

Health Systems in Transition

Vol. 13 No. 5 2011

Hungary

Health system review

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Health System Review 2011



The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

Keywords:

DELIVERY OF HEALTH CARE

EVALUATION STUDIES

FINANCING, HEALTH

HEALTH CARE REFORM

HEALTH SYSTEM PLANS – organization and administration

HUNGARY

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Printed and bound in the United Kingdom.

Suggested citation:

Gaál P, Szigeti S, Csere M, Gaskins M, Panteli D. Hungary: Health system review. *Health Systems in Transition*, 2011; 13(5):1–266.

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Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policymakers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources,

including the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiTs and HiT summaries are available on the Observatory's web site at <http://www.healthobservatory.eu>.

Acknowledgements

The Health System in Transition (HiT) profile on Hungary was co produced by the European Observatory on health Systems and Policies and Semmelweis University, which is a member of the network of National Lead Institutions that work with the Observatory on country monitoring.

The NLI network is made up of national counterparts who are highly regarded at national and international level and have particular strengths in the area of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field and their track record of successful collaboration with the Observatory to develop and update the HiT.

Semmelweis University is one of the oldest Universities in Hungary and is internationally recognized as a leading institution in Europe in the area of Medicine and Health Sciences. Its Health Services Management Training Centre (HSMTC) was officially founded in April 1995 and aims at enhancing health services management both in Hungary, in the region and on the international level. Its activities span education, consultancy and research as well as participation in many international programmes and networks.

This edition was written by Péter Gaál (Health Services Management Training Centre, Semmelweis University, Budapest), Szabolcs Szigeti (WHO Country Office, Hungary) and Márton Csere (junior fellow, Health Services Management Training Centre, Semmelweis University, Budapest). It was edited by Matthew Gaskins and Dimitra Panteli of the Observatory's team at the Department of Health Care Management, Berlin University of Technology. Research Director for the Hungarian HiT was Reinhard Busse (Department of Health Care Management, Berlin University of Technology).

This HiT draws upon the previous edition from 2004, written by Péter Gaál and edited by Annette Riesberg. The current edition benefited greatly from the insight and input of Ewout van Ginneken (Department of Health Care Management, Berlin University of Technology).

The Observatory, Semmelweis University and the authors are grateful to Róza Ádány (Head of the Department of Preventive Medicine, Dean of the Faculty of Public Health, University of Debrecen), Julianna Nagy (senior expert, National Health Insurance Fund Administration), Imre Boncz (Director, Institute for Health Insurance, University of Pécs, Hungary), Gyula Pulay (Director General, Research Institute of the Hungarian State Audit Office) and Éva Orosz (Head of the Health Policy and Health Economics Department, Faculty of Social Sciences, Eötvös Loránd University, Hungary) for reviewing the report. Thanks go to Tamás Evetovits (Senior Health Financing Specialist, WHO Regional Office for Europe) for his insightful reviews and continued cooperation.

The authors are grateful to the State Secretariat for Healthcare under the Ministry of National Resources for their assistance in providing information and for their invaluable comments on previous drafts of the manuscript and suggestions about plans and current policy options in the Hungarian health system. The authors are particularly indebted to Zoltán Vokó (Eötvös Lóránd University) and Gergely Németh (National Health Insurance Fund) for their comments on intersectorality and pharmaceutical reforms, respectively.

A particular mention is due to Zsafia Pusztai, Head of the WHO Country Office for Hungary, for her dedication to the project and her coordination of the report production process, as well as for her invaluable review of several chapters. Thanks are also extended to the WHO Regional Office for Europe for their European Health for All database from which data on health services were extracted; to the European Commission for Eurostat data on European Union (EU) Member States; to the Organisation for Economic co-operation and Development (OECD) for the data on health services in western Europe; and to the World Bank for data on health expenditure in central and eastern European countries. Thanks are also due to national statistical offices that have provided data. The HiT reflects data available in April 2011 and organizational structures as of December 2010.

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The Observatory team working on the HiT profiles is led by Josep Figueras, Director, Elias Mossialos, Martin McKee, Reinhard Busse and Suszy Lessof. The Country Monitoring programme of the Observatory and the HiT series are coordinated by Gabriele Pastorino. The production and copy-editing process was coordinated by Jonathan North, with the support of Caroline White, Sophie Richmond (copy-editing) and Steve Still (design and layout).

List of abbreviations

Abbreviations	
ALOS	Average length of stay
A&E	Accident and emergency departments
BMI	Body mass index
CAM	Complementary and alternative medicine
CARK	Central Asian Republics and Kazakhstan
CCS	Care coordination system
CÉDE	<i>Céljellegű decentralizált támogatás</i> , target-type decentralized grants
CEE	Central and Eastern Europe
CEO	Chief executive officer
CIS	Commonwealth of Independent States
CMI	Case-mix index
COPD	Chronic obstructive pulmonary disease
CT	Computed tomography
DALE	Disability-adjusted life expectancy
DDD	Defined daily dose
DRGs	Diagnosis-related groups
ECG	Electrocardiogram
ECU	European Currency Unit
EEA	European Economic Area
EHIC	European Health Insurance Card
EHIS	European Health Interview Survey
EIA	Environmental Impact Assessment
EU	European Union
EU12	12 countries that joined the EU in 2004 and 2007
EU15	15 EU Member States before May 2004
EU27	All 27 EU Member States as of 2010
EU-SILC	European Statistics of Income and Living Condition
FFS	Fee-for-service
GDP	Gross domestic product

Abbreviations	
GPMSSP	General Practitioners' Morbidity Sentinel Stations Programme
HCSO	Hungarian Central Statistical Office
HDGs	Homogeneous disease groups (Hungarian DRGs)
HFSA	Hungarian Financial Supervisory Authority
HIF	Health Insurance Fund
HISA	Health Insurance Supervisory Authority
HTA	Health technology assessment
HUF	Hungarian forint
IMF	International Monetary Fund
IT	Information technology
LAU	Local administrative units
LTNC	Long-term nursing care
MCH	Mother and child health
MRI	Magnetic resonance imaging
MSA	Medical savings account
NATO	North Atlantic Treaty Organization
NCHAI	National Centre for Health Care Audit and Inspection (no longer under this name)
NBSS	National Blood Supply Service
NCU	National Currency Unit
NGO	Non-governmental organization
NHA	National Health Accounts
NHIFA	National Health Insurance Fund Administration
NISHR	National Institute for Strategic Health Research
NPHMOS	National Public Health and Medical Officer Service
NPHP	National Public Health Plan
NPIFA	National Pension Insurance Fund Administration
NUTS	Nomenclature of Territorial Units for Statistics
OECD	Organisation for Economic Co-operation and Development
OHAAP	Office of Health Authorization and Administrative Procedures
OOP	Out-of-pocket (payment)
PET	Positron Emission Tomography
PIF	Pension Insurance Fund
PPP	Purchasing Power Parity
PPRI	Pharmaceutical Pricing and Reimbursement Information
PPS	Purchasing Power Standard
SDR	Standardized Death Rate
SDS	Alliance of Free Democrats (<i>Szabad Demokraták Szövetsége</i>)
SHI	Social health insurance
TAJ	Social Insurance Identification Number (<i>Társadalombiztosítási Azonosító Jel</i>)
VAT	Value added tax

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Abstract

Hungary has achieved a successful transition from an overly centralized, integrated Semashko-style health care system to a purchaser–provider split model with output-based payment methods. Although there have been substantial increases in life expectancy in recent years among both men and women, many health outcomes remain poor, placing Hungary among the countries with the worst health status and highest rate of avoidable mortality in the EU (life expectancy at birth trailed the EU27 average by 5.1 years in 2009). Lifestyle factors – especially the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – play a very important role in shaping the overall health of the population.

In the single-payer system, the recurrent expenditure on health services is funded primarily through compulsory, non-risk-related contributions made by eligible individuals or from the state budget. The central government has almost exclusive power to formulate strategic direction and to issue and enforce regulations regarding health care. In 2009 Hungary spent 7.4% of its gross domestic product (GDP) on health, with public expenditure accounting for 69.7% of total health spending, and with health expenditure per capita ranking slightly above the average for the new EU Member States, but considerably below the average for the EU27 in 2008. Health spending has been unstable over the years, with several waves of increases followed by longer periods of cost-containment and budget cuts. The share of total health expenditure attributable to private sources has been increasing, most of it accounted for by out-of-pocket (OOP) expenses. A substantial share of the latter can be attributed to informal payments, which are a deeply rooted characteristic of the Hungarian health system and a source of inefficiency and inequity. Voluntary health insurance, on the other hand, amounted to only 7.4% of private and 2.7% of total health expenditure in 2009. Revenue sources for health have been diversified over the past 15 years, but the current mix has yet to be tested for sustainability.

The fit between existing capacities and the health care needs of the population remains less than ideal, but improvements have been made over the past 15 years. In general, the average length of stay and hospital admission rates have decreased since 1990, as have bed occupancy rates. However, capacity for long-term nursing care in both the inpatient and outpatient setting is still considered insufficient. Hungary is currently also facing a health workforce crisis, explained by the fact that it is a net donor country with regard to health care worker migration, and health care professionals on the whole are ageing.

Although the overall technical efficiency of the system has increased considerably, mainly due to the introduction of output-based payment systems, allocative efficiency remains a problem. Considerable variations exist in service delivery both geographically and by specialization, and equity of access is far from being realized, a fact which is mirrored in differing health outcomes for different population groups. A key problem is the continuing lack of an overarching, evidence-based strategy for mobilizing resources for health, which leaves the health system vulnerable to broader economic policy objectives and makes good governance hard to achieve.

On the other hand, Hungary is a target country for cross-border health care, mainly for dental care but also for rehabilitative services, such as medical spa treatment. The health industry can thus be a potential strategic area for economic development and growth.

Executive summary

Introduction

Hungary is located in central Europe and has about 10 million inhabitants, some 1.7 million of whom live in Budapest, the country's capital. Despite strong economic growth between 2001 and 2006, Hungary was one of the countries in the region hit hardest by the global financial crisis, experiencing a 6.7% contraction in GDP in 2009. Hungary is a parliamentary democracy with a unicameral parliament and a four-year election cycle. Public administration has three levels, consisting of the central government and two tiers of local government: the counties and the municipalities. It has been a Member State of the EU since May 2004.

Despite substantial increases since the mid-1990s, life expectancy at birth in Hungary is still among the lowest in Europe, trailing the EU27 average by 5.1 years. The main causes of death are circulatory system disease, malignant neoplasms, digestive system disease and external causes – with mortality from each of these causes being higher than the EU27 average. Lifestyle factors – especially the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – play a very important role in shaping the overall health of the population. Infant mortality has decreased substantially since the 1950s but was still 20% above the EU27 average in 2009.

Organization and governance

The Hungarian constitution guarantees the right to a healthy environment, to an optimal level of physical and mental health, and to income maintenance benefits in the form of social security. It assigns overall responsibility for social welfare and health care provision to the central government, but other actors also take part in decisions related to the organization and functioning of the health system. In the single-payer system, recurrent expenditure on health services is funded

primarily through compulsory, non-risk-related contributions made by eligible individuals or by the government (from the state budget). Entitlement to benefits is based on these contributions. The contributions themselves are pooled in the Health Insurance Fund (HIF), which is administered by the National Health Insurance Fund Administration (NHIFA). The latter is the sole payer in the system. It is under the direct control of the state, has no discretion over revenue collection or budget setting, and has only limited discretion over purchasing decisions.

The central government has almost exclusive power to formulate strategic direction and to issue and enforce regulations. It exercises strict control over revenue collection, as well as in determining the benefits package, setting uniform requirements for provider reports, setting budgets, allocating financial resources, and engaging in contracting and payment.

Local governments own most hospitals and other health care facilities and are responsible for the capital cost of health services and for ensuring the provision of care. Private entrepreneurs and businesses play a central role in primary and pharmaceutical care and an increasing one in specialist care. The use of private capital in the provision of inpatient care, however, remains controversial.

To date, health policy-makers have had little success in influencing the organizational framework of other areas of public policy in order to create the appropriate organizational framework for setting intersectoral health goals. Moreover, although some efforts have been made to improve access to health services among marginalized sections of society, planned interventions to deal with health inequities within the wider framework of social determinants of health are still lacking.

Financing

The issue of health system financing has dominated the health care agenda of consecutive governments since the changeover from the communist regime. The first wave of reforms (1989–1993) transformed the system from one financed primarily through taxes to one based on compulsory health insurance. In 2009 Hungary spent 7.4% of its GDP on health, with public expenditure accounting for 69.7% of total health spending. Health spending has been unstable over the years, with several waves of increases followed by longer periods of cost-containment and budget cuts. The share of total health expenditure

attributable to private sources has been increasing, most of it accounted for by OOP expenses. Voluntary health insurance, on the other hand, amounted to only 7.4% of private and 2.7% of total health expenditure in 2009.

Public expenditure on health is financed mainly through a combination of contributions and general tax revenue transfers to the health insurance scheme. There has been increasing reliance on the latter in recent years.

Participation in the health insurance scheme is compulsory for all citizens living in Hungary, and opting out is not permitted. Based on the current legal framework, coverage should theoretically be 100%, but the health insurance status of approximately 4% of the population is unclear. The benefits package is comprehensive but not exhaustive. Both a positive and a negative list are currently in place.

A considerable and relatively stable share of OOP expenses is attributable to informal payments, which are a well-known phenomenon within the Hungarian health care system. Voluntary health insurance does not play a significant role at present and has only supplementary and complementary functions. Other sources of finance also contribute to total health expenditure, such as EU capital grants, which are invested mostly in human resource and health care infrastructure development.

The collection and pooling functions in the Hungarian health insurance scheme are separate, but there is no complicated mechanism to distribute resources from the collecting agency (the Tax Office) to the main pooling agency (the NHIFA), which is also the sole payer in the system. The NHIFA does not have much discretion over active contracting, however, because purchasing is based on a contract model and the terms of contracts are determined by the National Assembly.

The provider payment system has become output-based, and payment mechanisms are geared to the type of service provided rather than the type of institution responsible for provision. Family doctor services are paid through capitation, outpatient specialist care through a fee-for-service point system, acute inpatient services through a payment system based on diagnosis-related groups (DRGs) and chronic care through per diem rates. Special rules apply to certain services, such as emergency patient transfers. Physicians are either salaried employees or private entrepreneurs contracted by the NHIFA, whereas other health professionals are mostly paid by salary.

Physical and human resources

Hungary had 175 hospitals in 2009 with an average capacity of 470 beds and a range of 10 to 2166 beds. Although geographic inequalities at the regional level have generally decreased over the past 20 years, the fit between hospital capacity and the health care needs of the population remains less than ideal. Hospital infrastructure has suffered from a lack of public investment in the refurbishment of buildings and equipment. In general, health care investments have been poorly coordinated and guided by local economic interests rather than by the health needs of the population.

In 2009, local governments owned 78% of all hospital beds, almost 20% of which were in Budapest. Hungary has followed the general European trend of reducing the number of acute hospital beds, both through real reductions and through bed reallocations to different types of services. The capacity for long-term nursing care in both the inpatient and outpatient setting is still considered insufficient and thus unable to meet the needs of the ageing population. In general, the average length of stay and hospital admission rates have decreased since 1990, as have bed occupancy rates.

With regard to human resources in the health care sector, Hungary had 3.1 active physicians per 1000 population in 2008. The number of physicians has dropped substantially since 2003, and increased professional mobility may lead to a further decline in this ratio in the near future. Physicians are unevenly distributed, both in terms of geography and specialties. A similar trend can be observed for the allied health care personnel. Given that (a) Hungary is also a net donor country with regard to health care worker migration and (b) health care personnel are ageing on the whole, the current health workforce crisis is easily explained.

The salaries of health professionals, especially of physicians, have remained low compared to those in other sectors of the economy and in western Europe. The practice of informal payments continues to be widespread, but these are not evenly distributed among health professionals.

Provision of services

Health care delivery is based on the constitutional obligation of the state to make health services available to all eligible residents. At the heart of the system lies the territorial supply obligation, which divides responsibility for

service delivery among local governments according to geographical areas and levels of care: municipalities are responsible for providing primary care and county governments are responsible for providing specialist health care services within their respective jurisdictions.

Public health services in Hungary fall within the remit of the central government, in particular the Ministry of National Resources, which provides these services through the National Public Health and Medical Officer Service (NPHMOS). The NPHMOS is responsible for public health; social medicine and health administration; supervising health service delivery; monitoring and evaluating sanitary conditions, epidemiological issues and changes in the population's health status; and for health promotion and prevention.

Municipalities are responsible for primary health care, including family doctor services (through family physicians and family paediatricians), dental care, out-of-hours surgery services, mother and child health (MCH) nurse services and school health services. The gatekeeping function of family doctors is neither exclusive (some specialist services can be accessed without referral) nor particularly successful. The provision of secondary and tertiary care is shared among municipalities, counties, the central government and private providers. The various providers engage in a wide range of activities depending on the level of care, the number of specialties covered and the type of care. Hungary had 11.95 outpatient visits per person per year in 2009, placing it third among the countries of central and south-eastern Europe after Slovakia and the Czech Republic.

The principle behind inpatient health care delivery is that patients must receive care at the lowest level of specialization that can provide adequate treatment, and may be transferred to hospitals with higher levels of specialization only if necessary. Avoiding unnecessary hospitalization has been recognized as a means of improving efficiency, and day care has been fostered through a number of regulations, especially over the past 15 years. Emergency care is built around primary care (family doctors, out-of-hours services), polyclinics, inpatient care facilities (night duty), the National Emergency Ambulance Service, and the Accident and Emergency (A&E) departments of hospitals at different levels of specialization.

There are four different types of pharmacies responsible for pharmaceutical care, all of which need NPHMOS authorization and are run under the personal responsibility of the pharmacist. In principle, every physician and dentist is entitled to prescribe pharmaceuticals. The cost of selected pharmaceuticals is covered by the health insurance scheme, but the type and extent of

reimbursement varies. Products submitted for inclusion in the reimbursement list are evaluated according to a variety of criteria, including health policy considerations and cost-effectiveness. The price of medicinal products is determined by the market.

Medical rehabilitation is underfunded and short-staffed, and access to services is subject to substantial regional disparities. Long-term care is provided by both the health and the social sectors. Local governments are responsible for providing social care, which takes the form of cash and in-kind benefits provided mostly to impoverished individuals and those with disabilities. Palliative care is still in its infancy. The importance of informal carers, who in some cases are eligible for financial assistance, has been recognized. Mental health care is integrated into the main health and social care system, both organizationally and in terms of financing. Chronic outpatient care is provided by dispensaries, while inpatient care can also take place on a daytime hospital basis. Most dental services are available free of charge and are divided into primary care, specialist or out-of-hours services. Dental care is an area of health care in which private provision is predominant. Hungary is also a target country for over 40% of all dental tourism in Europe.

