European Observatory on Health Systems and Policies

HiT summary

Hungary

Introduction

Government and recent political history

Since 1989, Hungary has been a multi-party democracy with a social market economy, headed by a president. Public administration has three levels: the national government, the county local governments and the local governments of municipalities. Hungary is a member of the Council of Europe, the Organisation for Economic Cooperation and Development (OECD) and the North Atlantic Treaty Organization (NATO); it acceded to the European Union in May 2004.

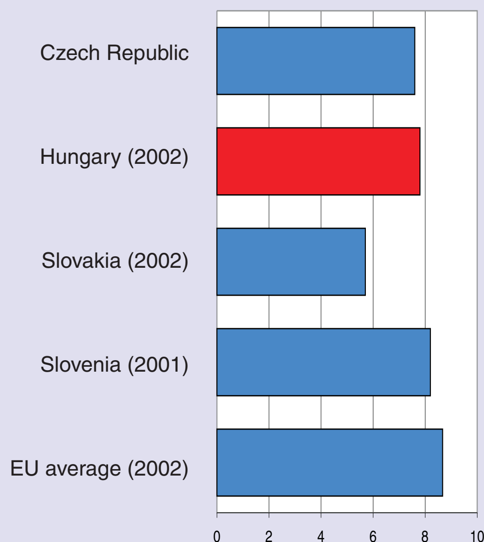
Population

In 2002, the Republic of Hungary had 10.2 million inhabitants, with about 99% holding Hungarian citizenship. The largest national minority is the Roma community. The share of elderly above 64 years has increased to 15% of inhabitants in 2002 and the share of youth below 15 has decreased to 16%. The unemployment rate was 5.8% in 2002.

Average life expectancy

By 2002, life expectancy had increased to 68.4 years in men and 76.6 years in women, but still ranked below the average levels in the countries of central and south-eastern Europe and in the European Union (EU).

Fig. 1. Total health care expenditure as % of GDP, comparing Hungary, selected countries and EU average, 2003



Source: WHO Regional Office for Europe health for all database, January 2005.

Leading causes of death

Cardiovascular diseases account for half of all causes of death, while the second most common cause is neoplasms (cancer), representing about a quarter of all deaths. These are followed by diseases of the digestive system and deaths from external causes. All leading causes of death have shown a decreasing trend since the mid-1990s. Nevertheless, standardized mortality rates are still among the highest in central and south-eastern Europe and well above the EU average rates.

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Recent history of the health care system

The collapse of the communist system initiated a large-scale reform of the health sector at the end of the 1980s and led to the reintroduction of social health insurance structures.

Reform trends

The dominant trends have been decentralization and cost containment. The financing of current expenditure and purchasing functions have been delegated to a single National Health Insurance Fund. The Fund has, however, been placed under tight central control since the government abolished the self-governmental structures in 1998 in order to realize strict expenditure control policies. The responsibility for service provision has been devolved to local governments, along with the ownership of most health care facilities. Service delivery by private providers, however, is still limited.

Health care expenditure and gross domestic product (GDP)

In 2002, Hungary spent 7.8% of its GDP on health care. Three quarters of that figure represented expenditure from public sources (Fig. 1).

Overview

The health care reforms of the 1990s sought answers to the crisis of the state-socialist health care system, which had suffered from inefficiency and inequity of service provision. Many structural reforms have been implemented against the background of 4 years of economic recession and 8 years of tough cost-containment policies. These have included the introduction of a purchaser-provider split in social health insurance structures, the introduction of new prospective and performance-oriented payment methods, as well as a reduction in and geographical reallocation of inpatient capacity. The new model is functioning, but the tight expenditure control policies have come to create substantial tensions in the system.

Organizational structure of the health care system

The Hungarian constitution guarantees virtually universal access to comprehensive health care services, the recurrent expenditure being financed by the Health Insurance Fund. The national government is the key regulator of the system and its budget covers capital expenditure. Its role in service delivery has been limited to special services or to certain sectors. For example, the Ministry of Health provides care through the National Emergency Ambulance Service, the National Blood Supply Service and the various specialized national institutes of health. Clinical university departments are owned by the Ministry of Education. The Ministries of Defence, Internal Affairs and Transport still run their own health care institutions.

