatric practice training is operated under the supervision of the department of family physician. All this, too, indicates the disadvantage of paediatric primary care to the system of family physician.

Do the proposals get to the place where they should get?

We try to do our best to get them to the right places. We have been working on it for 15 years, so I dare to say we have become experts on our field. Our coherent suggestions mainly refer to primary care, but they would not leave other areas of the care system intact. We are aware of the labour force situation and our age profile, we know the direction we need to go, we know where money is needed and where finances disappear, we know what badly organized night duty system means, and are fully aware of the dangers of a paediatrician taking care of adults and a family physician taking care of children. We know that cases to be treated in primary care are hospitalized in emergency wards, that a lot of money is wasted within the frames of our training, we identify the problems in care and the consequences of immature regulations.

Based on all that, still we can expect that our opinion is heard and listened to. We had been hopeful whenever a new government came, but by mid-term we lost our hopes.

You seem to be a bit skeptic…

I am, but it is understandable. We are talking about a „glass half full and half empty".

I'm proud that paediatric primary care is still systematically existing in Hungary and statistic data are better and better. We have managed to maintain the finances of paediatric primary care in parity with that of the family physician for 15 years. We have organized 12 scientific conferences each with 500 participants plus 15 conferences about professional policy. The „Hírvivő", our newsletter is widely read. We have European representation, and the Association of Primary Care Paediatricians has international reputation.

At the same time I'm unsatisfied about the fact that characteristically in areas where we did not have paediatricians 15 years ago, we still do not have them. That is we did not manage to achieve changes in the 70/30% proportion of children treated in paediatric care and in mixed practices. We could not step forward in most of the major issues and I see no concept, no governmental intention and no commitment for the development of primary care of children. We have repeatedly explained that whatever is not developed will wither. Is that the intention?

Don't you believe that those who decide on neglecting the development of paediatric primary care and thus implying the elimination of the paediatric primary care system take upon a historic responsibility? Can you see any layer in the medical society that on a short term could take over the modern primary care of children?

Some believe that on a Northern or Western European example a family physician system completed with a well organized district nurse system would be operable. Yet, the Swedish, Norwegian, British or Dutch infrastructure, economic level and health care culture is incomparable to the Central, Eastern or Southern European situation. Moreover, those who want to introduce those systems in Hungary now, fail to hear the voice of Patricia Hamilton. The British paediatrician, former President of the European Academy of Paediatrics, former leader of the Paediatric Association in Britain warns us saying that in England the number of avoidable death cases of children is on the increase, there are problems with the early stage recognition of solid tumors, British family physician do not get sufficient paediatric knowledge, in the case of 40% of these family physician paediatric training does not appear in their CME training and obviously for reason, more and more parents, dissatisfied with family practitioners' care, tend to turn to – the more expensive service – emergency wards.

Where and by who a child is treated is basically determined by tradition rather than by indicators analyzing the efficiency of paediatric primary care. Anyway, most of the indicators today are fully unsuitable to detect the fine differences in care of the countries with relatively developed health care system. (For example: is the time of diagnosis of partial disabilities and the effectiveness of the treatment properly sensed, are the consequences of late recognition identified and analyzed?)

Whose interest would it be in reality to eliminate the paediatric primary care system?

Let me stress: no one has declared that our system is meant to be eliminated. But there are professional leaders who would trust school doctors to screen the 16-year-olds, others are organizing mixed practices in the place of an emptied paediatrician's position, and again others come up saying that mixed practices are perfectly suitable to diagnose and treat a cold or a diarrhoea. And I think I do not have to explain the implications of the fact that a vaccination of an adult against H1N1 is worth 2000 HUF net, whereas the same vaccination of a child is worth 200 HUF gross including the doctor and the nurse.

How would the association modernize the care system?

First of all the principles that the Paediatric College has accepted will have to be accepted by all the affected parties: professional politics, professional organizations, heads of departments and primary care providers, local governments and parents. We have to make people aware that all children should be provided – even at the level of primary care – equal opportunity: that it is better if children in the area are treated by paediatricians day and night, on weekdays and at weekends. The often mentioned demographic obstacles of setting up paediatric practices can be overcome by centralized care and structure. And also, we have to make people understand that childhood lasts until the end of growing.

We need political intention and support. We have to do away with old stereotypes like we cannot bring a paediatrician to every village with a population of 4-500 people. We have been

repeating for 15 years that this is not what we want, this would make no sense. We would like to rationalize care, to get rid of unnecessary work, the waste of money and wish to have effective care. We try to convince local municipalities to maintain a central paediatric practice, a place where out of hours paediatric care and part-time sub specialists would be available. We have to move to this direction not only because of the current state of human man power, but also because of modern information, knowledge and expectations.

Isn't it somehow contradictory that a professional safeguarding association is fighting for the rationalization of the present network of 1500 people?

There is a contradiction, but only seemingly. Despite the large membership of the present network of care, there are many small practices that are impossible to operate and there are large areas without paediatric care, so there are signs of disorganization. It might sound demagogic although it is rather evident that we are fighting for a better care, for the future of paediatric primary care. If we want any future, we cannot escape modernization. We want better care, an attractive career option for young people and reasonable life conditions for those retiring. I am convinced that with a more reasonable practice policy and task management, fewer paediatricians would be able to provide a better care for children.

Does the association have a specific picture how many new doctors would be needed in a rationally built-up new system, within how many years and where exactly?

We would like to map the situation so that we could present specific data together with the specific recommendations based on a precise picture. What we know for sure at the moment is, where the child is registered with their social security card, but we cannot be sure where they get treated. Are they treated in paediatric practice? In a paediatric department? In an emergency unit? In private praxis? Who gets paid for their work? Is it the person who treats the child or someone else?

It would be a huge step forward if we could get a complex picture of the details of paediatric care. Without this we cannot speak about conscious planning. If we do not see clearly and let the processes happen, there will be serious problems in care, a lot more serious than the ones today. Time is an important factor and it does matter when we start interfering.

What are your plans? How long are you planning to go on?

As I said before, I am a sceptic. But I have to add that I am naive too as I am still ready to get enthusiastic. I believe that there will be a chance to move forward. I think I am a born optimist somewhere deep in my heart, otherwise I would not continue doing it.
I would like to see the system en route. If I now saw the people I can hand over the task, I would stand up right away. We are trying to include younger colleagues in the leadership, we would need youngsters with fresh spirit and firm knowledge who share the values we represent and are ready to work for them.

Finally are you still happy with your music band?

Bras on Bras is in the bottom of my heart. We play better and better, and although we are not very good at managing ourselves, we still get lots of invitations. Honestly, I simply forget everything when I sit down to the piano. And I have wonderfully talented companions in music as well. But you know that very well: it seems you also get tuned in when you hear Summer time or St. Louis Blues.
And I do not think it is only because of the beer….

Ferenc Kádár, Mihály Kálmán