Recent health care reforms

A variety of reforms have been implemented and attempted since the previous HiT profile on Hungary was published in 2004, with varying success. The most important of these aimed to reshape the stewardship and organization of the health care system in several ways, such as by strengthening the care coordination system; introducing new ways to regulate the capacities of providers; supporting the corporatization and outsourcing of public providers; encouraging intersectoral cooperation to implement the National Public Health Programme (NPHP); introducing managed competition to the health insurance system by replacing the NHIFA/HIF with multiple health insurers under partial private ownership; and setting up the Health Insurance Supervisory Authority (HISA). Despite extensive government efforts to push forward these measures most of the reforms did not meet their stated objectives.

Since 2004, cost-containment has remained the dominant health policy objective, and public expenditure on health has declined substantially, falling to 5.2% of GDP in 2009. This, in turn, has had a direct impact on the growing human resource crisis in the health system. Regarding revenue collection, successive governments since 2004 have failed to formulate an overall policy

framework that might mobilize a stable and predictable flow of resources for the health system. This is arguably the most serious shortcoming of the Hungarian health system today. The funding of the health system is strongly influenced by policy goals not directly related to health, such as labour and broader economic policy objectives.

Looking back at the recent health reforms, transparent, evidence-based policy-making often played a limited role in the area of health policy in several important respects. Major reforms have usually not been supported by detailed policy instruments, such as discussion papers, strategies, action plans or impact assessments. At the same time, mechanisms allowing stakeholders to take part in the decision-making process in a timely and transparent manner have been lacking.

Assessment of the health system

In Hungary the objectives of the health system are either set explicitly in various laws, regulations and policy documents, or implicitly by the actions taken by the government. They mostly revolve around the protection and promotion of patient rights, the assurance of equal access to services for equal need, the provision of evidence-based, effective services and the achievement of system efficiency.

Very few households experienced catastrophic or impoverishing health expenditure between 2003 and 2007. At the same time, avoidance and evasion have been a persistent problem, especially in the health care system. Combined, unpaid health and pension insurance contributions amounted to almost 1% of GDP in 2008. A study conducted in 2002 found that the taxes and social insurance contributions used to finance the health care system were, on the whole, mildly regressive.

Residents of Hungary are generally dissatisfied with their health system, and Hungary ranked 26th among the 27 EU Member States in 2009 in terms of population satisfaction. Large variations exist in service delivery, both geographically and by specialization, and equity of access is far from being realized. This is also mirrored in differing health outcomes for different population groups. Overall, life expectancy at birth is relatively low and avoidable mortality rates are high.

Attempts to improve the efficiency of the health system have centred mostly on payment reforms over the past 20 years. The introduction of output-based payment methods led to substantial improvements in the technical efficiency of the system – at least within particular levels of care – and potentially paved the way for an increase in allocative efficiency by freeing resources for reallocation, although this has yet to be assessed. However, allocative efficiency in the health care system is still problematic, something that cannot be addressed by adjusting the payment system alone. Remaining issues with efficiency include the overtreatment, DRG-creep and point inflation induced by the current system, as well as the use of ineffective or obsolete technologies, parallel service provision and the medicalization of social problems. Initiatives to tackle these issues, such as the Care Coordination System (CCS), have been implemented with varying degrees of success.

Transparency and accountability in the health care system are unevenly developed for different areas of service provision and for different actors. A comprehensive system for monitoring performance has not been established, with the exception perhaps of that related to expenditure. Responsibilities for ensuring equity are not clearly defined and are limited to waiting lists, and the quality of care is controlled for the most part indirectly. Although a range of initiatives have been developed to measure and track the quality of care using quality indicators, these have yet to be implemented in a systematic fashion. A professional supervisory system maintained by the National Centre for Healthcare Audit and Inspection was created in 2005 based on the principles and practice of clinical audit.

Conclusions

Since the mid-1990s, Hungary has seen substantial increases in life expectancy among both men and women. Nevertheless, many health outcomes remain poor, placing Hungary among the countries in Europe with the worst health status. Prevention and health promotion are underfunded, their organization underdeveloped and the activities of the NPHP have been substantially curtailed in recent years. Intersectoral activities are poorly coordinated, and growing inequities have yet to be addressed in an appropriate manner. Some indicators of avoidable mortality, however, paint a more positive picture, as does Hungary's excellent immunization record, with virtually 100% coverage against childhood diseases.

Hungary has achieved a successful transition from an overly centralized, integrated Semashko-style health care system to a purchaser-provider split model with new payment methods that have created incentives to improve technical efficiency. Hungary's unique patient identification system, which provides patient-level information on pharmaceutical consumption and the use of specialist inpatient and outpatient services represents a rich, integrated data set whose potential has yet to be fully realized in academic research and health policy decision-making.

Stewardship of the single-payer health insurance system has become increasingly blurred. The governance structure of the HIF has gone through a series of changes that have increased direct central control, reduced stakeholder participation and exposed the system to political pressure, thus leading to less transparent and unpredictable funding arrangements. Although large-scale and strategic reform initiatives addressing the stewardship function of the system have failed in most cases, there have been several useful technical improvements, especially in the area of health financing. Examples include the successful introduction of health technology assessment (HTA) and the creation of incentives to increase generic competition.

Health care reforms have also been unable to address increasing problems related to allocative efficiency, even though technical efficiency has improved over time. Ensuring appropriate incentives to increase efficiency in patient pathways has been addressed by successive governments. The CCS (introduced as a pilot programme in 1999) had many innovative features and provided a country-specific response to the problem of allocative efficiency, but was eliminated in 2008 without a full scientific evaluation.

A key problem is the continuing lack of an overarching, evidence-based strategy for mobilizing resources for health. Without this, the health system remains vulnerable to broader economic policy objectives. A diversification of revenue sources for health seems to be developing along with a recent strategic policy on taxation, but it remains to be seen whether the mix of insurance contributions and budget transfers from general taxation will provide a stable funding arrangement.

Two further challenges the government faces in achieving a more efficient and more equitable service delivery system are to reorganize existing capacities based on health needs assessment and to tackle informal payments. At the same time, several existing initiatives could provide substantial improvements if they are expanded upon and refined. New information systems have made the health care system more transparent and accountable. Although attempts

have been made to measure the quality of care using various quality indicators, these have yet to be implemented in a systematic fashion. Good governance, however, would require more evidence-based and transparent policy-making, performance-monitoring and accountability at the health policy level.

Finally, Hungary is a target country for cross-border health care, mainly for dental care but also for rehabilitative services, such as medical spa treatment. The health industry is thus seen by the government as a potential strategic area for economic development and growth.

1. Introduction

1.1 Geography and sociodemography

Located in the Carpathian Basin in central Europe, Hungary covers an area of 93 000 km², more than half of which consists of lowlands surrounded by mountain ridges and hills. The Danube River, the Tisza River and Lake Balaton – the biggest freshwater lake in central Europe – are the country's main sources of water (HCSO, 2009a). Hungary is bordered to the north by Slovakia, to the east by Ukraine and Romania, to the south by Serbia and Croatia, and to the west by Slovenia and Austria (Fig. 1.1).

Fig. 1.1

Map of Hungary



Source: Authors' own compilation.

In December 2010, Hungary had just under 10 million inhabitants, some 99% of whom held Hungarian citizenship (HCSO, 2011a). Roughly 5 million ethnic Hungarians live outside of the country's borders, having left the country during several waves of emigration (such as after the First and Second World Wars, or after the 1956 revolution against communist rule) or else because they live in areas that were located within the territory of Hungary before the 1920 Treaty of Trianon.

According to the most recent census, 3.1% of the population in 2001 considered themselves to be members of a national minority group. The largest of these groups, the Roma community, was estimated to number 190 000 individuals (HCSO, 2009a), but other data suggest a total that is two to three times higher (Hablicsek, 2009). Of the 89% of the population that provided information about religious affiliation, 58% considered themselves to be Roman Catholic, 18% Calvinist, 3.5% Lutheran and 3% Greek Catholic; 17.5% of respondents had a different or no religious affiliation (HCSO, 2009a). The official language, Hungarian, is part of the Finno-Ugric language group.

Almost half of the country's population lives in communities of less than 20 000 inhabitants. In 2010, Hungary had 24 large cities, 304 medium and smaller-sized towns, and 2824 villages. A total of 1.7 million people live in Budapest, the country's capital (HCSO, 2010b).

The population of Hungary has been decreasing since the 1980s, mainly because the birth rate has remained below the mortality rate since 1981. The share of people 65 years of age or older has been increasing steadily, accompanied by a decrease in the share of those 14 years old and younger (Table 1.1).

1.2 Economic context

Between 2001 and 2006, the Hungarian economy grew at an annual rate of more than 4%, which resulted in a positive output gap. This was accompanied by sharp fluctuations in the fiscal deficit, which reached a peak of 9.2% of GDP in 2006. Surprisingly, the economic growth during these years did not have a substantial impact on the employment rate, which stagnated at around 57% between 2000 and 2008 for individuals between 15 and 64 years of age. Within the EU27, only Malta had a lower rate of employment in this age group in 2008 (HCSO, 2011b).

Table 1.1

Main population/demographic indicators, 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
Population on 1 January, total (thousands)	10 709	10 375	10 337	10 222	10 098	10 031
Population on 1 January, female (% of total)	51.6	52.0	52.2	52.4	52.5	52.5
Population aged 0–14 years (% of total)	21.9	20.5	18.3	16.9	15.6	14.9
Population aged 65 years and more (% of total)	13.5	13.2	14.1	15.0	15.6	16.4
Population aged 80 years and more (% of total)	2.0	2.5	2.9	2.5	3.3	3.8
Population growth (crude rate of natural increase)	0.3	-1.9	-3.2	-3.7	-3.8	-3.4 ^c
Population density (people per km ²) ^a	115.1	111.5	111.0	109.9	108.5	107.8
Fertility rate, total (births per woman)	1.9	1.9	1.6	1.3	1.3	1.3
Crude birth rate (per 1 000 population)	13.9	12.1	10.8	9.6	9.7	9.6 ^c
Crude death rate (per 1 000 population)	13.6	14.0	14.1	13.3	13.5	13.0 ^c
Age dependency ratio (population aged 0–14 years and 65+ years to population aged 15–64 years)	54.8	51.0	47.9	46.8	45.5	45.4
Distribution of population (% urban) ^a	57.0	61.8	62.8	63.6	66.1	68.4
Single-person households (% of total) ^a	19.6	24.3	n/a	26.2 ^b	29.1	n/a
Population aged 25–64 years with at least a secondary-school qualification (% of total) ^a	n/a	n/a	n/a	69.4	76.4	80.6

Sources: European Commission, 2011; ^a Unpublished data from HCSO, 2011.Notes: ^b Data from 2001; ^c Provisional value; n/a: Not available.

The coalition between the Hungarian Socialist Party (*Magyar Szocialista Párt*) and the Alliance of Free Democrats (*Szabad Demokraták Szövetsége*), which was in power between 2002 and 2008, introduced several strict austerity measures as of 2006 to improve the budget situation, cutting government investment and public service expenditure. The minority government formed by the Hungarian Socialist Party between 2008 and 2010 continued along these lines. Between 2007 and 2009, these measures and, subsequently, the global financial crisis led to a sharp drop in economic growth, which fell from 3.2% in 2005 to 0.8% in 2008 and subsequently to -6.7% in 2009, representing the deepest recession in Hungary since 1989. At the same time, the unemployment rate increased to 10% in 2009, with public debt amounting to 78.4% of GDP (Table 1.2).

Hungary was one of the countries in the region hit hardest by the global financial crisis, experiencing a complete freeze in the government bond market from late 2008 to early 2009, and an average depreciation of some 30% in the Hungarian forint (HUF) against the major currencies by March 2009 (European Commission, 2010). The latter had a devastating effect on the thousands of households with mortgages denominated in foreign currencies, especially Swiss francs. In mid-2010, 23% of mortgage accounts were in arrears by more than 90 days, and 8.2% – equivalent to more than 2% of GDP – had gone into default (HFSA, 2010).

Table 1.2

Macroeconomic indicators, 1995–2009 (selected years)

	1995	2000	2005	2008	2009
GDP at market prices (million €)	34 922	51 411	88 574	106 373	92 942
GDP at market prices (in millions of PPS)	78 170	107 763	143 073	162 142	153 161
GDP at market prices (per inhabitant, €)	3 400	5 000	8 800	10 600	9 300
GDP at market prices (PPS per inhabitant)	7 600	10 600	14 200	16 300	14 800
Real GDP growth rate (%)	0.7 ^a	4.9	3.2	0.8	-6.7
Total general government expenditure (% of GDP)	55.7	46.8	50.2	48.8	50.5
Net lending (+)/net borrowing (-) (% of GDP)	-8.7	-3.0	-7.9	-3.7	-4.4
Total receipts from taxes and social contributions (% of GDP)	40.9	39.0	37.6	40.1	39.6
Government consolidated gross debt (% of GDP)	85.2	55.0	61.8	72.3	78.4
Industry, value added (% of GDP) ^a	32.3	32.2	30.2	29.5	n/a
Agriculture, value added (% of GDP) ^a	7.1	5.4	4.2	4.3	n/a
Services, etc., value added (% of GDP) ^a	60.6	62.4	65.6	66.2	n/a
Labour force (total) ^a	4 175 464	4 162 578	4 268 262	4 268 267	n/a
Unemployment rate (% of labour force)	9.6 ^a	6.4	7.2	7.8	10.0
At-risk-of-poverty rate	n/a	11.0%	13.5%	12.4%	12.4%
Gini coefficient	n/a	26.0	27.6	25.2	24.7
Central bank interest rate (official deposit rate), annual	19.0	9.8	5.0	9.5	5.3
Euro/ECU exchange rate (HUF)	164.6	260.0	248.1	251.5	280.3

Source: European Commission, 2011.

Notes: ^aData from 1996; ECU: European currency unit; HUF: Hungarian forint; PPS: Purchasing power standard; n/a: Not available.

In the second half of 2008, Hungary was among the first wave of countries seeking international assistance. Stand-by loans from the International Monetary Fund (IMF), the EU and the World Bank totalling some €20 billion helped the country avert economic collapse. The government's crisis management programme included an increase in value added tax (VAT) from 20% to 25% and major cuts in the pension and welfare systems, such as eliminating 13th month pension payments as of 1 July 2009; increasing the retirement age; reducing the general sick pay rate; freezing social benefit levels; reducing public transport subsidies; and eliminating energy subsidies for homeowners. Pledging to reduce the budget deficit was a key condition for receiving the bail-out package. In total, 1.4% of GDP was cut from the central budget between February and May of 2009 (Government of the Republic of Hungary, 2010c), and additional cuts amounting to 2% of GDP have been scheduled for 2010 (European Commission, 2010).

According to the *TÁRKI European Social Report*, Hungary was one of a large number of nations in the EU in 2005 with a Gini index above 25% but below 30%, placing it squarely between low-inequality countries such as the Nordic states or Luxembourg and high-inequality countries such as the Baltic states,

Poland, Greece and Portugal (Tóth, 2008). In 2009, Eurostat data show that the Gini index in Hungary was 24.7%, which was lower than the EU27 (30.4%), EU12 (30.7%) and EU15 (30.3%) averages (European Commission, 2011).

1.3 Political context

After more than 40 years within the sphere of influence of the USSR, Hungary regained its full sovereignty and declared itself an independent republic on 23 October 1989. Since then, the country has had a stable political system with organized political parties and coalition governments.

In Hungary, executive, legislative and judicial duties are carried out within the framework of a parliamentary democracy. Known as the National Assembly (*Országgyűlés*), the unicameral parliament has 386 seats and a four-year election cycle. The electoral system combines majority and proportional systems. Citizens choose candidates (in 176 single-candidate constituencies) and also cast their votes for a political party under a proportional voting system. The prime minister is head of government; he or she is nominated by the President and elected by a majority of votes in the National Assembly. The President, who has a largely ceremonial role, is elected by the National Assembly every five years.

Over the past 20 years, four main political parties have been typically represented in parliament: the Fidesz–Hungarian Civic Union (*FIDESZ–Magyar Polgári Szövetség*), the Hungarian Socialist Party, the Hungarian Democratic Forum (*Magyar Demokrata Fórum*) and the Alliance of Free Democrats. The most recent election, in April 2010, brought significant changes, however. After eight years of governing coalitions led by the Hungarian Socialist Party, the Fidesz–Hungarian Civic Union together with the Christian Democratic People's Party (*Keresztény Demokrata Néppárt*) secured, with 263 seats, a two-thirds majority in parliament. Whereas the Hungarian Democratic Forum and the Alliance of Free Democrats failed to win enough votes to pass the election threshold, two new parties appeared: the radical right-wing Jobbik party (*Jobbik Magyarországért Mozgalom*) with 47 seats, and a liberal green party known as Politics Can Be Different (*Lehet Más a Politika*) with 16 seats.

Public administration has three levels, consisting of the central government and two tiers of local government: the counties and the municipalities. Local government elections are held a few months after the general election. Policy-making at the national level establishes the framework within which the

decision-making of local governments takes place. The Hungarian constitution guarantees the right of local governments to take decisions on local affairs; disputes over authority between the central and local governments can be settled by the Constitutional Court (1989/4)¹.

The territory of Hungary is divided into 19 counties, each covering a population between 200 000 and 1 000 000 (HCSO, 2009a). Since 1996 the country has also been divided into seven larger units, the so-called regions, each of which consists of three counties, except for the region of Central Hungary (Budapest and Pest County). For the most part, the regions have served mere planning and statistical functions for regional development (1999/10), but starting in 2006, some government institutions that had county offices were reorganized on a regional basis. An example is the NPHMOS (*Állami Népegészségügyi és Tisztiorvosi Szolgálat*). Under the government elected in April 2010, however, the regions are unlikely to occupy a central role in the reorganization of public administration. Indeed, many functions of the central government are currently being integrated into central government offices at the county level.

The decision-making process at the central and local levels is open to input from various stakeholders. The interests of workers are represented by six main trade unions, the two most influential of which are the National Coalition of Trade Unions (*Magyar Szakszervezetek Országos Szövetsége*) and the Democratic League of Independent Trade Unions (*Független Szakszervezetek Demokratikus Ligája*).

Hungary became a full member of the United Nations in 1955, the Council of Europe in 1990, the World Trade Organization in 1995, the OECD in 1996 and the North Atlantic Treaty Organization (NATO) in 1999. It was in the first wave of pre-accession countries that started negotiations with the European Commission in 1998, and Hungary became a full member of the EU in May 2004. In January 2011 Hungary assumed the Presidency of the Council of the EU for the first half of that year.