The Health Insurance Fund is administered by the National Health Insurance Fund Administration, which is the single most important purchaser. Its income is collected by the National Tax Office since the self-governing structures were abolished in 1998 in favour of more governmental control. The major decisions relating to the Health Insurance Fund, such as contributions, the annual budget of the Health Insurance Fund, and provider payment methods, are made centrally by the National Assembly, the government or the Ministry of Health. Since 2001, the Ministry of Health has been responsible for covering any deficit of the Health Insurance Fund from its budget and has been empowered to demand funds to be reallocated between the various sub-budgets of the Health Insurance Fund.

Local governments are the main service providers in the system, owning most health care

facilities, including hospitals, polyclinics and the surgery sites of most primary care physicians. While local governments are responsible for making health services available to the local population, they are allowed to contract out service delivery to private providers. Nevertheless, the private sector is small, except at the level of primary physician care, where the scheme of functional privatization has been implemented.

Professional and voluntary organizations have been growing in number and importance since 1990. The Hungarian Medical Chamber is responsible for licensing and professional self-regulation.

Planning, regulation and management

The National Assembly determines the yearly budget of the Health Insurance Fund and its division into sub-budgets. Health care capacities have been centrally regulated through service contracts, but service volume and quality are not subject to regulation. All other aspects of the production process, however, including the registration and licensing of qualified health care personnel, pharmaceuticals and medical devices, and the factor and service prices within the framework of social insurance, are extensively regulated.

Decentralization of the health care system

The system has undergone major decentralization. Financing of recurrent expenditure has been delegated to the Health Insurance Fund and service provision has been devolved to the municipalities and counties. Privatization has been limited to the pharmaceutical industry, to primary care and to a few hospitals previously owned by the Church. In 2000, 85% of primary care physicians worked within the contractual framework of functional privatization, while nearly all specialist care is still provided by salaried staff. In 2001 and 2002, the government created health-care-specific rules for the management and ownership of hospitals and the outsourcing of services to non-profit providers and freelance medical practices, and introduced several constraints. Their implementation was interrupted, however, when the new government suspended most of the clauses of that legislation after entering office in mid-2002. Instead, it plans to introduce far-reaching privatization policies within a strict regulatory framework. Those plans have, however, caused substantial controversy.

Health care financing and expenditure

In 2001, 63% of total expenditure was financed by the Health Insurance Fund and 12% by the national and local governments. As regards private sources, 21% of total expenditure was financed by out-of-pocket payments and 1% by private health insurance.

Main system of coverage: statutory health insurance

Participation in the statutory health insurance scheme is compulsory for all citizens. Employers pay 11% and employees 3% of their gross salary. Since the self-governing structures of the Health Insurance Fund were abolished in 1998, the contributions have been collected by the Ministry of Health. In addition, a small hypothecated lump sum tax, complemented by an 11% proportional income tax which is levied on relevant non-contribution incomes, for example rents, is allocated to the health budget. These transfers from the national budget are categorized as social health insurance sources in the new national health account.

The Health Insurance Fund has local branches which contract with providers and reimburse them according to national, uniform rules.

Health care benefits and rationing

The benefit package is comprehensive. If we were to list negatives, certain treatments have thus far been excluded, including massage and sterilization without medical indication. Certain special services, such as high-cost, high-tech interventions and public health and emergency ambulance services, are financed (and delivered) by the central government.

Complementary sources of finance

Local governments are responsible for financing investment and depreciation expenditure in the health and social care facilities which they own. The central government offers substantial help through conditional and matching grants. The national government thus finances most investments in health care and a small share of certain recurrent expenditure. In addition, it covers the exemption from co-payments for the poor and finances health education, research and development.

Private sources consist mainly of out-of-pocket payments since the market of private for-profit and not-for-profit health insurance is still small. Out-of-pocket payments include a conservative estimate of informal payments and co-payments. Co-payments apply mainly to medicines, but also to medical aids and prostheses, balneotherapy, chronic long-term care or above-standard hotel services. In principle, they also apply to specialist care when the patient bypasses referral regulations. Patients pay the full price for excluded services or fee-for-service to providers practising privately (often part-time), which have no contract with the National Health Insurance Fund Administration.

The practice of making informal payments became widespread in the state socialist system and has probably increased since then. While the extent and magnitude of informal payments are debated, it has been established that "gratitude payments" are not equally distributed among professions, specialties or the kinds of service provided.