¹ The laws and regulations in this document are referred to by the year of enactment and by an Arabic number, which is not the official number of the law, but corresponds to the numbers used in section 9.1 *Laws and regulations in chronological order*. In that section, laws and regulations are grouped chronologically according to years. Important acts are mentioned in the text by their name, the year of enactment and by their official (Roman) number.

1.4 Health status

Since the end of the Second World War, the health status of the Hungarian population has passed through four main phases. The first phase, which lasted until the mid-1960s, saw major advances, with life expectancy at birth reaching levels comparable to those seen in the more developed western European countries for both men and women. Coupled with improvements in the socioeconomic situation of the population, the early public health efforts of the communist regime, including widespread immunization programmes, succeeded in bringing communicable diseases under control.

During the second phase, which lasted from the mid-1960s until the late 1980s, mortality from non-communicable diseases came to play a larger role, leading to an increasing health gap between Hungary and western Europe. Whereas life expectancy at birth continuously improved in western European countries during this period, it levelled off in Hungary (Table 1.3), increasing slightly for women (from 72.2 years in 1970 to 74.0 years in 1989) and, despite a slight upswing between 1985 and 1988, decreasing on the whole for men (from 66.4 years in 1970 to 65.5 years in 1989) (WHO Regional Office for Europe, 2010). Importantly, this decline in male life expectancy would have been more pronounced if continuing improvements in infant mortality had not counterbalanced the rise in adult mortality among men during this time. Similar trends were seen over this period in other EU12 countries, such as the Baltic states, but not in the Czech Republic or Slovenia (WHO Regional Office for Europe, 2010).

Starting in 1989, there was a clear decline in health status, further widening the gap between Hungary and the EU. This marked the beginning of a third phase, which lasted until the mid-1990s. Among men, life expectancy at birth decreased in Hungary by more than a year and a half between 1988 and 1993 while steadily increasing in the EU as a whole (WHO Regional Office for Europe, 2010). This decline was unique in central Europe in this period (Ádány, 2008). Among women, life expectancy at birth plateaued after 1989, showing virtually no change over the next four years. During this time, the gap also widened in relation to Poland and especially the Czech Republic, where the effects of the transition period were less marked and the socioeconomic recovery had begun sooner (WHO Regional Office for Europe, 2010).

The fourth phase started in the mid-1990s and has lasted until the present day. During this time, Hungary has seen a strong and steady increase in life expectancy at birth among men and women alike (see Table 1.3). Half of this

increase has been attributed to a decrease in cardiovascular mortality over the same period. Indeed, after three decades of decline in population health status due to non-communicable diseases, this turnaround was interpreted as the beginning of a new era in population health (Józan, 2009). Some researchers are sceptical of this view and have pointed out that the gap in life expectancy at birth between Hungary and neighbouring Austria, the other Visegrád Group countries and the EU15 average has remained essentially unchanged for women and narrowed only somewhat for men over this period (Széles et al., 2005). Moreover, since the mid-1990s, mortality due to ischaemic heart disease in individuals younger than 65 years in Hungary has actually increased relative to the EU15 and Visegrád Group averages (Széles et al., 2005). Finally, compared to the EU15 average, the relative risk of mortality from cardiovascular disease, malignant neoplasms and respiratory disease among both women and men of all ages has continued to rise (Ádány, 2008).

Table 1.3

Mortality and health indicators, 1970–2009 (selected years)

	1970	1980	1990	1995	2000	2005	2009
Life expectancy at birth, total (years)	69.3	69.1	69.5	70.1	71.9	73.0	74.5
Life expectancy at birth, male (years)	66.4	65.5	65.2	65.5	67.6	68.8	70.3
Life expectancy at birth, female (years)	72.2	72.8	73.9	74.8	76.3	77.2	78.5
Crude death rate per 1 000 population, total	11.6	13.6	14.0	14.1	13.3	13.5	13.0
Crude death rate per 1 000 population, male	12.5	14.8	15.4	15.7	14.5	14.6	13.9
Crude death rate per 1 000 population, female	10.8	12.4	12.8	12.6	12.2	12.5	12.1

Source: WHO Regional Office for Europe, 2010.

In short, Hungary still ranks among the lowest in Europe with regard to life expectancy at birth, trailing the EU27 average by 5.1 years and the EU15 average by 6.3 years in 2009. When taking the overall disease burden into account, this gap persists, with disability-adjusted life expectancy (DALE) in Hungary reaching 65.8 years in 2007 (Table 1.4) compared to 73.0 years in the EU15, 71.7 years in the EU27, 71.3 years in Slovenia, 69.9 years in the Czech Republic, and 67.1 years in Poland (WHO Regional Office for Europe, 2010).

Table 1.4

DALE in years, 2000–2007 (selected years)

	2000	2001	2002	2007
Male	57.9	58.0	61.5	62.3
Female	65.4	65.5	68.2	69.3
Total	61.6	61.8	64.9	65.8

Source: WHO Regional Office for Europe, 2010.

As can be seen in Table 1.5, the main causes of death in Hungary are diseases of the circulatory system, malignant neoplasms, diseases of the digestive system (including liver disease) and external causes (including suicide). This pattern has remained essentially unchanged since 2000, and mortality from each of these causes continues to be higher than for the EU27 and, in the case of malignant neoplasms and digestive system disease, the EU12 and WHO European Region averages (WHO Regional Office for Europe, 2010).

Table 1.5

Main causes of death (SDR, all ages, per 100 000), 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
<i>Communicable diseases</i>						
<i>Infectious and parasitic disease</i>	13.4	8.5	7.2	5.6	4.1	3.8
Tuberculosis	10.9	6.1	5.5	3.3	2.1	1.4
HIV/AIDS ^a	n/a	n/a	0.1	0.2	0.1	0.1
<i>Noncommunicable diseases</i>						
<i>Diseases of circulatory system</i>	688.7	643.9	592.0	521.0	502.4	421.2
Ischaemic heart disease	229.4	239.7	248.7	226.9	261.3	214.8
Cerebrovascular disease	218.0	177.2	158.6	141.7	108.2	90.8
<i>Malignant neoplasms</i>	239.9	266.7	276.2	268.2	237.4	243.2
Trachea/bronchus/lung cancer	44.5	61.2	65.0	65.0	60.8	65.9
Breast cancer (female)	29.0	32.2	32.7	32.5	27.4	28.1
Cervical cancer	11.0	9.6	8.4	7.3	6.5	5.9
<i>Diseases of the digestive system</i>	62.9	81.4	106.4	87.0	70.6	65.6
Chronic liver disease and cirrhosis	27.4	50.6	79.0	60.1	44.5	41.3
<i>Diseases of the respiratory system</i>	89.4	57.1	52.5	40.3	47.7	44.3
<i>Mental disorders and diseases of the nervous system and sensory organs</i>	12.1	19.4	25.5	22.2	22.3	29.6
Diabetes	16.9	16.2	14.8	17.3	25.6	17.9
<i>External causes</i>						
<i>External cause injury and poison</i>	114.3	121.1	100.9	82.2	67.9	59.0
Suicide and self-inflicted injury	44.4	38.1	30.5	29.2	23.2	21.8
Motor vehicle traffic accidents	15.8	24.4	16.2	12.0	12.1	8.5

Sources: WHO Regional Office for Europe, 2010; ^a European Commission, 2011.

Notes: SDR: Standardized death rate; n/a: Not available.

Overall, mortality from circulatory system disease in Hungary has been on the decline among both men and women since the mid-1980s, closely following the trend seen in other EU12 countries. Nevertheless, in 2009 the rate in Hungary was almost twice as high as the EU27 average (421.2 vs. 234.5 deaths per 100 000 population). This is in large part attributable to deaths from ischaemic heart disease, which were two and half times more common in Hungary than in the EU27 as a whole in 2009. In fact, among women, mortality from ischaemic heart disease actually increased for much of the 1990s and has shown a clear downward trend only since 2005 (WHO Regional Office for Europe, 2010).

In 2009 Hungary had the highest rate of mortality from malignant neoplasms in the entire WHO European Region. After rising steadily between the 1970s and early 1990s, the rate has plateaued ever since. Although mortality data show a substantial decrease from 2004 to 2005 (WHO Regional Office for Europe, 2010), this may be more the result of changes in death certification and coding practices (e.g. the implementation of a more rigorous validation system) than a reflection of any real phenomenon. Among individuals aged from 25 to 64 years, malignant neoplasms were the dominant cause of mortality for woman and the second most important cause of mortality among men between 2005 and 2007 (Ádány, 2008). A notable exception to these trends is cervical cancer mortality, which – though still well above the EU27 and EU15 averages – has declined rapidly since the early 1980s and has remained below the EU12 average since at least 1990. Another exception, albeit negative, is lung cancer mortality among women, which has risen steadily since 1970 and, at 37.5 cases per 100 000 population, was almost twice as high as the EU27, EU 12 and EU15 averages in 2009 (WHO Regional Office for Europe, 2010). Since 2002, lung cancer has been the most frequent cause of cancer death among women (Ádány, 2008).

Mortality from diseases of the digestive system (including chronic liver disease and cirrhosis) has decreased strongly among men and women in Hungary since peaking in the mid-1990s, when it was more than twice the EU12 average. Despite this positive development, mortality from these causes is still much too high; indeed, in 2009, Hungary had the third-highest rate of death from digestive system disease in the WHO European Region (among countries for which data were available), ranking only after Kyrgyzstan and Romania (WHO Regional Office for Europe, 2010).

Deaths due to external causes have decreased, for the most part, since at least the early 1990s. Although suicide rates in Hungary have been part of this favourable trend, they were still more than twice as high as the EU27 average

and one and a half times higher than the EU12 average in 2009. Motor vehicle traffic accidents, on the other hand, were only slightly higher than the EU27 average in 2009, and well below the average for the EU12 (WHO Regional Office for Europe, 2010).

Communicable diseases play a subordinate role in Hungary, with the incidence and mortality rates for most childhood infectious diseases continuing to be lower than the EU12 average (WHO Regional Office for Europe, 2010) and the mortality rates for viral hepatitis and HIV remaining lower than the EU15 average (European Commission, 2011).

Lifestyle factors – especially the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – still play a very important role in shaping the overall health of the population. According to the European Health Interview Survey (EHIS) conducted in 2009, 21.5% of male respondents and 18.9% of female respondents reported that they were obese (BMI ≥ 30) and 39.4% and 31.1%, respectively, reported that they were overweight (BMI ≥ 25 and < 30) (HCSO, 2010e).

With a 12.5 litre per-capita consumption rate for pure alcohol in 2005 among individuals over the age of 15 (Table 1.6), Hungary ranked among the countries with the highest rate in the entire EU27. This statistic is backed up by the findings of the 2009 EHIS, in which 4.6% of those who completed the survey – or some 8.3% of all male and 1% of all female respondents – reported being heavy drinkers (HCSO, 2010e). The consumption of illegally distilled homemade spirits represents an additional risk factor for the development of alcohol-induced cirrhosis and may contribute to the high level of cirrhosis mortality in Hungary (Szucs et al., 2005).

Table 1.6

Factors affecting health status, 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
Regular daily smokers in the population, age 15+ years (%)	n/a	44.0 ^c	37.0	30.2	30.4 ^d	31.4
SDR, selected smoking-related causes per 100 000 population	566.24	536.76	531.08	489.53	490.5	427.8
Pure alcohol consumption, litres per capita, age 15+ years	15.0	13.9	12.2	12.5	12.5	n/a
SDR, selected alcohol-related causes per 100 000 population	185.23	229.89	237.26	159.86	129.47	114.42
Number of registered alcoholics per 100 000 population	466.3 ^a	621.0 ^a	n/a	414.4 ^b	326.4 ^b	150.5 ^b

Sources: WHO Regional Office for Europe, 2010; ^a HCSO, 2007; ^b HCSO, 2010c.

Notes: ^c Data from 1992; ^d Data from 2003; n/a: Not available; SDR: Standardized death rate.

In 2009, an estimated 31.4% of the population in Hungary aged 15 years and above were regular daily smokers. Between 2000 and 2009, the share of daily smokers among both men and women decreased in all age groups except for people 65 years of age or older in the total population and for women aged 35 to 64 years. Importantly, the share of the heavy smokers (defined as someone who smokes 20 or more cigarettes per day) reportedly decreased from 66% to 46% among men, and from 43% to 24% among women between 1994 and 2009 in those aged 15 to 64 years (HCSO, 2010e).

In 2009 the death rate from causes related to alcohol and smoking was almost twice as high as the EU27 average and substantially higher than the EU12 average (WHO Regional Office for Europe, 2010).

The European Statistics of Income and Living Condition (EU-SILC) survey regularly assesses the self-reported health status of the population in the EU. In 2008, 19.2% of respondents in Hungary reported that their health status was “bad” or “very bad”, compared to 9.5% in the EU27 as a whole. Conversely, the share of respondents reporting that their health status was “good” or “very good” was 55.2% in Hungary versus 68% in the EU27. There was a marked difference in self-reported health status between men and women in Hungary, with 58.9% of men compared to 52% of women reporting that their health status was “good” or “very good”, and 17% of men compared to 20.1% of women reporting that their health status was “bad” or “very bad” (European Commission, 2011).

An important source of morbidity data in Hungary is the General Practitioners’ Morbidity Sentinel Stations Programme (GPMSSP), a joint initiative of the Faculty of Public Health at the University of Debrecen (*Debreceni Egyetem Orvos- és Egészségügyi Centrum Népegészségügyi Iskola*) and the NPHMOS. As part of the programme, participating family doctor practices use standardized protocols to report data continuously on the prevalence of cardiovascular disease, diabetes mellitus, cirrhosis and some forms of malignant neoplasms (Széles et al., 2005).

Table 1.7 shows selected findings of the GPMSSP for 2009. Hypertension and diabetes mellitus are clearly important sources of disease burden in the Hungarian population. Moreover, looking at men and women separately reveals that acute myocardial infarction was almost twice as common – and chronic liver disease almost four times as common – among men as among women in 2009. Other data from the GPMSSP show that the prevalence of chronic liver disease was especially high in men aged 35 years and above (University of Debrecen, unpublished data from the General Practitioners’ Morbidity Sentinel Stations Programme, 2011).

Table 1.7

Prevalence of selected noncommunicable diseases in Hungary, 2009
(adults aged 20+ years, per 1000 population)

	Hypertension	Diabetes mellitus	Chronic liver disease	Acute myocardial infarction	Stroke
Men	273.0	74.0	13.2	12.5	20.4
Women	339.7	73.5	3.5	6.9	17.0
Total	308.9	73.7	8.0	9.5	18.6

Source: Unpublished data from the General Practitioners' Morbidity Sentinel Stations Programme, Faculty of Public Health, University of Debrecen, 2011.

The results of the EHIS also provide an interesting picture of health status in Hungary, albeit one limited by the shortcomings of self-reported data. As can be seen in Table 1.8, the results of the survey indicate that Hungary had the highest share of respondents among all comparator countries for each of the selected diseases with the exception of asthma. Table 1.9 shows the share of respondents in Hungary, broken down according to age group, who in 2009 reported that they had been diagnosed with one or more diseases over the past 12 months. All self-reported statements on disease prevalence were followed up in the survey by a question asking whether the disease or condition had been diagnosed by a physician.

Table 1.8

Share (%) of EHIS respondents in Hungary and available comparator countries reporting to have been diagnosed with one or more diseases (ICD-10) during the past 12 months, 2009

	Diabetes mellitus	Depressive disorders	Hypertensive diseases	Pulmonary heart disease and diseases of pulmonary circulation	Asthma
Austria	5.6	n/a	18.7	3.7	4.3
Bulgaria	4.2	0.8	22.6	3.3	2.0
Cyprus	5.6	2.4	17.5	2.4	3.9
Czech Republic	6.1	2.8	22.2	2.7	4.0
Estonia	3.5	n/a	17.7	2.1	2.3
France	5.2	3.7	12.4	4.3	7.0
Hungary	7.9	4.9	31.1	4.7	5.3
Latvia	3.7	1.6	21.7	3.3	2.3
Romania	3.1	0.8	13.7	1.7	1.6

Source: European Commission, 2011.

Notes: ICD-10: International Statistical Classification of Diseases and Related Health Problems 10th Revision; n/a: Not available.

Table 1.9

Share (%) of EHIS respondents in Hungary reporting to have been diagnosed with one or more diseases (ICD-10) during the past 12 months, according to age group, 2009

	Total	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	75–84 years	85+ years
Hypertensive diseases	31.1	n/a	5.0	15.1	32.4	53.0	64.0	70.9	58.0
Diabetes mellitus	7.9	0.5	0.8	2.1	8.2	12.8	20.8	20.6	7.6
Pulmonary heart disease and diseases of pulmonary circulation	4.7	1.2	2.4	2.2	3.7	8.6	7.0	9.8	12.3
Asthma	5.3	3.9	3.2	4.7	4.6	8.2	7.5	6.2	6.0
Depressive disorders	4.9	1.1	1.6	2.8	7.2	9.1	7.1	5.9	5.1

Source: European Commission, 2011.

Notes: ICD-10: International Statistical Classification of Diseases and Related Health Problems 10th Revision; n/a: Not available.

Infant mortality has decreased substantially since the 1950s and has remained consistently below the EU12 average since the late 1980s. Nevertheless, it was still 20% above the EU27 average in 2009 (5.1 vs. 4.3 deaths per 1000 live births). The probability of dying before the age of five in Hungary has followed a similar trend (WHO Regional Office for Europe, 2010). Table 1.10 shows some of the most important maternal and child health indicators for the period between 1980 and 2009.

Table 1.10

Maternal and child health indicators, 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
Adolescent pregnancy rate, per 1 000 women aged 15–19 years ^a	100.7	74.9	66.8	50.4	41.2	39.8
Abortions per 1 000 live births	544.0	719.3	686.8	607.1	499.4	447.7
Infant deaths per 1 000 live births	23.2	14.8	10.7	9.2	6.2	5.1
Neonatal deaths per 1 000 live births	17.8	10.8	7.3	6.2	4.1	3.4
Perinatal deaths per 1 000 births	23.1	14.2	6.7	5.7	5.0	4.7
Postneonatal deaths per 1 000 live births	5.3	4.0	3.4	3.1	2.2	1.7
Probability of dying before the age of 5 years per 1 000 births	25.5	16.8	12.4	10.8	7.5	6.0
Maternal deaths per 100 000 live births	20.9	20.7	15.2	10.3	5.1	18.7
Caesarean sections per 1 000 live births	n/a	n/a	136.1	201.5	274.4	294.5 ^b

Sources: WHO Regional Office for Europe, 2010; ^aUnpublished data from HCSO, 2011.

Note: ^bData from 2008.

Aside from Hungary lagging behind the EU27 and even the EU12 averages for many health indicators, the persisting geographical and social inequalities in health within Hungary itself are also a matter of concern. For instance, the gap between regions with the highest and lowest healthy life years was 8.1 years for men and 7.7 years for women in 2008 (HCSO, 2009a). Unfortunately, reliable morbidity and mortality data are not available to describe the health status of the Roma minority, but it can be assumed that their health status is considerably worse than the population average (Ádány, 2008). A recent survey comparing the health of people living in Roma settlements to that of the general population found that the self-reported health status of the former group was substantially worse than that of the latter. Moreover, the share of people who indicated that they felt they could do much to promote their own health was 13% to 15% lower among individuals living in Roma settlements than in the general population, and smoking and unhealthy eating habits were 1.5 to 3 times more prevalent than in the lowest income quartile of the general population (Kósa et al., 2007). The highest concentration of Roma in Hungary can be found in the region known as the Northern Great Plain. Unemployment is much higher among this group than among ethnic Hungarians, and many live in slum conditions without running water or sewerage (Kósa, Daragó & Ádány, 2009). Infant mortality rates among the Roma are thought to be high, and life expectancy at birth is presumably far lower than for the rest of the population (Ádány, 2008).

The Hungarian vaccination system is well organized and serves the public health needs of the population. Among children, measles immunization coverage was 99.8%, in 2009, which is an outstanding result among all OECD countries and also in the WHO European Region. Coverage for immunization against diphtheria, pertussis and tetanus is equally high (WHO Regional Office for Europe, 2010).

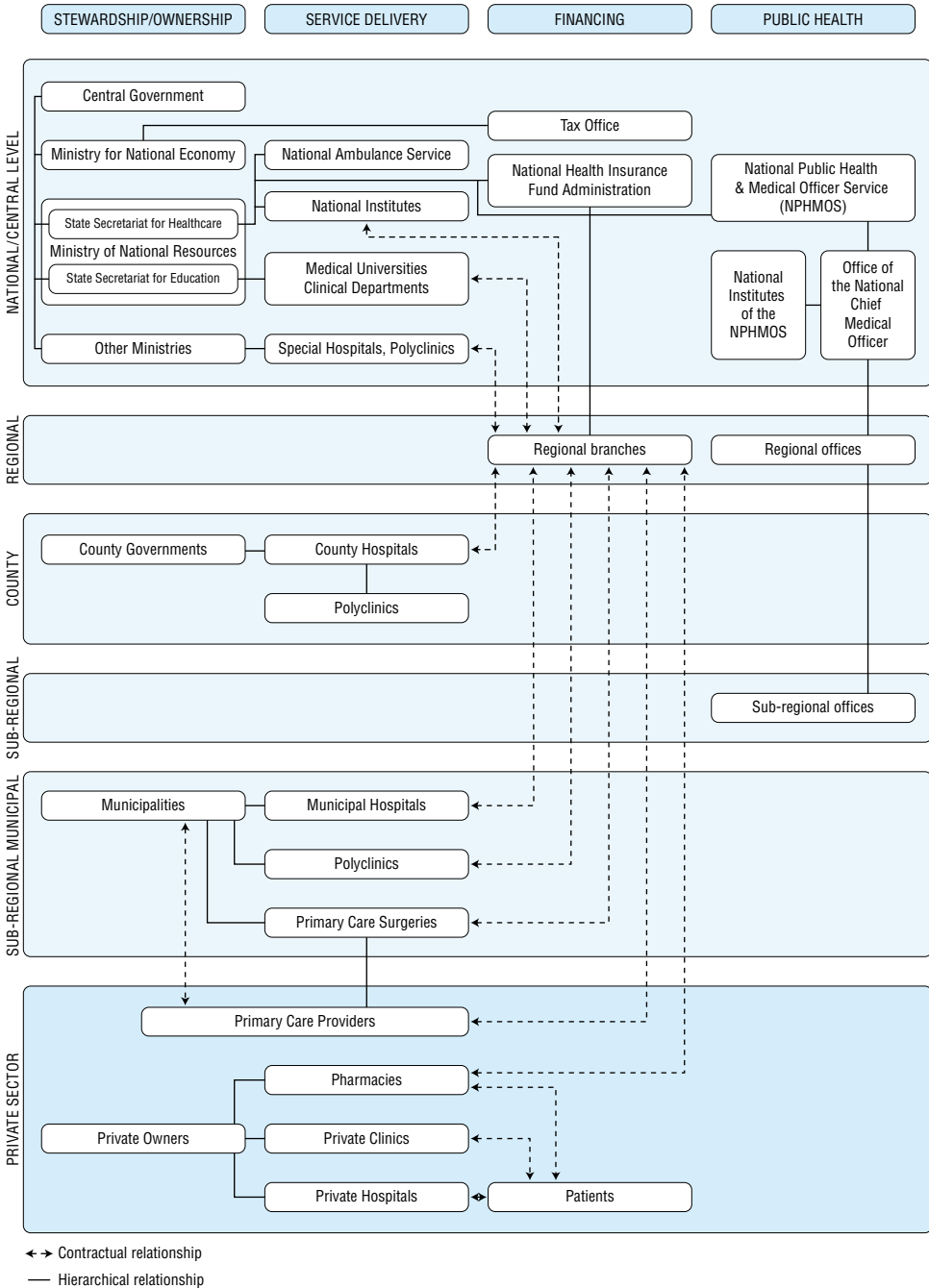
2. Organization and governance

The Hungarian constitution guarantees the right to a healthy environment, an optimal level of physical and mental health, and income maintenance benefits in the form of social security. The constitution assigns overall responsibility for social welfare and health care provision to the central government, but other actors such as the National Assembly, local governments, the regional health councils, the NHIFA and the NPHMOS also take part in decisions related to the organization and functioning of the health system. The current structure of the Hungarian health system represents a considerable departure from the highly centralized, Semashko-style model in place during the communist era.

2.1 Overview of the health system

Fig. 2.1 presents the organizational structure of the Hungarian health care system in 2010. The main actors are grouped into columns according to four main functions: stewardship/ownership, service delivery, financing and public health. The nature of the relationships between these actors is shown as being hierarchical (solid lines) or contractual (dotted lines). The figure illustrates only the typical organizational arrangements. For instance, although voluntary health insurance exists in Hungary, it represents a negligible source of health care financing and therefore does not appear in the figure (see section 3.5). Similarly, local governments can contract out primary and secondary care services to private providers while retaining ownership of facilities. Known as “functional privatization”, this model is open to providers at all levels of care, but is the dominant form of service provision in primary care alone. As a result, only primary care providers appear in the figure as being part of the private sector (see section 2.8.2).

Fig. 2.1
Organizational chart of the Hungarian health system, 2010



Source: Adapted from Gaál, 2004.

2.2 Historical background

Hungary has a long-standing tradition of health services dating back to the infirmaries established and run by monasteries beginning in the eleventh century. The first municipality to build a hospital was Selmec, in the northern part of the Kingdom of Hungary, in 1224. Its primary purpose was to treat injured miners. In the late Middle Ages, groups of miners joined together in this important mining town to create their own mutual assistance funds (*bányatársláda*), which aimed to cover the costs of sickness and injuries. The first known mutual assistance fund dates back to 1496 (Sárdi, 2003).

This era of private medicine, mutual assistance funds and church-dominated charities was followed by a period during which the state assumed an increasingly dominant role in the health sector, especially in the provision of health services to the poor, public health and health insurance. In the fifteenth century, town physicians were employed to make services available to the poor, and in 1752 every county in the Kingdom of Hungary was required to offer such services. Hospitals were separated from almshouses in 1856 and offered free health care to the eligible poor in special surgeries. Act XIV of 1876 was the first piece of legislation related to public health to be passed in Hungary. Only the second of its kind in Europe, it stipulated that village and district doctors, as well as chief medical officers, must provide health services free of charge to residents with very low incomes.

With regard to evolution of health insurance, Act XVI of 1840 legitimized voluntary mutual assistance funds for industrial workers (Sárdi, 2003). Some years later, in 1854, the Habsburg Emperor obliged all companies engaged in mining to set up mutual assistance funds. In 1870 the General Fund of Sick and Disabled Workers was established to manage the contributions of employers and the provision of services to employees (Tarsoly, 2000). Membership in the fund was voluntary, and its financial commitments were guaranteed by the state. These efforts produced mixed results, with 40.6% of industrial workers covered in this manner by 1885 (NHIFA, 2011).

A landmark in the development of mandatory social health insurance (SHI) was Act XIV of 1891, which made such insurance compulsory for industrial workers and provided for guaranteed benefits-in-kind and cash benefits. This Act was the third of its kind in Europe, following similar legislation in Germany in 1883 and in Austria in 1887. It was refined in 1907 through legislation that set the main principles for governing SHI funds (Sárdi, 2003). At the turn of the century, a national scheme for agricultural workers was set up to cover work-related injuries (Tarsoly, 2000), and the National Fund of Patient Care was established in 1898 to reimburse health care costs for the poor.

Act XXI of 1927 led to the establishment of the National Social Insurance Institute, which administered the first nationwide SHI scheme to cover both industrial workers and public employees, including their family members. It did not cover agricultural workers, and although parliament accepted a resolution to set up a separate scheme for this group, it was not implemented until 1945 (Tarsoly, 2000). By the 1930s, approximately one-third of the population was insured.

Until the 1940s, health care was delivered mainly through the private sector and in some state hospitals. Various SHI funds employed physicians and also owned health care facilities. Rural areas were not well served, despite the efforts of the Green Cross Service, which was staffed mainly by nurses.

Soon after it came to power in 1949, the communist regime nationalized the economy, including the institutions responsible for funding and delivering health care. The provision of health care services was declared to be a state responsibility (1950/1), and the remaining tasks of the National Social Insurance Institute were transferred to the National Council of the Trade Unions (Tarsoly, 2000). Private health enterprises, such as insurance companies and private general practices, were dismantled and replaced by centralized state services. Measures such as better sanitation and the compulsory immunization of children soon led to substantial advances in public health and better control of infectious disease (see section 1.4).

The Constitution of the Republic of Hungary, adopted in 1949, declared health to be a fundamental right to be guaranteed by the state (1949/1). Throughout the communist period, this was interpreted to mean that the state alone was responsible for financing and delivering health services. The Ministry of Health thus funded and delivered the whole spectrum of health services; in primary care, a system of district physicians was established (1952/1). District physicians were public employees and worked in single-handed practices. Private medical practice was allowed only on a part-time basis (1972/2).

The improvements in population health status seen in the 1950s slowed in the 1960s. Central planning allowed little flexibility to respond to changing circumstances and weighted the health sector heavily towards achieving quantitative targets. Moreover, resource allocation was subject to political influence, which resulted in inequalities in service provision in terms of geography and physician specialties. Although Act II of 1972 on Health confirmed the link between citizenship and access to health services, and promised comprehensive coverage free of charge, an increasing gap developed between rhetoric and reality. By the 1970s, the system was suffering from

excess capacities, deteriorating service quality and a culture of widespread informal payments. Between 1970 and 1989, life expectancy at birth declined by almost one year for men and increased by only 1.8 years for women (see section 1.4) (WHO Regional Office for Europe, 2010).

During the 1970s, the responsibility for providing outpatient care was shifted mainly to hospitals; the aim of doing so was to facilitate the integration of health services. Emphasis was placed on specialist care and district physicians had a low status among medical doctors. Indeed, new entrants to the field preferred to work in inpatient care, and patients themselves preferred to bypass district physicians. As a result, the care provided by district physicians was not comprehensive.

The need for radical health care reform became increasingly apparent in the 1980s (see section 1.4). The widening gap in health status between Hungary and western European countries called for change, and the changing political climate opened the way for reform. The first steps were taken in 1987, when the Ministry of Social Affairs and Health¹ established a Reform Secretariat to produce policy proposals. During this short period of reform in the last years of the communist era, several important changes were made. Restrictions on the private provision of health care were lifted (1988/2, 1989/5), and a Social Insurance Fund, which pooled social insurance contributions separately from the government budget, was created (1988/4) and made responsible for financing the recurrent costs of health services (1989/6). The task of administering the new fund was given to the National Social Insurance Administration, which was already in place and had been responsible for collecting payroll-related social insurance contributions and administering cash benefits – both of which were elements of social insurance that had persisted during the communist era. The head of the Reform Secretariat stayed in office under the new government elected in 1990, allowing for a degree of continuity in health sector reform during the period of profound economic and political transition that followed.

The first post-communist government was formed in March 1990 by a coalition of the Hungarian Democratic Forum, the Independent Smallholders' Party and the Christian Democratic People's Party. This coalition successfully established the contract model in the health care system between 1990 and 1994. Act LXV of 1990 on Local Government created the provider side of the new contract model (1990/3), devolving the ownership of primary care surgeries, polyclinics and hospitals from central government to local governments along with the responsibility, known as the “territorial supply obligation”, to ensure

¹ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

the supply of health care services to the local population. As part of the reform of public health and the modernization of health system administration, the NPHMOS was established as a state agency in 1991 (1991/1). After a debate on whether to move towards a single-insurance model or a system with multiple, competing health insurers, a single-insurance model was chosen, but the option of introducing competition among multiple insurance plans in the future was left open (1991/3).

From 1990 until 1992, health insurance and pension insurance in Hungary were financed through the Social Insurance Fund. In 1992, however, the government divided the Social Insurance Fund into two entities: the HIF and the Pension Insurance Fund (PIF) (1992/2). The administration of these funds was reformed in mid-1993, when the National Social Insurance Administration was divided into the NHIFA and the National Pension Insurance Fund Administration (NPIFA) (1993/7).

Act LXXXIV of 1991 defined quasi-public bodies for supervising the HIF and PIF, the so-called self-governments, which consisted of representatives of employers and employees (1991/5). The Health Insurance Self-Government and its pension counterpart began to operate in 1993, after the general population (or, more precisely, the insured population) elected employee representatives from candidates put forward by various trade unions, while employer representatives were delegated by employer associations (1993/3). Until the self-governments were formed, supervisory rights were exercised first by the Minister of Welfare (1990/1), as the State Minister for Health was then known, and later by a ten-member parliamentary committee (1991/5). The self-governments were granted extensive rights over budgetary decisions and given a veto on government decisions related to social insurance.

During the legislative period 1990–1994, a range of policies were gradually introduced to strengthen primary care. In 1991 the National Institute of Family Medicine was established to coordinate efforts at raising professional standards in this sector (1991/6). In 1992, the system of district physicians was reformed: the administration of primary health care was removed from the remit of hospitals, “district physician services” were renamed “family doctor services”, and family medicine was introduced as a new and compulsory specialization to be attained by all physicians working in primary care (replacing the specialty in general practice that had been introduced in 1976) (1992/3). The separation of adult and child care in large municipalities, which had been a characteristic of the district physician system, was maintained². People were also given

² Throughout this review the term “family doctor” includes family physicians and family paediatricians.

the right to choose their own family doctor (1992/3), and capitation payment and contracting of family doctor services were introduced (1992/4). Family doctors were encouraged to enter into private practice, contracting with their local government for the provision of primary care services, but working in surgeries and with equipment still owned by the local government. This kind of arrangement is often described as “functional privatization” and is the dominant form of provision in the primary care sector in Hungary (see section 5.3).

New payment mechanisms for all other health care services were initiated during this period. The introduction of output-based payment methods, such as fee-for-service payment in outpatient specialist care, Homogeneous Disease Groups (HDGs, the Hungarian version of DRGs) and per diem payments in inpatient care, was coupled with the capping of the various sub-budgets of the HIF (see sections 2.3.8, 3.4.3 and 3.7) (1992/8, 1993/5, 1993/6). From a cost-containment perspective, these measures have remained an effective tool under the oversight of successive governments (see section 7.5).

In late 1993, the National Assembly created the legal framework for establishing voluntary non-profit health insurance (1993/10). Voluntary health insurance funds in Hungary provide complementary and supplementary coverage for health and preventive services. These voluntary schemes cannot operate, however, as substitutive insurance (see sections 2.3.11 and 3.5 for more details). In 1994 the Hungarian Medical Chamber and the Hungarian Chamber of Pharmacists began to operate on a self-regulatory basis, with compulsory membership for practising physicians and pharmacists (1994/2, 1994/5). National drug companies and the wholesale and retail industries were mostly privatized, and the pharmaceutical market liberalized.

The elections in 1994, which brought a coalition of the Hungarian Socialist Party and the Alliance of Free Democrats to power, were followed by a period of cost-containment, including cuts in the overall budget for health care and a shifting of costs to patients. The latter development was somewhat counterbalanced by tax rebates for the purchase of voluntary non-profit health insurance (1995/14). In addition, the responsibility for occupational health services was shifted to employers (1995/8).

The government also decided to address the size of the hospital sector, assigning the Minister of Welfare to determine the capacities the NHIFA had to contract for under the territorial supply obligation (1995/9). As a result, about 9000 beds were ultimately removed from the system. In 1996, however, reliance on the direct intervention of the Minister of Welfare was replaced by a needs-

based formula to determine health care capacities. This formula called for cuts in hospital beds in most counties, but left the details to county consensus committees (1996/4).

Another target of the cost-containment measures was the self-government of the HIF. Since the extensive rights of the HIF on budgetary decisions made it difficult to cut the HIF budget, these rights were curtailed in 1996 (1996/3, 1996/11). In addition, the government weakened the self-governance of both the HIF and PIF through restructuring in 1997 (1997/5).

The government's revenue-side strategy consisted of three components: widening the HIF contribution base, decreasing the employer HIF contribution rate and introducing a lump-sum tax, known as the hypothecated health care tax (1996/9, 1997/8). One aim of these measures was to increase HIF revenue by combating the evasion of HIF contributions (see section 3.3.2).

A proposal was prepared in 1998, which envisaged a reform of health system financing involving the introduction of competing health insurance funds, but the government had no time to debate or put this idea into practice as the 1998 elections brought the opposition into power.

In May 1998, the Fidesz-Hungarian Civic Party formed a coalition government with the Hungarian Democratic Forum and the Independent Smallholders' Party. One of the government's first measures was to abolish the self-government of the HIF and PIF (1998/15). Control of the NHIFA was transferred to the Prime Minister's Office (1998/16) and subsequently to the Ministry of Finance (1999/5). Instead of reforming the financing side, the policy focus was shifted to the health care delivery system, but against the background of the persistent efforts to contain overall health expenditure.