Health care expenditure

In 2002, according to WHO data, Hungary spent 7.8% of its GDP on health care. The current level of health care expenditure is the result of 4 years of economic recession followed by strict cost-containment measures, which were continued even when the economy started to grow substantially from 1997 onwards. Public expenditure and even total expenditure on health as a share of GDP have decreased in Hungary since 1994. Despite stringent expenditure-control measures, the Health Insurance Fund has been in deficit since its inception, partly because of an insufficient income base and partly because of the economy, the labour market, tax evasion and fiscal constraints.

The share of private expenditure shows an increasing trend. Pharmaceutical expenditure has also shown a continuous increase, while the costs for curative health services have decreased slightly. The allocation of financial resources from the curative and preventive services budget of the Health Insurance Fund between primary, outpatient specialist and inpatient care has remained by and large unchanged in the past seven years.

Health care delivery system

The responsibility for making health services available to the local population lies mainly with local governments. According to the principle of division of tasks, municipalities are responsible for primary care and county governments for secondary and, in certain cases, tertiary care. However, according to the principle of subsidiarity, if municipalities are willing and able to provide secondary care, county governments are obliged to transfer the responsibility for such care to the former. Nevertheless, this "territorial supply obligation" does not oblige local governments to deliver services themselves; they can contract out service delivery to private providers; the latter then become responsible

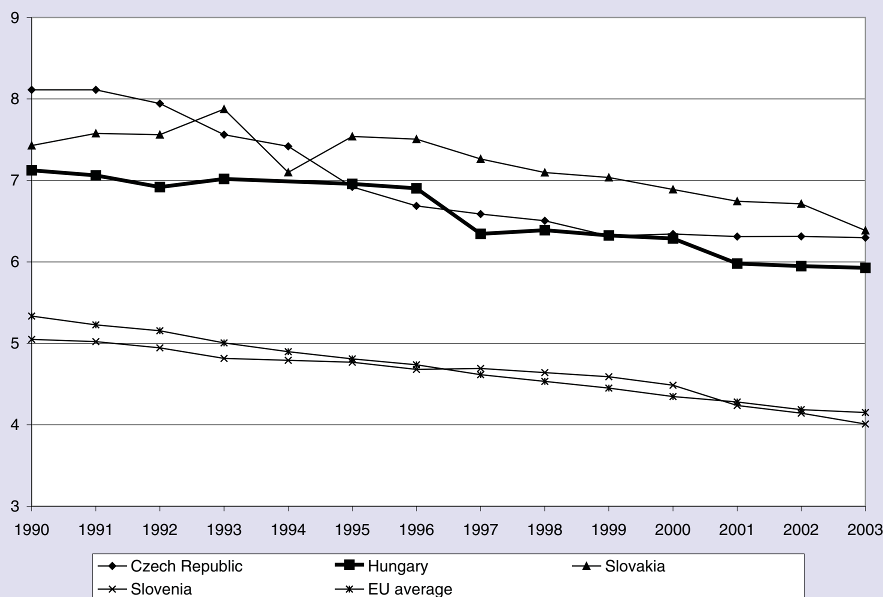
for providing the capital costs, according to the principle of maintenance obligation.

Primary and secondary outpatient care

Since 1992, patients have been allowed to choose their family doctor freely; a change is possible once a year. Doctors are not allowed to refuse to register patients who live in their primary care district. Local governments must ensure that the following services are available to the local population: (a) family physician and family paediatrician services, (b) dental care, (c) out-of-surgery-hours services, (d) mother-and-child health services, and (e) school health services. Municipalities designate the primary care districts for family doctor services within their territory, with a lower limit of 1200 residents for family physician services and 600 children for family paediatrician services. Municipalities can also decide whether they deliver family doctor services themselves or contract such services out to private providers. In 2000, among the 6729 working family doctors, 85% worked in functionally privatized practice (being reimbursed directly by the Health Insurance Fund but renting accommodation and equipment from local governments) and 15% of primary care physicians were working under other contract conditions, for example in private surgery. Private practising physicians need to prove that they serve a list of at least 200 patients to become eligible for reimbursement from the Health Insurance Fund. Secondary outpatient care is provided mainly by salaried physicians and other health care professionals who work in public multi-specialty polyclinics or in dispensaries for patients with certain chronic illnesses.

In principle, to gain access to most specialist services, patients need to be referred by their family doctor; otherwise, co-payments for specialist care apply. However, due to regulatory exemptions and circumvention in practice, gatekeeping is not effective and direct access

Fig. 2. Hospital beds in acute hospitals per 1000 population, Hungary, selected countries and EU average, 1990–2003



Source: WHO Regional Office for Europe health for all database, January 2005.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2003 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Czech Republic	6.3	20.4	8.4	74.1
Hungary	5.9	23.2	6.7	77.2
Slovakia	6.4	17.7	8.5	64.8
Slovenia	4.0	16.2	6.1	68.1
EU average	4.2	18.0	6.8[a]	76.9[b]

Source: WHO Regional Office for Europe health for all database, January 2005.
Notes: [a] 2002; [b] 2001.

to specialists is common. Utilization of both specialist and primary physician care is high in comparison with other countries in central and south east Europe and/or in the EU, with an average of 12 visits per resident per year.

District mother-and-child health and school health services are provided by highly qualified nurses, trained at college level.

Public health services

The National Public Health and Medical Officer Service of the Ministry of Health is organized on a regional basis with national organs, county offices and local municipal offices. The Service is responsible for the control, coordination and supervision of mother-and-child services, public hygiene, occupational health, communicable diseases and health promotion. In addition, it is in charge of several duties which used to be performed by the Ministry's health administration, such as compulsory registration and licensing, and the professional supervision of health care providers.

The delivery of public health services is performed in cooperation with other actors. For instance, the Service coordinates the compulsory immunization programme and supplies the vaccines, while family physicians and paediatricians and the school health service vaccinate the children. These well-organized programmes are probably a key factor in the excellent immunization record of the country.

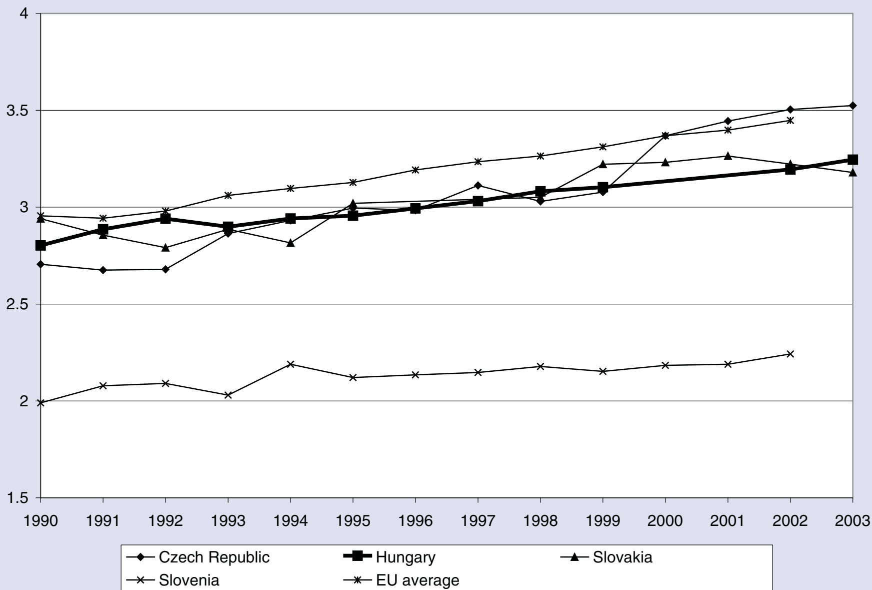
Secondary and tertiary hospital care

Secondary and tertiary hospital care is mainly provided in publicly owned polyclinics, dispensaries and hospitals of different specializations. In 2000, 77% of total inpatient beds were owned by local governments, 2% by churches and charities and 21% by the national government (10% by the Ministry of Education in teaching hospitals, 7% by the Ministry of Health in national institutes of health and 4% by other ministries).

By 2002, the number of acute beds had been reduced to 6.0 per 1000 population (Fig. 2). In the same year, the average length of stay was 6.9 days and the bed occupancy rate was 72%. Hospital expenditure accounted for only 28% of total expenditure on health, although the admission rate to acute hospitals of 23 per 100 inhabitants ranked second in the WHO European Region.

Despite the introduction of new provider payment methods, increased managerial capacity and the downsizing of the hospital sector, some inefficient practices, such as unnecessary hospitalization, persist.

Fig. 3. Physicians per 1000 population, Hungary, selected countries and EU average, 1990–2003



Source: WHO Regional Office for Europe health for all database, January 2005.

Social care

In general, the poor and the disabled are eligible for social assistance, including access to health care services and exemption from pharmaceutical co-payments.