During its time in power, the government targeted both the revenue and expenditure sides of the HIF. To overcome the problem of contribution evasion, the government added a proportional component to the hypothecated health care tax (1998/19). At the same time, it decreased the HIF contribution substantially (1998/20). The government also shifted the responsibility for collecting HIF contributions to the Tax Office (1998/26) (see sections 3.2 and 3.3.2).

After rejecting renewed proposals to introduce health insurance competition, the Ministry of Health³ implemented the government's first delivery-side reform measures in early 2000, introducing a complex quota system for family doctor practices based on practice permits (known in Hungarian as the "practice right",

³ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

or *praxisjog*) (2000/1, 2) (see section 2.8.2 for more details). The government also offered subsidized loans to family doctors to help them buy facilities and equipment from local governments (2000/2).

On 1 January 2001, a new Minister of Health was appointed, who regained control of the NHIFA from the Ministry of Finance (2000/10). Act LXIII of 1996, which had introduced a needs-based formula to determine health care capacities, was repealed (2001/5), and a 10-year public health action programme was elaborated to increase the life expectancy of men and women to 70 and 78 years, respectively (2001/9) (see subsection *Intersectorality and public health* in section 6.1.1). The reform of the delivery system continued with the encouragement of the corporatization of public providers (2001/12) (see subsection *Ownership and management of health care providers* in section 6.1.1).

The Hungarian Socialist Party and the Alliance of Free Democrats were voted back into power in May 2002. A substantial pay rise was introduced for public employees, including health care professionals (2002/16). This increase of about 50% and an extra bonus for nurses aimed to reduce the exodus of health care professionals. Later, the social status of non-medical health care personnel was also raised by establishing the Chamber of Non-Medical Health Professionals (2003/18).

The government eliminated some of the restrictions on the privatization of facilities delivering health care (2002/16, 17) and gave more room for private investment in the health care system (2003/5, 2003/6). However, the impact of the new regulation on the delivery system was curtailed, as it was later annulled by the Constitutional Court (2003/23) (see subsection *Ownership and management of health care providers* in section 6.1.1).

Starting in 2002, more emphasis was placed on health planning and prevention (see subsection *Intersectorality and public health* in section 6.1.1). The government also encouraged regional health planning by forming regional health councils and elaborating regional health plans (2003/4, 2004/11) (see subsection *Capacity regulation* in section 6.1.1).

Between 2004 and 2007, major reforms and initiatives focused on reshaping stewardship and organization in the Hungarian health care system. This included another (unsuccessful) attempt to introduce managed competition to the SHI system; strengthening the CCS, launched as a pilot programme in 1999 but ultimately abandoned in 2008; introducing new capacity regulations for providers; supporting the corporatization of providers and the outsourcing

of their management; encouraging intersectoral cooperation to implement the NPHP; and starting to use HTAs systematically in the reimbursement decisions of the NHIFA on pharmaceuticals. Section 6.1.1 provides more details on these and other reforms enacted during this period.

To compensate for revenue lost due to the large reductions in the employer HIF contributions after 2006, the share of the central government budget in financing the HIF was significantly increased (see subsection *Revenue collection* in section 6.1.2). Several other measures were introduced to address the financial balance of the HIF, especially the relatively high share of pharmaceutical spending (see subsection *Pharmaceuticals* in section 6.1.2).

With the stated aims of improving allocative efficiency and making the provision of health care more equitable, a flat co-payment for outpatient care and a per diem co-payment for inpatient care were introduced in February 2007 (2006/9) and provider capacities were newly regulated starting in April 2007 (2006/12). Intense political and public opposition led to a successful referendum against the new co-payments. Public dissatisfaction with other social policy reforms and the global economic downturn ultimately led to the collapse of the governing coalition (for more details see subsection *A third attempt to introduce managed competition to the health insurance system* in section 6.1.1).

Forming a minority government, the Hungarian Socialist Party embarked upon a crisis management programme with a package of severe and deeply unpopular austerity measures. In June 2009, however, the Fidesz party won the European parliamentary elections, paving the way for a landslide victory for a coalition of Fidesz and the Christian Democratic People's Party, which ran together in the April 2010 parliamentary elections.

In May 2010, the government published a policy agenda outlining some of its plans for the health system, including increasing public expenditure on health, especially for the public health programme; strengthening the role of outpatient services; preserving the single-payer health insurance system; introducing a new system of capacity regulation based on health needs assessment and decreasing the length of waiting lists by 50%. In October 2010, the Ministry of National Resources (which was formed by merging the five ministries previously responsible for social, family and youth affairs; health care; education; culture; and sport) published a strategic plan (known as the Semmelweis Plan) for public debate to prepare for a government resolution containing a detailed strategy for the health care system. Moreover, a number

of technical groups were established to prepare policy interventions with the participation of representatives of the professional organizations in the autumn of 2010.

2.3 Organization

The main actors responsible for providing or financing health services are defined in Act CLIV of 1997 on Health (1997/20). The most important of these are the National Assembly, the central government, the State Secretariat for Healthcare (within the Ministry of National Resources), the NPHMOS and, in general, the owners of health facilities, who since 1990 have been mainly country and municipal governments (1990/3).

2.3.1 The National Assembly

The National Assembly is Hungary's unicameral parliament and a key actor in decision-making at the national level for all areas of public policy, including health. The final size of the HIF budget (and of its more than 30 sub-budgets), for example, is legislated by the Assembly, as are provider payment methods (see section 3.4.3 and subsection *Provider payment methods* in section 6.1.2). The Assembly also sets the HIF contribution rate on an annual basis. Although most of the Assembly's decisions need only a simple majority, the constitution requires a two-thirds majority to pass legislation related to fundamental democratic institutions, such as local governments. This provision limits the discretion of the government in enacting health care reform.

2.3.2 Central government

The central government formulates, evaluates and implements health policy and is also the most important regulator of the health sector. Indeed, it is the chief regulator of health services, exercises statutory supervision over the HIF, and has direct control over the NHIFA, including its purchasing decisions. In addition, the central government provides conditional and matching grants to local governments for renovating health care facilities. The central government also delivers public health and some tertiary care services.

Since 1990 the central government has no longer been the main source of funding or main supplier of health services. Together with the National Assembly, it is responsible for administering health financing, resource allocation and provider payment methods through its direct control of the

NHIFA (see section 2.3.7). This does not mean, however, that the central government does not play an important role in directly financing the health sector. Indeed, it is responsible for:

- financing high-cost, high-tech interventions, public health, prevention of communicable diseases, emergency ambulance and blood supply services, health sciences education and research (1997/20, 1998/4);
- partially covering capital expenditure by providing country and municipal governments with conditional and matching grants for renovating health care facilities, for replacing equipment and for new investment via the so-called earmarked and target subsidies (1992/9);
- transferring revenue from the hypothecated health care tax to the HIF to compensate for non-contributing groups (1997/8, 1998/19);
- paying the HIF contribution for certain non-contributing social groups (2005/5);
- covering the HIF deficit (upon approval of the National Assembly) (1992/6, 1997/8);
- covering co-payments for certain pharmaceuticals, medical aids and prostheses for residents with low incomes (as determined by means testing) (1993/1);
- giving tax rebates on the purchase of voluntary, non-profit health insurance and savings accounts (1995/14).

Although counties and municipalities have provided the majority of health services since 1990, the national government is involved in service delivery in several ways by:

- directly providing public health services through the NPHMOS, emergency services through the National Emergency Ambulance Service, and blood products through the National Blood Supply Service;
- supplying mainly tertiary health care through medical universities and the National Institutes of Health;
- providing undergraduate and postgraduate health sciences education, and some continuing education and research at the various academic medical centres and at the Institute for Basic and Continuing Education of Health Professionals, which is run by the State Secretariat for Healthcare.

Responsibility for this wide variety of tasks is divided among ministries according to various governmental decrees and these responsibilities were recently redefined (2010/7, 8). The primary responsibility for stewardship and financing in the health system remains with the State Secretariat for Healthcare (2010/8), but other ministries are also involved in service delivery and health care financing.

2.3.3 State Secretariat for Healthcare

In 2010 the government created the Ministry of National Resources by merging the five ministries previously responsible for social, family and youth affairs; health care; education; culture; and sport (2010/7). These former ministries have since been reclassified as State Secretariats, each of which is led by a Minister of State. The aim of this change was to reduce the cost of public administration and create effective platforms for intersectoral cooperation.

Within the Ministry of National Resources, the State Secretariat for Healthcare is responsible for preparing legislation related to the direction of health care provision at the national level and at institutions of higher education, and for regulating national public health care tasks at the national level. The State Secretariat for Healthcare shares responsibility with the Ministry for National Economy and the Ministry of Interior for health care financing.

The main functions of health policy formulation, coordination and regulation are carried out by a number of institutions under the direct control of the State Secretariat. In addition to these administrative functions, some of these institutions provide health services themselves, including public health, emergency ambulance services, blood supply, tertiary care services and rehabilitation; they also help prepare health policy initiatives. Since January 2001, the State Secretariat has also exercised direct control over the NHIFA.

One of the most important agencies of the State Secretariat for Healthcare, the NPHMOS provides public health services, including the traditional public hygiene and infectious disease control, disease prevention and health promotion. It is the central authority responsible for implementing, monitoring and enforcing regulations, including the registration and licensing of health care providers. The NPHMOS is also responsible for monitoring the quality of health services and plays an important role in capacity planning (see sections 2.8.2, and 5.1–5.3).

The NPHMOS was formed in 1991 on the basis of the State Supervisory Agency for Public Hygiene and Infectious Diseases and is headed by the National Chief Medical Officer, who is appointed by the Minister of State for Health (1991/1, 2006/22). The NPHMOS is organized on a territorial basis at three different levels: central, regional and subregional (*kistérség*). Subregions in Hungary are equivalent to level 1 of the local administrative units (LAU) that are part of the of Nomenclature of Territorial Units for Statistics (NUTS) system developed and used by the EU for statistical and other purposes. In Hungary there are 175 subregions with a population between 6000 and 300 000 inhabitants, with the exception of Budapest, which has a larger population and is considered both a county and a subregion. In 2007 the NPHMOS was reorganized, resulting in its current territorial division: the county offices, of which there used to be 19, were merged into 7 regional offices, and the municipal offices were reorganized into subregional offices (2006/22).

At the central level, the NPHMOS is headed by the National Chief Medical Officer, who is appointed by the Minister of National Resources based on the recommendation of the State Secretariat for Healthcare. The Office of the Chief Medical Officer directs, supervises and coordinates the work of the territorial units of the NPHMOS and the nine National Institutes of Health, each of which is responsible for a special area of public health, such as epidemiology, radiation biology, chemical safety, environmental health and nutrition science (see section 5.1 for more details on the NPHMOS and public health).

The middle level of administration consists of seven regional offices, each covering the population of two to three counties. At the lowest level, subregional offices cover the population of 1 to 5 subregions, while Budapest has 12 district offices. The organizational structure of NPHMOS before 2007 is depicted in the 2004 HiT profile for Hungary (Gaál, 2004).

The State Secretariat for Healthcare also runs state hospitals, most of which are sanatoria for medical rehabilitation. They accept patients from throughout the country and are partly financed through the HIF.

The State Secretariat for Healthcare is responsible for coordinating and supervising the education and training of medical and non-medical health professionals; the responsibility for providing secondary and higher education in the health sciences, however, falls within the remit of the State Secretariat for Education. The State Secretariat for Healthcare plays only a limited role in providing education and training, offering professional educational programmes for nurses and other paramedical health workers through its own training institute.

2.3.4 Ministry for National Economy and the Tax Office

In 2010 the government created the Ministry for National Economy by merging the former Ministry of Finance with policy units in economy and labour; industry and commerce; foreign trade; and research and innovation from other ministries (2010/5). The Ministry for National Economy is responsible for fiscal policy and plays a central role in planning and approving budgets of the central government, local governments and the HIF. The Ministry is concerned primarily with the macroeconomic implications of health care financing and, in particular, with the impact of any deficit of the HIF, on fiscal balance, because the government is obliged to cover any such deficit. The Ministry is able to apply a very strict cost-containment policy by setting the budget objective for the HIF, but it has generally done so without taking into account the real needs of the HIF with regard to health care provision and financial balance.

The Tax Office, which is a governmental office under the supervision of the Ministry for National Economy, took on the function of collecting social insurance contributions (that is, HIF and PIF contributions) from the NHIFA in January 1999 and has been performing this function ever since.

2.3.5 State Secretariat for Education

The State Secretariat for Education and the State Secretariat for Healthcare jointly supervise higher education institutions in health. Before 1993 the Ministry of Health was responsible for medical universities and their health services (1993/8, 2005/7). Subsequently, the Ministry of Education took over this responsibility, except for the supervision of the specialist training and the supervision and provision of professional educational programmes for nurses and other paramedical health workers. The division of responsibilities was further clarified in 1996, when the Ministry of Health was designated as the main financier, coordinator and supervisor of health research and development. Notably, neither of the State Secretariats may interfere with or restrict the autonomy that institutions of higher education in Hungary enjoy in education and research.

2.3.6 Other ministries

Three large ministries have retained their health care facilities and are thus involved in the provision of care. The origin of these parallel systems dates back to the first half of the 20th century, when several private and public insurance funds employed physicians and owned health care institutions. The Ministry for National Economy, which among its many responsibilities runs

the Hungarian State Railways, has its own comprehensive system of health service delivery within which railway workers and their dependants are given priority (1994/3). The number of providers and their capacities, however, were significantly reduced in 2007 (2007/4). The Ministry of Defence has its own inpatient and outpatient services, which are open to the general public, although special rules give priority to its employees. According to the general principles applied in health care financing, both ministries cover the capital costs of services, whereas recurrent costs are financed through the HIF. The Ministry of Public Administration and Justice provides health services to prisoners; this is entirely separate from the main system of provision.

Finally, the Ministry of the Interior deals with issues for local governments, which are the owners of most primary and secondary care facilities. Among other duties, the Ministry administers the allocation of capital grants for health care equipment and buildings to local governments (1992/9).

2.3.7 HIF and the NHIFA

The HIF is the most important financing agent for the recurrent costs of health services, and finances certain cash benefits, such as sick pay. The HIF is separate from the government budget in so far as any surplus it generates cannot be used by the government for other purposes. The government is obliged to cover any shortfall in the HIF (1997/8), and shortfalls in the HIF appear in the government budget deficit. The HIF is divided into more than 30 sub-budgets according to type of service (e.g. acute inpatient care, chronic inpatient care and outpatient specialist care). Most of these sub-budgets are capped, and the provider payment mechanisms help to ensure that the caps are, in fact, observed.

The NHIFA is a government office and thus under the direct control of the state. It administers the HIF and is the sole payer in the Hungarian health insurance system. It has no discretion over revenue collection or budget setting, however, and has only very limited discretion over purchasing decisions (see sections 2.3.2 and 3.4.3). The NHIFA has territorial units and subunits at the regional and county levels, respectively. These units manage administrative work and other tasks delegated by the NHIFA central office, but have no autonomy in contracting and paying local health providers. Moreover, the budget of the NHIFA has remained centralized since its inception.

HIF contributions are not collected by the NHIFA but by the Tax Office. The responsibility for administering cash benefits financed through the HIF lies with the Ministry of Public Administration and Justice, although various details of the benefits are determined by the NHIFA and Ministry of National Resources.

2.3.8 Professional Colleges and the National Institutes of Health

Various institutes and professional bodies assist the State Secretariat for Healthcare. Some of them, such as the professional colleges (*Szakmai Kollégiumok*) and the National Institutes of Health, provide expert input on particular medical specialties (1989/2, 1999/11, 2008/6), while others, such as the Health Care Scientific Council (1989/3, 2003/3) or the Health Care Professional Training and Continuing Education Council (1998/21, 2010/1), deal with more general areas, including science and policy issues or education. The members of the professional colleges consist of the leading consultants from particular medical specialties, and are elected by delegates from the Hungarian Medical Chamber, medical schools and the relevant scientific associations. Currently there are 49 professional colleges for specialists in fields ranging from internal medicine to neurosurgery and health informatics, and for pharmacists and nurses (1999/11, 2008/6).

The National Institutes of Health are the centres of excellence for particular medical specialties (1997/20). They supervise and support clinical work across the country, provide continuing education, conduct scientific research, and in certain cases engage in prevention activities and provide patient care, especially highly specialized, tertiary care services for the entire population. The National Institutes of Health issue clinical guidelines, setting out protocols and standards, and some are attached to university departments. Their clinical work is financed by the HIF, whereas their other activities are covered by the central government.

Some of the National Institutes carry out special administrative duties. For instance, the Information Centre for Health Care – a department of the NHIFA since 2004 – runs a system of provider output reports, which are used as the basis for determining hospital payment (1987/1) (for details see section 3.7.1). Another example is the National Institute for Strategic Health Research (NISHR), which is the policy research institute of the State Secretariat for Healthcare and was created, in part, from the National Institute and Library for Health Information (MEDINFO), and has conducted policy research in

health informatics, health economics, health systems sciences and technology assessment since 2004. The Institute also helps inform health policy-making at the national level.

The National Institute of Pharmacy is responsible for registering and licensing pharmaceuticals (1982/1, 2006/22). The Authority for Medical Devices, which is an office of the State Secretariat for Healthcare, runs a similar system for medical equipment, including medical aids and prostheses (2000/5). The Authority replaced the Institute of Hospital and Medical Engineering, which was renamed and serves as one of several organizations responsible for quality control and audit in this area (1990/2).

On the basis of the provisions of Act CLIV of 1997 on Health a new body, the National Health Council, was established in 1999 to advise the government on health policy and promote consensus on health priorities, thereby facilitating their implementation. The members, with a four-year mandate, are representatives of the relevant stakeholders such as professional and patient organizations, unions and local government representatives (1997/20, 1998/28)⁴.

2.3.9 Local governments and the regional health councils

A two-tiered system of local government – that is, at the county and municipal levels – was established in 1990, replacing the council system (*tanácsrendszer*) in place previously. Since then, local governments have become key actors in the health sector in Hungary. Although central government policy determines the broad local policy framework, the Hungarian constitution guarantees the right of local governments to take decisions on local affairs; disputes regarding authority between the central and local governments can be settled by the Constitutional Court (1989/4).

Act LXV of 1990 on Local Government defined the basic structure, rights and duties of local governments, as well as their sources of funds. Local governments share responsibilities based on the principle of subsidiarity. This means that county governments take over only those public services that municipal governments cannot undertake and are willing to transfer to the county level (1990/3). The Act also assigned responsibility for planning and providing local health services to local governments. The responsibility for primary care rests with municipalities and that for secondary care with counties, but both tiers of local government are allowed to contract out service delivery to private providers. A large proportion of primary care has been contracted out

⁴ The Council is to be eliminated in 2011.

to private practice family doctors under the functional privatization scheme (for more details see section 2.8.2). Similar arrangements have grown increasingly common in secondary care since the late 1990s.