In-kind benefits for the disabled include primary social care, which is provided in the home of the disabled person, and special social care, which is provided by institutions. Primary social care includes catering, domestic help and family help, while social care institutions provide services for the elderly, people with physical and mental disabilities, drug addicts and the homeless in the form of long-term residential care, rehabilitation, day care or transitory (short-term) institutional care. A special form of institutional care is the community home, which typically houses between 8 and 14 people with physical or mental disabilities who are at least partially able to care for themselves.

Contracting with private providers is more prevalent in the social care sector than in the health care sector. In 2000, almost a quarter of social care providers were nongovernmental.

The social services are financed by several sources. The national government provides two types of capitation payments and special conditional grants, while the local government can top up the available funds using their own revenue from local taxation. In 2000, 202 persons per 100 000 population were on waiting lists, half of whom had been waiting for more than one year; 70% of that figure represented applicants for residential homes for the elderly.

Human resources and training

In 2003, Hungary had 3.2 medical doctors (Fig. 3) and 8.6 nurses per 1000 population. The average number of medical doctors hides geographical as well as specialization inequalities. Physicians

practising as family doctors, for example, account for only 20% of all active physicians.

The education and training of health care professionals is well organized in Hungary. The number of students admitted is regulated by quotas.

Pharmaceuticals

The pharmaceutical industry has been privatized, trading has been liberalized and the whole supply chain is comprehensively regulated. The registration and licensing system is operated by the National Institute of Pharmacy of the Ministry of Health. Licensed pharmaceutical products can be subsidized by social health insurance only if they are included in the national, positive drugs list. In 1999, 2172 of the 3705 licensed drugs were eligible for some sort of subsidy. In annual negotiations, the representatives of pharmaceutical companies, wholesalers, retailers, the Ministry of Health, the Ministry of Finance and the National Health Insurance Fund Administration determine the national drugs list, the approved consumer price, price margins for wholesalers and retailers, as well as the extent to which a product will be subsidized by the Health Insurance Fund. In addition, a more restricted list of pharmaceuticals is drawn up to which co-payment exemption schemes apply. Patients need a valid prescription from an authorized medical doctor to purchase the medicine at the subsidized price. Subsidies may account for 9%, 50%, 70%, 90% or 100% of the price, the subsidized amounts represented by the two last percentages being restricted to specialist-only prescriptions, for example for diabetes patients. The validity of prescriptions is monitored by the National Health Insurance Fund Administration.

Pharmaceutical expenditure for outpatient care has increased substantially, from 22% of total expenditure in 1992 to 34% in 2001. One third of spending was attributable to out-of-pocket payments and two thirds to payments from public sources. Measures adopted by the Health Insurance Fund to contain drug expenditure include cost-shifting to patients by revising the subsidy system and strict overspending controls. Since 1999, the Ministry of Health has been able to reallocate funds between sub-budgets. Cost-containment measures introduced in 2001 included a three-year agreement with pharmaceuticals producers to keep price increases below inflation level, a reduction of wholesale and retail price margins, stricter controls over physician prescribing and the extension of fixed-amount subsidies. In 2002, guidelines for the economic evaluation of drugs were issued to introduce the criterion of cost-effectiveness into reimbursement decisions.

Financial resource allocation

Third-party budget setting and resource allocation

The public health care budget is made up of three components: the budget of the Health Insurance Fund, the central government budget and local government budgets. A key principle of resource allocation is the separation of capital and recurrent expenditure (dual financing) in inpatient as well as outpatient care. While investment and depreciation are financed by local or national governments, reimbursement of the Health Insurance Fund covers only recurrent costs of services. Its budget is divided into over twenty budget lines (sub-budgets). The major budget-setting decisions are made centrally. The National Assembly, for example, determines annually the size of contributions, the ceiling of the budget of the Health Insurance Fund and the division of its sub-budgets. Most of these sub-budgets, with the notable exception of pharmaceuticals, have been capped. Transfers between sub-budgets have been permitted since 1999. The National Assembly also determines the provider payment methods for the various sectors of care that will ensure that the predetermined budget ceilings cannot be exceeded.

Payment of physicians

Family doctor services are paid for by an adjusted capitation fee. Some medical doctors run a private practice, usually on a part-time basis. They are paid out of pocket by their patients on a fee-for-service basis. Most family doctors, specialists and other health care professionals also receive some informal payments.

Most medical specialists and other health care personnel are public employees and salaried according to a pay scale determined by the National Assembly.

Their employers, mainly local governments, are reimbursed by the Health Insurance Fund according to the corresponding reimbursement system, for example global budgets for dispensaries or fee-for-service points for outpatient specialist services. Under capped budget conditions, the points per service are floating. To reduce income uncertainties, the service volumes are reported and monetary values are calculated on a monthly basis.

Since 2002, the current government has raised the salary of all public employees substantially by an average of 50%. It has also paid a loyalty bonus to nurses and other qualified paramedical workers who have been working for at least four years. However, the average salary in the health care sector is still lower than in most other sectors of the economy.

Payment of hospitals

For the reimbursement of acute and rehabilitation inpatient care, a system based on diagnostic-related groups (DRGs) has been gradually introduced since 1987. Since 1993 the DRG reimbursement system has been applied countrywide. Only a few high-cost medical interventions, such as bone marrow transplantation, are reimbursed on a case basis. Chronic (long-term) care is paid on the basis of patient-days adjusted according to the complexity of the case.

While the line-item budgets of the state-socialist era were in keeping with geographical inequities and inefficient service provision, there is evidence that the current DRG system under capped budget conditions encourages over-treatment, DRG-creep and point inflation. Hospitals currently have no financial incentive to treat people as outpatients rather than inpatients, and there are no effective incentives or control mechanisms in place to prevent unnecessary hospitalization. A regionally managed care pilot project, which was initiated in 1998 and aims to introduce financial incentives for efficiency across all levels of care, has been extended by the current government.

Health care reforms

The health care reforms of the 1990s have sought answers to the crisis of the state-socialist health care system, in the context of massive political, social and economic changes. Early structural reforms, which established the new contract model of health services and introduced incentives for efficiency by means of prospective and performance-oriented provider payment methods, have been implemented successfully. However, further reform efforts have been impeded by strict cost-containment policies, which have been characterized by centralization and direct government interventions that have diverted attention from the goal to secure sufficient funds for health care.

The government that held office between 1998 and 2002 launched a regionally managed care project and re-decentralized health care capacity planning. The National Assembly also passed a law which created health-care-specific rules for the management and ownership of health care providers, although some providers, for example, for-profit investors, were excluded. However, most of the restrictive clauses of this law were suspended when the current government took office in April 2002.

One of the first measures of the current government was to increase the salaries of all public employees by an average of 50% from the

autumn of 2002; in addition, a loyalty bonus was paid to nurses and other paramedical workers. It is not clear, however, whether these measures will be sufficient to minimize the exodus of health care professionals, especially of nurses and other paramedical workers. The current plans to privatize providers are meeting fierce opposition from trade unions. A bill that would allow for the privatization of health care institutions, including ownership by for-profit investors, even pharmaceutical companies, is being debated in the National Assembly. The much-debated draft also plans to guarantee a "fair" return on capital and depreciation for private investors through the Health Insurance Fund. As far as the financing side is concerned, the government has decided to extend the managed care pilot project, but has not yet ruled out the possibility of introducing competition among insurance funds.

Conclusions

The health care reforms of the past 15 years have created a functioning new model of health care provision, which has brought about noticeable improvements in both the technical efficiency and geographical equity of service provision, while preserving access to a comprehensive set of benefits. However, effective incentives and regulations still need to be put in place to prevent overprovision of care, to encourage quality of care and to shift resources from inpatient care to outpatient care, from products to services and from curative care to long-term care and prevention.

The tasks that policy-makers and stakeholders face in Hungarian health care are indeed complex. The health care system will need to be transformed to respond to the health needs of an ageing population. At the same time, the legacies of the country's socialist past will need to be overcome, and attempts made to minimize the adverse effects of recent reforms. Furthermore, the reforms will need to be adapted to meet the challenges of the European internal market.

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HiT summary

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The Health Care Systems in Transition (HiT) profile on Hungary was written by Péter Gaál (Health Services Management Training Centre, Semmelweis University, Budapest) and edited by Annette Riesberg (European Observatory on Health Systems and Policies, Technische Universität Berlin). The associate research director for the Hungarian HiT was Reinhard Busse (European Observatory on Health Systems and Policies, Technische Universität Berlin). It is based on the HiT profile on Hungary 1999 which was written by Péter Gaál, Balázs Rékassy (Health Care Research Institute, Budapest) and Judith Healy (European Observatory on Health Care Systems).

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.