The same Act transferred the ownership of most primary care facilities, polyclinics and hospitals from the national government to the local governments (1990/3). As a result, local governments have become the main health care providers in the Hungarian health care system. Municipalities usually own primary care facilities and, in the case of larger municipalities, may own and run outpatient clinics and municipal hospitals. County governments usually own large county hospitals, which provide secondary and tertiary care.

As the owners of health care facilities, local governments are responsible for funding the capital costs of the health services they provide. Since these costs are usually higher than the revenue of local governments, the central government provides conditional and matching capital grants through the system of earmarked and target subsidies (1992/9). It has often been argued, however, that even local and central funds together are not sufficient to cover capital costs over the long term, thus threatening the sustainability of the system.

In 2004 the National Assembly formed regional health councils to support the creation of regional health policies and development projects; to facilitate cooperation among the stakeholders, especially regarding negotiations on the distribution of regional capacities within secondary and tertiary care; and to conduct evaluations of patient satisfaction and access to care and draw up appropriate recommendations. The council members consist of representatives of the counties, churches, medical universities, health care providers, the State Secretariat for Healthcare, the NHIFA and patient associations.

2.3.10 Professional organizations, associations and unions

The work of voluntary associations and trade unions was kept under tight control until the second half of the 1980s. In the late 1980s, when the health sector trade union of the communist regime lost its monopoly, several new unions were established, the largest being the Health Workers' Democratic Union. A notable feature since the mid-1990s has been the rapid growth in the number of other voluntary organizations, some of which are not just simple interest groups, but have been delegated regulatory functions that were formerly under direct governmental control.

Abolished by the communist regime, the Hungarian Medical Chamber began to function again in 1988, initially on a voluntary basis. Act XXVIII of 1994 on the Hungarian Medical Chamber made membership compulsory for practising physicians and dentists, and defined the structure, tasks and responsibilities of the Medical Chamber, including issuing a code of ethics for medical practice (1994/2). The Chamber can discipline those who violate its rules, and it has the right to voice opinion on a range of medical issues and to veto contract conditions between medical doctors and the NHIFA. The Hungarian Chamber of Pharmacists was also established in 1994 (1994/5).

In 2003 the government decided to extend professional self-regulation to other qualified health care workers by establishing the Chamber of Non-Medical Health Professionals (2003/18). Compulsory membership in the professional chambers was eliminated and the regulatory rights of the Chamber of Pharmacists were curtailed along with the liberalization of the pharmaceutical retail market in 2006 (2006/8, effective 2007).

There are many other professional and scientific associations in Hungary. Examples include the Hungarian Hospital Association, the Association of Health Care Financial Directors, the Association of Nursing Directors, the Hungarian Nursing Association, the Hungarian Pharmacists' Association and the Hungarian Dental Association. The largest professional organization in Hungary is the Federation of Hungarian Medical Societies.

Patient associations in Hungary are growing in number and influence. Their participation has been institutionalized in waiting list committees, in the National Health Council, regional health councils and in hospital supervisory councils (1997/20, 1998/24, 1998/25, 1998/28).

2.4 Decentralization and centralization

In the early 1990s, health reform in Hungary sought to move the sector from central government control. Decentralization was the dominant tendency throughout the restructuring process, and the health care sector became decidedly more pluralist, with responsibilities divided among several players. For example, the responsibility for the provision of certain public services was devolved to local governments in 1990, along with the ability to raise and spend revenue. As part of this process, the ownership of most health care facilities was transferred to local governments, which became the dominant providers in the health care system.

The role of the central government as the direct provider of services has continued to decrease since the mid-1990s, but its role as a funder (see subsection *Revenue collection* in section 6.1.2), purchaser and regulator has grown. Indeed, successive governments since that time have gradually restored more central control, mainly focusing on the NHIFA as a way to limit health spending. For example, whereas the supervision of financing for health services and the control of the NHIFA were delegated to the Health Insurance Self-Government in 1993, these duties were reassumed by the central government in 1998. Another example is the regulation of the medical profession, which was partly delegated to the Hungarian Medical Chamber in 1994, but partly centralized again in 2007 when the government abolished compulsory membership in the Chamber for practising physicians and withdrew some of the Chamber's disciplinary rights (2006/7). Similarly, the consultation rights of the Chamber of Pharmacists in the licensing of new pharmacies was curtailed with effect from 2007 (2006/8).

However, there have also been developments in the opposite direction. Successive governments between 2002 and 2010, for example, have revitalized the idea of regional planning and development, providing the legal basis and financial support for regional health councils entrusted with the elaboration of regional health plans on a voluntary basis (2003/4) (see section 2.3.9 and subsection *Capacity regulation* in section 6.1.1).

With regard to health care providers, although the legal background for the different types of privatization was created in the early 1990s, significant privatization has taken place only in primary care (section 5.3) and among pharmacies (section 5.6). A few hospitals have been given back to their original church owners and are run on a non-profit basis, but the majority of providers of specialist health services remained in local government ownership. In secondary outpatient care, many physicians offer part-time private clinics in addition to their public sector employment. In addition, some private polyclinics have been established, where patients pay for services out-of-pocket. The role of private capital in inpatient care remains controversial in Hungary and is described in detail in subsection *Ownership and management of health care providers* in section 6.1.1.

2.5 Planning

Reforms in the 1990s transformed the Hungarian health care system into a split purchaser–provider contract model. The two crucial steps in moving away from the integrated, Semashko-style model were (a) the establishment of the HIF, the Health Insurance Self-Government, and the NHIFA and (b) the transfer of responsibility for service provision and the ownership of the majority of health care facilities to local governments, which act as providers. The decentralization of both purchasing and service delivery initially left the central government with the regulatory role only. The expectation was that local governments would plan for local health needs and would be able to do away with the legacy of excess capacity without direct intervention from the central government. For a number of reasons, however, this did not happen. The most important of these was not a lack of administrative, methodological or information technology (IT) capacities in health planning, but rather the political consequences of closing down a hospital which, in certain cases, was the biggest employer in a given town.

Governments reacted to the situation in two waves, both of which were targeted at the purchaser's side. First, between 1994 and 1998, the government regulated the NHIFA's capacities for contracting with the providers. Initially, the Minister of Welfare (now known as the State Minister for Health) was appointed to make downsizing decisions (1995/9), but this was later found to be unconstitutional because of the ad hoc nature of the decision-making process (1995/13). Act LXIII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms approached the problem in a more systematic manner, defining capacities in terms of outpatient specialist consultation hours and hospital beds per county according to a needs-based formula (1996/4). Local governments' responsibility for health care provision – the so-called territorial supply obligation – was defined based on these capacities (see section 2.2 and the introductory section of Chapter 5). Second, the government in power from 1998 to 2002 regained full control over the purchasing function when it abolished the self-governments of the HIF and PIF (see section 2.2). In reality, the government had never lost control of health care financing, since the budget and sub-budgets of the HIF had always been approved by the parliament, and new investments had always been controlled through the system of so-called earmarked and target subsidies. Cutting out negotiations simply made the government's purchasing decisions, such as controlling pharmaceutical expenditure, easier to implement (1998/26).

Within the current regulatory framework, the central government exercises strict control in revenue collection, determining the benefits package, setting uniform requirements for provider reports, budget setting, financial resource allocation, and contracting and payment. Most of these tools, however, have been used primarily in the context of cost-containment. The NHIFA is allowed to engage in selective purchasing only in the field of pharmaceuticals.

2.6 Intersectoriality

After the National Assembly stressed the importance of an intersectoral, multilevel national collaboration with a particular focus on non-communicable disease in its resolution on the ten-year NPHP (2003/1), the Ministry of Health⁵ set up an Intersectoral Public Health Committee (Vokó, 2009). The necessity to incorporate the priorities of the NPHP in the decision-making process for intersectoral policy-making in public policy was underlined again by the National Assembly in 2004 (2004/11). Despite this high-level legal and political support, a sustainable and appropriate organizational framework was not established (Vokó, 2009).

According to several leading experts in the field, health policy-makers have not been able to influence the organizational framework of the other public policy programmes. Although the members of the Intersectoral Public Health Committee reported on the planning and implementation of their own activities, they were unsuccessful in pursuing and setting intersectoral health goals, and rather could only initiate activities that were restricted to the health care sector (Vokó, 2009). After the change of government in 2006, the NPHP was no longer a government priority, and the activities of the NPHP were greatly decreased.

The WHO Framework Convention on Tobacco Control was incorporated into Hungarian law in 2005 (2005/1), although prior to that the legal protection of non-smokers had been in effect since 1999 to protect all persons from exposure to tobacco smoke and to regulate the consumption of tobacco products, including packaging and labelling (1999/2). Upon evaluation of the legislative tools in this area, further measures were proposed and accepted by the National Assembly in April 2011, on making public places, including restaurants and bars, smoke free. The implementation of the new regulation will start as of January 2012.

⁵ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

The characteristics and extent of health inequities in Hungary since the mid-1980s have been thematized in scientific literature (Kósa, 2009; Kósa et al., 2007). The NPHP intended to address primarily the marginalized sections of society, such as Roma minorities, disabled people and the homeless, especially with regard to improving their access to health services. Planned interventions to deal with health inequities within the wider framework of social determinants of health have been lacking, however (Kósa, 2009).

The regulatory framework for health impact assessments was incorporated into the legal framework of environmental assessment. According to this, the government defines those activities where environmental assessment is either obligatory or optional (1995/7). In 2005, the government refined the regulation of health aspects more in detail (2005/10). There is a tendency towards the increased use of health impact assessments at the local level, but health impact assessment is often overlooked in the political decision-making process since there is no effective approach to involve the political stakeholders, such as the Health Committee of the National Assembly, more deeply in the procedure.

2.7 Health information management

2.7.1 Information systems

A transparent and consistent strategy for information and communications technology in the Hungarian health system is still lacking. Based on a national IT centre created as part of the first government IT programme at beginning of the 1970s, the Information Centre for Health Care was founded in 1987. That year, the centre began a pilot project to collect cost data in hospitals to be used in the HDG system (1987/1). The Centre played a key role in running the financing reporting system of the providers and in preparing policy decisions, especially with data collection. Since 2004 it has continued its work within the organizational framework of the NHIFA. In addition, the NISHR was assigned to take part in developing eHealth policy proposals by establishing a special management unit (WHO, 2006).

With regard to all contracted and financed services of the NHIFA, the data collection and reporting obligations of the providers are clearly linked to health financing. Even family doctors must send itemized performance reports to the NHIFA despite their being paid, for the most part, through capitation. The structure and content of the reports are strictly regulated by the government (1999/1). Despite the high priority placed on information and communications

technology in health investments and reforms in last decades, there are still several problems in the Hungarian health information system, including serious concerns about data quality; a lack of trustworthy and up-to-date master databases; sluggish data delivery, outdated patient record structure and data collection requirements; and data security problems, especially in sharing patient information among providers (Ministry of National Resources, 2010).

To provide patients, health professionals and the wider public with health care information, the State Secretariat for Healthcare developed an internet and call centre-based health information service called Dr. Info (www.dr.info.hu). The service is available around the clock and provides information on a wide variety of topics, including the availability of health care providers (addresses, phone numbers, opening hours) and of civil organizations related to health care; medicines, including price, reimbursement, prescription information; the structure, availability and function of the health care system (summaries of laws and regulations); electronic medical books and dictionaries with descriptions of illnesses; quality indicators of hospitals; general information about lab tests; and an International Classification of Diseases code interpreter.

2.7.2 HTA

HTAs have gradually begun to take root in the Hungarian health care system. Starting in the late 1990s, cost-effectiveness increasingly came to be recognized as an important criterion in reaching resource allocation decisions, and it was first made into an obligatory criterion in purchasing decisions in the case of pharmaceuticals (2000/7, 2001/3). In 2002 the Ministry of Health⁶ issued a national guideline on preparing economic evaluation of health care interventions (2002/12). The guideline provides a detailed description of the structure and content of a model economic evaluation, including certain country-specific parameters. This was a significant step towards a systematic application of economic evaluation to support decision-making on services covered by the HIF.

The Hungarian Health Economics Association was created in 2003 by health economists and academic health professionals, but it now has an extensive membership, including experts from the public and the business sector as well as from research and academic institutions dealing with HTA. The real breakthrough in the field of HTAs, however, started in 2004, when the government was obliged by EU law to incorporate Directive 89/105/EC into national legislation. The Directive stipulates that the NHIFA must decide on

⁶ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

reimbursement applications by the producers and traders within a maximum period of 90 or 180 days, respectively, after submission. This clearly provided the main incentive for the much more extensive and elaborate use of HTAs in recent years, as well as for the substantial rise in the number of journal publications analysing the cost-effectiveness of medical technologies, especially pharmaceuticals.

In 2004 the NISHR was established, which among other things assists in health policy decision-making through HTA, especially by providing technical support to the Health Technology Appraisal Committee of the NHIFA. This task is performed by the National Institute's Office of Health Technology Assessment, which carries out a critical review of the evidence submitted by producers. The Health Technology Appraisal Committee, which is responsible for making the final recommendations on the inclusion of new substances in the positive list, appraises this review along with all other available information from the NHIFA and other professional bodies (2004/4). HTA has since been expanded to include other medical technologies and equipment, and will, it is hoped, strongly incentivize further development in the area (2010/3).

2.8 Regulation

The chief regulatory role in the Hungarian health system is played by the government and relevant ministries, but other actors, such as the professional chambers, National Institutes of Health and the NPHMOS, are also involved. All aspects of the service production process are regulated. With regard to health care inputs, there is extensive regulation of human resources, medical devices and medical facilities.

2.8.1 Regulation and governance of third-party payers

Although the head of the NHIFA is appointed by the prime minister, the NHIFA is directly supervised by the State Secretariat for Healthcare (2006/16). For its part, the NHIFA plays an important role in preparing the policy decisions of the State Secretariat for Healthcare, and it also makes proposals for improving existing regulations.

The package of benefits covered by the HIF is defined in Act CLIV of 1997 on Health (1997/20) and Act LXXXIII of 1997 on the Services of Compulsory Health Insurance (1997/9). The HIF scheme provides nearly universal coverage and a comprehensive benefits package with few exclusions and little or no

co-payment except for pharmaceuticals, medical aids and prostheses and some additional services. There is still no regular mechanism for reviewing the benefits package to exclude services that are not cost-effective (see section 3.3.1).

Strategic health planning and systematic needs assessment are not applied in purchasing decisions. Similarly, a framework for systematic performance measurement is also lacking. As a result, mechanisms for ensuring accountability are restricted mainly to audits conducted by the State Audit Office, which focuses for the most part on financial and legal aspects of providers' business operations. On an annual basis, the State Audit Office also publishes a global report on any changes made to the regulatory framework of the health system.

The establishing and functioning of private insurers, including the rules of competition, are regulated by the National Assembly and supervised by the government (1995/12).

Cross-border care and care for non-resident citizens of other EU Member States are described in section 2.9.6.

2.8.2 Regulation and governance of providers

According to the primary division of tasks between counties and municipalities, only the former are responsible for the provision of secondary and tertiary care to the local population. In practice, however, municipalities also provide specialist care on the basis of the principle of subsidiarity. In general, county governments own large multi-specialty hospitals, which provide secondary and tertiary inpatient and outpatient care to the acutely and chronically ill, whereas larger municipalities own a range of institutions, including polyclinics (independent, multi-specialty institutions providing outpatient specialist care), dispensaries (single-specialty institutions providing outpatient care to the chronically ill), and multi-specialty municipal hospitals (which provide secondary acute and chronic inpatient and outpatient care). Outpatient care is provided in hospitals or in independent polyclinics. Since 2004, the outsourcing of hospital management has become more common (see section 2.4).

The central government also owns hospitals, which provide acute and chronic inpatient and outpatient care. These are divided among the Ministry of Interior, the Ministry for Economic Development, the Ministry of Defence, the Ministry of Justice and the Ministry of National Resources (see section 2.3.3). The Ministry of National Resources owns university hospitals. The single-specialty clinical departments of the medical faculties provide both secondary and tertiary care. The Ministry of National Resources also manages

single-specialty providers known as the National Institutes of Health, which for the most part deliver highly specialized tertiary care only, as well as state hospitals, which are mainly sanatoria that provide medical rehabilitation.

The territorial supply obligation applies to all public providers, but the size of the catchment area is determined by the NPHMOS and depends on the type of care provided and on the estimated number of people in need (see sections 5.3 and 5.4). The same health care institution can have different catchment areas for different types of care. In general, secondary outpatient care services have been assigned the smallest catchment area, which are, however, still larger than primary care districts. Tertiary care is offered at least on a regional basis. Highly specialized tertiary care services, which are provided to patients suffering from rare diseases, have the largest catchment area, namely the whole country (1990/3, 1997/20).

Health care providers must obtain a licence to practice from the NPHMOS, which maintains a registration database (1989/5, 1996/5, 1997/11). Before issuing a licence, medical officers from the NPHMOS inspect the facilities and ascertain whether minimum standards for infrastructure, hygiene, personnel and material supplies have been fulfilled. Special rules apply to a number of services, such as primary care (2000/3), home care (1996/7), patient transfer (1998/6), emergency ambulance services (1998/7), human fertility treatment (1998/13), sterilization procedures (1998/10) and organ transplantation (1998/23). The provision of complementary and alternative medical treatment is also regulated in terms of related educational, infrastructure and administrative requirements (1997/1).

In 2000, the government introduced a complex quota system based on practice permits for family doctors. Each family doctor working in a primary care district with a territorial supply obligation in 2000 was granted such a permit (known as a “practice right”, or *praxisjog*; see section 5.3).

Family doctors currently have four employment options.

- 1) The municipality can employ family doctors on the basis of a monthly salary.
- 2) Family doctors can contract with the municipality as private providers for a primary care district, but they work in a surgery owned by the local government and use equipment owned by the local government. The family doctor is paid an adjusted capitation fee directly from the HIF to cover recurrent expenses, according to the number of registered

inhabitants, while the municipality remains responsible for capital costs according to the principle of maintenance obligation. This scheme is known as “functional privatization”.

- 3) Family doctors can work as independent private providers with no municipal contract and no territorial supply obligation, if patients choose them, but they are only entitled to capitation payment from the HIF if they have a minimum of 200 registered patients. It is worth noting that the system of “practice rights” established in 2000, does not apply to this group of practitioners.
- 4) Employment options were widened in 2001 and 2003 through the introduction of the so-called freelance medical doctor status (2001/12 and 2003/19), which removes doctors from public employee regulations, but does not make them self-employed private entrepreneurs. Physicians who opt for a freelance status contract with the health care provider and are free to negotiate fees; they are also allowed to form group practices.

Health service provision is supervised by the NPHMOS. Monitoring of providers is regular and includes checking personnel and material minimum standards, and the quality of services delivered. The system consists of supervisory chief medical doctors at the municipal, county and in some cases regional level for various medical specialties, and there is one national supervisory chief medical doctor for 54 specialty areas. The National Centre for Healthcare Audit and Inspection is responsible for appointing these supervisory chief medical doctors upon the approval of the national and regional chief medical officers and in collaboration with the professional colleges and the National Institutes of Health.

Reimbursement prices and utilization, including the scope of benefits, referrals and waiting lists are also regulated within the health insurance system.

To ensure the quality of training and minimum standards of service provision, all health workers are expected to improve their professional knowledge, and medical doctors must achieve a minimum of 250 credit points on accredited courses in a five-year continuing education cycle.

To ensure the quality of care provided, the government decided to develop a national accreditation system and create a system of quality assurance in 1994 (1994/7), requiring the professional colleges to take part in elaborating the standards of the quality assurance system (1995/4). In 1996 the government established the National Quality Award, for which the providers can apply based on the European Foundation for Quality Management model. But it was

only in 1997 that the National Assembly regulated the mechanism to ensure quality in health care by setting up internal and external mechanisms (1997/20), including the controlling and accreditation of the system. In this context, every institution is required to maintain internal quality system in order to develop services continuously and to prevent possible mistakes. At the same time, the external system ensures the proper licensing of the providers, which includes determining, maintaining and publishing standards, as well as the supervision of providers in this respect. The latter task is the responsibility of the NPHMOS. On a voluntary basis, the providers can seek additional assessment of the quality of their business operations by professional companies to obtain different certificates or they can participate in peer reviews.

Earlier, the requirements of the internal quality assurance systems were clarified in a guideline published by the Ministry of Health;⁷ however, the guideline was not updated after its expiry in 2005, although the Ministry of Health should have reviewed it every two years. Also, an overall quality monitoring system has yet to be introduced. For its part, the NPHMOS is charged with checking the existence of the internal quality assurance system of the providers and also other related activities regarding quality policies; these tasks are carried out via the National Centre for Healthcare Audit and Inspection. Based on its findings, it proposes only recommendations to refine the national standards published by the Ministry of Health (Ministry of Health, 2007).

In 2007 more than half of all Hungarian hospitals had some kind of certified quality assurance system, while most of these apply the International Organization for Standardization (ISO) 9000 quality system and other operational standards (Legido-Quigley et al., 2008). However, there is still no overall consolidated strategic plan for developing quality in health care (Gódeány & Csath, 2008).

There is elaborate legislation regarding medical negligence; the necessary procedures are carried out by the National Ethics Council and its county branches (1997/20), as well as the professional chambers in cases related to their members (2006/7) since 2006. For its part, the NPHMOS ensures the administrative support for the councils. In certain cases, the provider institutions have to apply Labour Code provisions regarding discipline. A professional-ethical procedure follows, during which councils or the chambers examine negligence cases and apply disciplinary measures. In many cases, the councils and chambers can start ethical/professional procedures when they are informed about a certain negligence of the professional staff (1997/20, 2006/7). All health

⁷ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

care providers are obliged to take out liability insurance to enable them to compensate patients appropriately in justified malpractice claims, which have to be checked by the NPHMOS (2003/7).

2.8.3 Registration and planning of human resources

Regulatory measures related to the registration, licensing and training of health professionals include:

- control of the number of health personnel to be trained by determining the number of students financed from the government budget (1998/4);
- control of recognition of foreign diplomas (1972/2, 1993/8, 1997/20);
- compulsory registration and licensing of health workers through the Office of Health Authorization and Administrative Procedures (OHAAP) (1998/12, 1999/6, 2007/5);
- regulation of the number of primary care practices with the introduction of the “practice right” (see section 2.8.2) (2000/1, 2000/2);
- determination of the minimum salary of public employee health workers (1992/5).

Medical professionals can proceed with their activities if they have the proper professional training, have completed their obligations regarding continuing education and are registered with the OHAAP. The EU standards for mutual recognition are applied in Hungary (1997/20). In 1998 the then Minister of Health established the Health Care Professional Training and Continuing Education Council to evaluate the professional and educational needs of the health system and to formulate proposals for developing the level of education, including for the accreditation of institutions offering education for specialists (1998/21, 2010/1).

2.8.4 Regulation and governance of pharmaceuticals

In Hungary, the pharmaceutical industry is comprehensively regulated, from production to marketing and distribution (1998/3). Pharmaceutical companies were previously owned by the state and not only supplied most of the domestic market but also exported to countries of the former socialist bloc. In the early period of the economic transition, the market was liberalized and all but one of the Hungarian pharmaceutical companies were privatized. The majority of

the wholesale and retail industries have also been privatized and, by the end of 1997, all of the previously state-owned pharmacies serving the general public were private (HCSO, 2002).

Because the National Assembly decided in 1990 not to use statutory pricing for pharmaceuticals, there is a system of free pricing at the manufacturer level for all pharmaceuticals in Hungary, whether these are prescription-only or over the counter (1990/4). Thus, pharmaceutical companies are free to set the prices of non-reimbursable pharmaceuticals as they wish, and there is no separate price-setting procedure. The retail and wholesale margins, however, are regulated by the State Secretariat for Healthcare, with the former being a combination of a proportional regressive and fixed mark-up, and the latter being a proportional regressive mark-up (2001/2, 2007/1). The retail margin is based on the wholesale price, and the wholesale margin is calculated based on the ex-factory or import price. The average mark-up of pharmacies was 19.5% in 2006 (PPRI, 2007).

In 1992 Hungary signed the European Free Trade Area agreement and the Pharmaceutical Inspection Convention, and now follows EU registration conventions and inter-country notification practices, and enforces mandatory standards of good laboratory, manufacturing and clinical practices. All pharmaceuticals must pass a registration and licensing procedure administered by the National Institute of Pharmacy (1982/1, 1998/3) before they can enter into trade.

Within the framework of reimbursement decisions, price negotiations for the outpatient sector used to take place between the producers and a governmental committee. Representatives of the Ministry of Health,⁸ the Ministry of Finance and the NHIFA took part in the annual negotiations, formalized as the Social Insurance Price and Subsidy Committee (2000/6). Currently, however, there is no overall price negotiation with the producers, and they have to apply for reimbursement to the NHIFA. The proposed price is evaluated by the NHIFA based on either external or internal reference pricing, as well as the use of HTA for new substances.

In the case of innovative pharmaceuticals, companies have to indicate external prices in their reimbursement application. The manufacturer price of a new preparation containing active ingredients cannot be higher than the lowest existing manufacturer price in the reference countries selected by the State Secretariat for Healthcare (2004/4). The companies must indicate external

⁸ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

prices in their reimbursement application. Thus, the manufacturer price of the substances cannot be higher than the lowest existing manufacturer price in the countries listed in the application form.

Since payment of hospitals includes all the costs that can occur during acute hospital care, including pharmaceuticals, every hospital has the autonomy to purchase the necessary medical products by tendering or public procurement. Pharmaceutical companies usually offer rebates (discounts) to hospitals. With regard to the reimbursement of these medicines, the NHIFA applies the same procedure as that used for medicines delivered in outpatient care and includes them in the positive list in the 0% reimbursement category.

The State Secretariat for Healthcare also determines the rules of prescription, which can have an effect on the amount of subsidy for which the patient is eligible (1995/2, 2004/5). Concerning the level of reimbursement, the subsidy in the normal positive list can be 0%, 25%, 55% or 80% of the agreed consumer price (including VAT as of 2009), while for expensive pharmaceuticals with approved special indications, such as insulin for diabetic patients, the reimbursement can be 50%, 70%, 90% or 100% of the consumer price if prescribed by a specialist or through the written recommendation of a specialist, otherwise they fall under the lower reimbursement levels of normal reimbursement as of 2006 (2004/4). The list of diseases is defined by the State Secretariat for Healthcare along with the Ministry for National Economy. In addition, there is special reimbursement for people with low incomes within the pharmaceutical co-payment exemption system, and pharmaceuticals can also be reimbursed through individual applications. In addition, certain very expensive drugs are purchased centrally by the NHIFA. In 2007 the reimbursement of the normal list accounted for 41.9% of the pharmaceutical expenditure of the NHIFA (PPRI, 2007).

Regarding generics, there are some specific regulations that determine the maximum reimbursement prices. Within the framework of internal reference pricing, a generic is eligible for reimbursement when its price is equal to or lower than the daily cost of therapy of the reference product that has the same active ingredient and the same strength. If its price is higher, then the product is eligible for fixed-amount reimbursement, classified either by substance or in certain cases by therapies. Through the mechanism of step pricing for generics, additional conditions for the inclusion of generics were laid down, namely that the manufacturer price of the product should be at least 30% below the manufacturer price of the original preparation as long as the first reference product or reference price is set (2004/4). Similarly, the next generic included

in the positive list in this substance group has to apply a 10% lower price compared with the first product, then the third product has to be priced 10% lower than the second one. Other competitors must simply apply a lower price for reimbursement than the previous ones from 2006 (2004/4, 2006/20).

Besides the clawback scheme for the pharmaceutical industry, there have been individual price–volume agreements with manufacturers for certain pharmaceuticals since 2003 (2002/21). Trader or manufacturer repayments are based on the annual sales volume. Overspending in the pharmaceutical budget caused by sales exceeding the contracted volume is covered by both the government and the industry. The higher the overspend, the higher the share covered by the industry. Monthly repayment can also be agreed in the individual contracts.

Since 2004, when Hungary joined the EU, it has been necessary to adopt the Transparency Directive of the European Commission (89/105/EEC). As a result of the introduction of the Transparency Directive, the government has to decide on reimbursement applications of traders and manufacturers with a maximum time of 90 days.

In the case of new substances, companies are required to submit their applications to the NHIFA together with a comprehensive study in order to demonstrate the cost–effectiveness of their products and to obtain reimbursement status for their pharmaceuticals, that is, to be accepted onto the positive list. The Pharmaceutical Department of the NHIFA transfers the complete documentation to the Office of Health Technology Assessment of the NISHR in order to carry out a critical appraisal of the documents. Further evaluation takes place by the Technology Appraisal Committee within the NHIFA, involving the experts of the professional colleges, to evaluate the merits and shortcomings of the application. The final reimbursement decision on new substances for outpatient care is made by the Head of the Pharmaceutical Department of the NHIFA, while in the case of hospital-only medicines, it is done by the Head of Department for Financing (formerly Curative-Preventive Provisions).

Effective 2007, the government focused increasingly on fostering more competition by refining the internal reference pricing system through laying down more rigorous rules for excluding the expensive products of competitive substance groups; liberalizing the ownership of the retail market, such as pharmacies; and increasing the accountability of physicians by setting standards and requiring more rational prescription of pharmaceuticals through centrally accredited IT programs (2006/8).

2.8.5 Regulation of medical devices and aids

The trading, distribution, prescription and use of medical aids and prostheses (such as hearing aids and wheelchairs) are regulated in a similar way to the pharmaceutical system. Registration and licensing have recently been reorganized according to EU regulations (1999/8). The system is run by the OHAAP of the State Secretariat for Healthcare (2000/4). Compared to pharmaceuticals, medical aids and prostheses have been less subject to cost-containment policies, for example, margins for wholesale and retail prices have not yet been regulated.

Medical devices, including medical aids and prostheses, fall under a registration and licensing system administered by the Authority for Medical Devices of the Ministry of Health⁹ (2000/4). In 2009, the government proposed the system for reimbursing medical aids, which follows a similar logic to that governing the reimbursement of pharmaceuticals. Therefore, since 2010, medical aids have also been reimbursed by the NHIFA through various financial techniques, such as by a proportional or a fixed amount (2010/9). In the case of proportional reimbursement, the categories are defined as 98%, 90%, 80%, 70%, 50% or 0%. Likewise, internal reference pricing is also used to determine the reimbursement of certain medical aids classified in reimbursement groups (see also section 2.7.2) (2010/13).

2.8.6 Regulation of capital investment

In 1990, the budget of the health service was transferred to the newly established Social Insurance Fund. Since the Social Insurance Fund was meant to cover the recurrent costs of services, funds for capital costs remained in the central government budget. In 1989, full private health care entrepreneurship was legalized and private providers were permitted (1989/5).

The owners of health care facilities are responsible for financing capital costs. Such investment costs are usually beyond the financial capabilities of local governments, which have owned the majority of health care providers since 1990 (1990/3). The central government provides subsidies via conditional and matching grants. Given that most capital investment comes from these funds, this system allows the central government to control health care investment (1992/9).

⁹ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

2.9 Patient empowerment

2.9.1 Patient information

Act CLIV of 1997 on Health made a systematic and elaborated move to address patient information, specifying in detail rights that were previously incorporated in the legal obligation of medical professionals or that could be deduced from judicial practice (Sándor, 1997) (1997/20). According to the Act, patients have the right to complete and detailed information from health care providers, particularly on their health status; on the recommended interventions with the alternatives, including clarifying the possible benefits and drawbacks; and on the decision rights of the patients regarding treatment. This should be done by the provider in understandable way, taking into account the age, schooling and mental capability of the patient, and ensuring a translator is provided if necessary. Also, the patient can refuse to be informed, although the precondition for any medical intervention is that the patient should be properly informed and give prior consent to the intervention in written form or as implied through their conduct.

Moreover, the Act stipulates that patient documentation should be carefully maintained by the medical provider, while giving the right of disposal of the data in the documentation to the patients – who have the right to read and obtain a copy of the documentation at their own expense – and guaranteeing the right to privacy (1997/20). To provide patients and the wider public with health information in meaningful way has taken effective form with the establishment of a web and call centre-based health information source for both patients and health professionals, but there are only few health promotion programmes that are aimed at increasing the health literacy of the population. Unfortunately, there is no systematic assessment of the accessibility and the usefulness of the available information, as well as to what extent the population has clear sense of the benefits to which they are entitled.

2.9.2 Patient choice

Since the HIF operates as single statutory structure at the national level, there is no competition between purchaser organizations. However, Act CLIV of 1997 on Health acknowledges and emphasizes the right of patient autonomy through which patients have, first of all, the freedom to decide whether they accept or refuse certain medical services (1997/20).

Moreover, the right of choice is given to patients with regard to some of the medical services financed by the NHIFA. Since 1992 people are allowed to choose a family doctor freely, with the restriction that they may change only once a year. Family doctors are not allowed to refuse patients who live in their primary care district, but are offered the choice of not accepting applicants from other districts (1992/3, 1997/9). Similarly, patients can contact specialists from a variety of disciplines without referral. The patients can choose to be referred to other health care providers than the providers originally assigned for the treatment, provided that the chosen provider is willing to accept the patient by stating this in written form. The chosen provider has to accept the patient unless there is no financed free capacity, or if the provided care would endanger the care of the patients who are assigned within the catchment area of the given provider. Also, patients can request other health professionals to treat them, but the providers can charge extra fee for this service (1997/9). See sections 5.3 and 5.4 for more details on primary and specialist care.

Co-payments are also due when non-emergency specialist services are obtained without referral from an authorized medical doctor, normally the family doctor; or patients choose to go to a provider other than the one they were referred to; or, finally, patients want to receive more services than the doctor prescribed (1997/9, 1997/18). See subsection *Depth of coverage* in section 3.3.1 for more details.

At health policy level, knowledge is limited on: how patients exercise their choices; whether the levels of information facilitate choice; and how the current level of choice affects equity and efficiency.

2.9.3 Patient rights

The chief significance of Act CLIV of 1997 on Health came from its declaration of patient rights, which had not been previously regulated in a comprehensive manner. The Act also established the institution of patient rights representatives and the institution of arbitration for resolving disputes between patients and health care providers (1997/20, 2000/9).

Following the Declaration on the Promotion of Patients' Rights in Europe by WHO in 1994, the approved Act CLIV of 1997 on Health incorporated these rights extensively, together with the patient's obligation regarding cooperation with the providers and respect for the rights of the other patients as well as the medical professionals. The chapters of the defined rights frame one of the core concepts of the law. Some of these rights have been discussed above in subsections 2.9.1 and 2.9.2. Partly repeating them here, the following rights were

established by this law: the right to provision of care; the right to human dignity; the right to maintain personal contacts while under treatment in hospital; the right to stop or refuse treatment and leave the medical institution providing the care; the right to autonomy and to give informed consent; the right to get to know the patient file; the right to privacy and the right to submit a complaint to the providers or to the owner of the providers (1997/20).

To enforce these rights, the institution of patient representatives was created by Act CLIV of 1997 on Health, with the aim of supporting patients in accessing their medical files and formulating their complaints, to represent the patient for the providers and to inform medical professionals of the change of the regulation regarding patient rights (1997/20), but the new institutional framework started in the organization framework of the NPHMOS as of July 2000 with the implementation of the regulation of the then Minister of Health (1999/14). After the resolution of the National Assembly in 2002 (2002/2), representation of the rights of the patients and citizens participating in social welfare programmes were integrated in one public foundation, while the representatives were employed and supervised by the Foundation for the Rights of Patients, Social Service Beneficiaries and Children (2004/1). With respect to hospitals, the representative has the obligation to work one full day in the hospital per week and also to be available for consulting hours once a week in the regional office of the Foundation (2004/1). According to the report of the Foundation, there were 52 patients' right representatives of the Foundation covering 144 hospitals and 29 outpatient providers. The report evaluated the cooperation with the management of the providers as effective, and the visibility of the contact information of the representative is 98% (Foundation for the Rights of Patients, Social Service Beneficiaries and Children, 2009). The representatives work mostly with case management in 45% of their working hours and with patient information in 20%. The Foundation handled 11 297 complaints in 2009, most of which addressed breaches of the right to health care provision but there is an increasing trend of breaches of the right to human dignity (Foundation for the Rights of Patients, Social Service Beneficiaries and Children, 2009).

These findings were confirmed by the observation of the members of the National Health Council, who concluded that the current implementation of the regulation should be improved and that the most critical areas are the right to human dignity, the right to information and the right to proper care (National Health Council, 2010). They called for the evaluation, development and restructuring of the institutional mechanism of patient rights.

2.9.4 Complaint procedures

In addition to patient rights representatives, there are parallel procedures for handling patients' complaints. Act CLIV of 1997 on Health introduced the institution and procedures of arbitration via so-called arbitration councils to resolve disputes between patients and health care providers without going to court (1997/20); the procedure was regulated in detail in 2000 (2000/9).

The complaint of the patients must be investigated by the provider, which must inform the patient on the findings within a maximum of 30 days, and which must regulate the procedure at the institutional level (1997/20). Furthermore, patients can turn to the so-called councils or the chambers of medical professionals that apply professional/ethical procedures when they examine cases of negligence, and can apply their own disciplinary measures. Also, it is possible to submit complaints to the departments of the State Secretariat for Healthcare or to turn to the Parliamentary Commissioner for Civil Rights or, finally, to initiate criminal proceedings. Currently, it is unknown to what extent patients use these alternative mechanisms.

2.9.5 Public participation

Patient associations are growing in number and influence. In 2000, there were over 80 organizations active in various fields of health and health care (Lengyel, unpublished data, 2009). Their participation has been institutionalized in waiting list committees, in the National Health Council and in hospital supervisory councils (1997/20, 1998/24, 1998/25, 1998/28).

Members of the National Health Council have said that it is important to create closer links between government bodies concerned with health, patients' associations and patient representatives (National Health Council, 2010), whose opinion is only weakly represented in the system, partly because the traditionally self-regulatory aspects of the archetypal SHI system do not exist in Hungary. The 2638 foundations and associations active in health care in Hungary in 2005 represented only 4.7% of the total number of non-governmental organizations (NGOs) working in Hungary that year (Péntek, 2009).

There have been several surveys on public satisfaction that investigated the level of satisfaction with the medical treatment available in the country. In 2007 the Gallup Organization, at the request of the Health and Consumer Protection Directorate-General, measured patient satisfaction across EU Member States, and the findings showed that compared both to the EU15 average (89%) and the EU27 average (83%) only 52% of Hungarians were satisfied with care received

– a fairly poor outcome, with only Romania and Bulgaria lagging further behind (European Commission, 2007). For more details on user experience of the health system see section 7.3.1.

2.9.6 Patients and cross-border health care

Cross-border care and care for non-resident citizens of other EU Member States are regulated mainly on the basis of the European Commission Regulation 883/2004, which is administered within the organizational framework of the NHIFA. Using the European Health Insurance Card (EHIC), Hungarians covered by the HIF may receive medically necessary treatment for unforeseen causes free of charge while staying abroad (1997/9). Regarding planned hospital care in other countries, a prior authorization from the NHIFA is obligatory (1997/9). The possibility for this kind of service was already available in 1988 (1988/1). The treatment of non-resident citizens of other EU Member States can be provided under separate bilateral agreements (1997/9).

Patient mobility has been increasing since 2004, when Hungary joined the EU, although it is still limited both in volume and in value. In 2007 total expenditure on medical services within the framework of the patient mobility, which includes payment both for Hungarians in other countries and the prepayment to the Hungarian providers by the NHIFA for foreigners using in health care services in Hungary, was only 0.32% of total health expenditure (Lengyel, unpublished data, 2009). Since 2004, foreign third-party payers issued certification in 24 000 cases for health care costs of their members in Hungary while the NHIFA did the same for 23 600 Hungarian residents who work in other EU countries (Lengyel, unpublished data, 2009). The number of pensioners who moved to Hungary is only 5318 since Hungary's accession. There is a decreasing trend in the number of foreign patients who pay the full cost of provided health care directly, and who come mainly from Romania, Germany and Austria (Lengyel, unpublished data, 2009)¹⁰. However, dental tourism is the predominant form of cross-border care in Hungary (see section 5.12 for more detail).

Between 2004 and 2008, the number of the patients who received health care using the E111 form was 13 371, the vast majority being German and Austrian residents. NHIFA expenditure on Hungarians who use care provided in other EU Member States, especially in Austria, is continuously increasing (Lengyel, unpublished data, 2009).

¹⁰ Provider data collection in this field is not strictly monitored; caution during interpretation is indicated.

It is surprising that, although the measured satisfaction level with received care is fairly low, Hungarians' motivation to travel to another EU Member State for medical treatment is very low compared with other EU countries, given all the motivating factors, such as reducing waiting times for medical treatment; receiving cheaper or better-quality care; receiving treatment from a renowned specialist; and receiving treatment that is not available at home (Lengyel, unpublished data, 2009).

3. Financing

3.1 Health expenditure

In 2009 Hungary spent 7.4% of its GDP on health, or a total of HUF 1940 billion (€7.0 billion). Based on OECD data, public expenditure on health accounted for 69.7% of total health spending that year. In 2009, per capita spending on health amounted to US\$ 1510.7 at purchasing power parity (PPP) (Table 3.1).

Between 1995 and 2000, private expenditure on health as a share of total health spending almost doubled and has remained close to 30% ever since. As a share of GDP, public expenditure on health dropped from 6.1% to 5.2% between 1995 and 2009, whereas the share of OOP payments increased from 1.2% of GDP to 1.8% of GDP. Although the predominance of public over private expenditure has not changed since the new system of health care financing started to operate in 1990, the share of OOP payments¹ in total health expenditure rose from 16.0% in 1995 to 26.3% in 2000 and has remained stable around 23.7% since 2005. Spending through voluntary health insurance, however, accounted for only 7.4% of private expenditure on health and 2.7% of total expenditure on health in 2009, up from 0.6% and 0.2% in 2000, respectively (Table 3.1).

Between 1988 and 1994, the health sector was accorded relative priority, which meant that health spending was allowed to rise – at least as a share of GDP – despite negative economic growth. Although the overall economy began to expand in 1994, the pace of growth slowed in 1995 and 1996. In anticipation of an economic crisis, the government implemented strict stabilization policies in 1995 and 1996, targeting public expenditure on health, among other areas. Although the economic growth that resumed in 1997 proved to be both substantial and stable, public expenditure on health decreased as a share of GDP, falling to 4.9% in 2001, its lowest level since 1995 (WHO Regional

¹ Including co-payments and co-insurance for pharmaceuticals.

Office for Europe, 2011). The economic stabilization policies implemented by the government in 1995 and 1996 were continued by the next administration, at least with regard to the health sector.

Table 3.1

Trends in health expenditure in Hungary, 1995–2009

	1995	2000	2005	2008	2009
Total expenditure on health (billions of HUF)	420	939	1831	1933	1940
Total expenditure on health (billions of US\$ at PPP) ^a	6.8	8.7	14.2	14.4	n/a
Total expenditure on health, US\$ per capita at PPP, WHO estimates	658	853	1411	1495.5	1510.7
Total expenditure on health as % of GDP	7.3	7.0	8.3	7.2	7.4
Public expenditure on health as % of total expenditure on health	84.0	70.7	72.3	71.0	69.7
Private expenditure on health as % of total expenditure on health	16.0	29.3	27.7	29.0	30.3
Public expenditure on health as % of total government spending ^a	11.3	10.6	12.0	10.5	n/a
Public expenditure on health as % of GDP	6.1	5.0	6.0	5.1	5.2
Private expenditure on health as % of GDP	1.2	2.1	2.3	2.1	2.3
Out-of-pocket payments as % of total expenditure on health	16.0	26.3	23.8	23.8	23.7
Out-of-pocket payments as % of private expenditure on health	100.0	89.8	85.9	82.1	78.2
Out-of-pocket payments as % of GDP	1.2	1.8	2.0	1.7	1.8
Spending through voluntary health insurance as % of total expenditure on health	0.0	0.2	1.1	2.2	2.7
Spending through voluntary health insurance as % of private expenditure on health	0.0	0.6	4.1	7.4	7.4
Spending through voluntary health insurance as % of total expenditure on health	–	0.2	1.1	2.1	2.7
Spending through voluntary health insurance as % of private expenditure on health	–	0.6	4.1	7.4	7.4

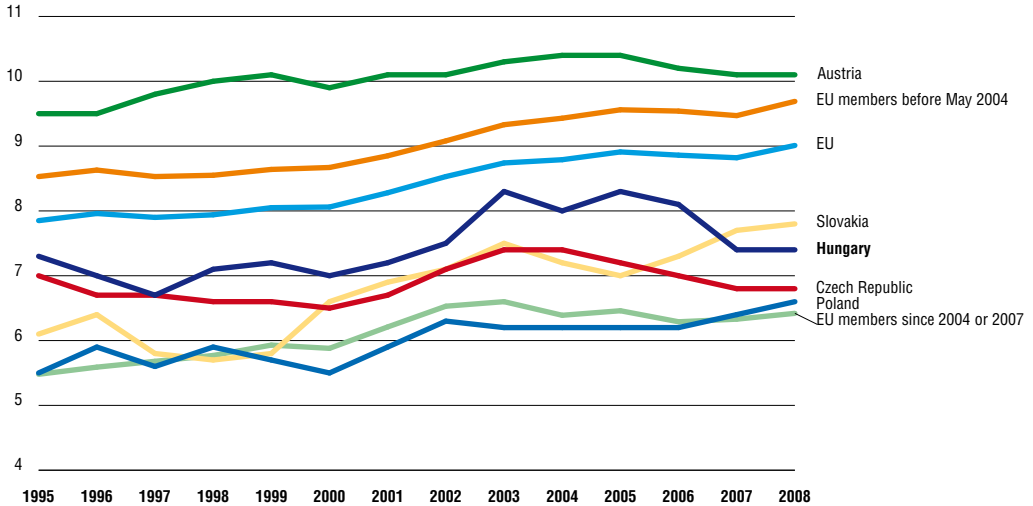
Sources: OECD (2011); ^a WHO Regional Office for Europe.

Due to a large increase in public sector wages in 2002, public expenditure on health increased as well, peaking for the second time since 1994 at around 6.0% of GDP between 2003 and 2005 (WHO Regional Office for Europe, 2011). However, austerity measures aiming to meet the financial criteria for introducing the euro in Hungary substantially reduced public spending on health, as did a spate of additional cost-containment measures taken in the wake of the global economic crisis, which hit Hungary with full force in the autumn of 2008. In late 2010, the macroeconomic climate was still unfavourable, and the government had little choice but to observe the deficit target set by the EU and the IMF, both of which appear to have taken a hard line as a result of the financial crisis in several EU countries. Substantial increases in public spending on health should therefore not be expected in the near future, despite government declarations to the contrary (Government of the Republic of Hungary, 2010a).

The most notable feature of health spending in Hungary is its instability, with several waves of short spending increases followed by longer periods of cost-containment and budget cuts. Successive Hungarian governments since 1990 have implemented effective cost-containment policies, reducing public expenditure on health from 6.1% of GDP in 1995 to 5.2% in 2009 (Table 3.1). Comparative data reveal that decreases in total health expenditure as deep as those seen in Hungary between 1994 and 1998, and again between 2005 and 2008, did not occur in any of the Visegrád Four countries after the mid-1990s (Fig. 3.1).

Fig. 3.1

Trends in health expenditure as a share (%) of GDP in Hungary and selected countries, 1994–2008 (or latest available year)



Source: WHO Regional Office for Europe, 2010.

In fact, Hungary (along with the Czech Republic) was one of two OECD countries where the average real annual growth of total health expenditure (3.7%) remained below the real annual growth of GDP (4.3%) between 1997 and 2007 (OECD 2009a). Between 1995 and 2009, public expenditure on health decreased not only in real terms but also as a share of total expenditure, falling from 84% to 69.7%. The latter percentage was lower than that of most central and south-eastern European countries, the Nordic countries and the UK, but similar to that in some western European countries, such as Spain and Belgium (Fig. 3.2). Taking into account that the informal economy has a larger share in

the GDP in Hungary and other transition countries than in the EU15 countries, the difference in health spending as a share of GDP between them is probably greater than shown in Fig. 3.3 (Schneider & Klinglmair, 2004).

The central government has been in a position to control HIF expenditure directly and, despite the predominance of local government in the ownership of health care providers, to control investments through conditional and matching capital grants (that is, earmarked and target subsidies).

As far as HIF expenditure is concerned, it was controlled initially directly by the National Assembly, but starting in 1996 the central government incrementally strengthened its control over the NHIFA, ultimately introducing full organizational control in 1998. The SHI system has been transformed in a way that allows the central government to contain the costs of most services. Since the mid-1990s, sub-budgets are assigned to the various services within the HIF (Tables 3.2 and 3.3). These sub-budgets are capped for curative and preventive services, and the corresponding provider payment methods ensure that the predetermined budget ceilings are not exceeded (see also section 2.8.1). As a result, public expenditure on health decreased (Table 3.1) and could be stabilized at a relatively low level.

Containing costs – in and of itself – does not ensure that resources will be allocated efficiently within the health sector. For instance, if patients are hospitalized for a disease that could have been managed effectively in an outpatient or primary care setting, resources are wasted. Although it is difficult to assess this kind of inefficiency based on aggregate spending data, the structure of HIF expenditure can be used as a crude proxy. Table 3.3 shows that the allocation of financial resources in Hungary has not changed significantly since 1995.

HIF expenditure growth for drugs, medical aids and prostheses proved to be hard to contain until 2007, when a strict cost-containment approach was applied for these HIF sub-budgets as well (see also section 6.1.2). Previously, rising pharmaceutical expenditure – attributable to the rapid liberalization of the pharmaceutical industry and the privatization of most state drug companies – had stymied successive governments, with overspending in the pharmaceutical sub-budget representing a major issue.

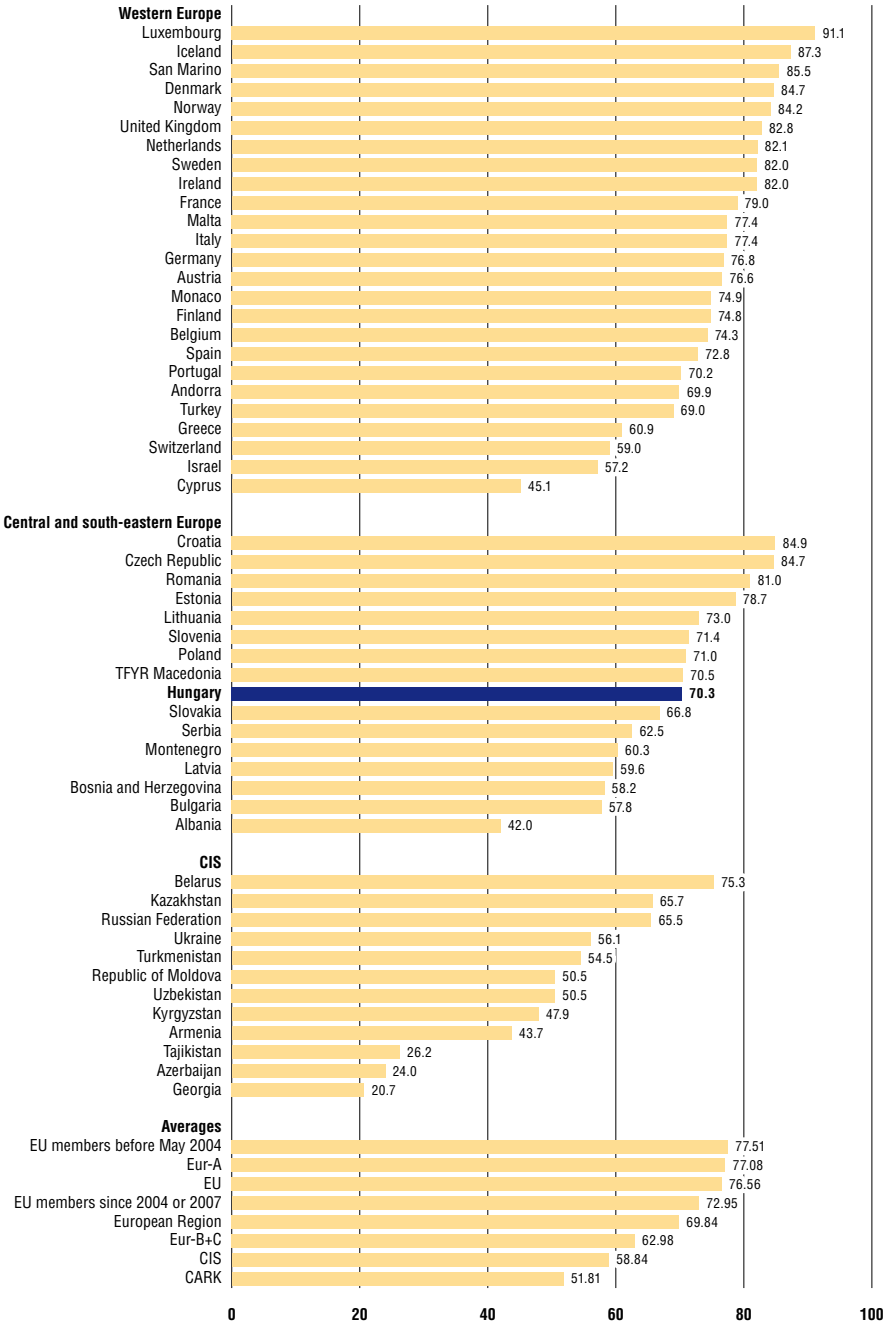
The first measures directed at containing pharmaceutical expenditure included shifting costs to patients by increasing co-payments, and decreasing the scope of subsidized pharmaceuticals. They contributed essentially to the significant increase of private expenditure on health while public expenditure

decreased and was stabilized at a low level (Table 3.1; see also section 3.4). The second intervention was the reallocation of financial resources within the health care budget, lowering the share devoted to curative-preventive services (Table 3.2). Third, between 1998 and 2002 the government introduced strict measures within the system of pharmaceutical subsidies, including the requirement that prior authorization be obtained for overspending in the pharmaceutical sub-budget of the HIF (1998/26), the extension of fixed-amount subsidies (2001/6), the lowering of wholesale and retail price margins for expensive drugs (2001/2), and stricter controls over physician prescribing (2001/3). The government in power between 2002 and 2006 continued to battle against rising pharmaceutical expenditure and managed to negotiate a price-volume agreement that made pharmaceutical companies financially responsible for subsidized drugs sold in excess of an agreed volume limit (2003/21). In 2007, as part of a general health care reform, several new measures were introduced to address the financial imbalance of the HIF and relatively high share of pharmaceutical spending by the NHIFA (see section 2.8.4).

The system of National Health Accounts is considered the official means for collecting health care financing and expenditure data in Hungary, although only through the OECD database (and not in the publications of the HCSO) do data appear regularly and in comprehensive form. The two most significant problems of the Hungarian National Health Accounts are related to estimating private expenditure and classifying the public sources of revenues. First, the true magnitude of informal payments in Hungary is unclear, with estimates ranging from 0.06% to 0.6% of GDP (see also section 3.4). Second, in the current version of the System of Health Accounts there is no distinction between the sources of revenues for the health insurance system, although a considerable amount comes from general tax revenues in addition to the SHI contributions. This issue is discussed in greater detail in section 3.2. Finally, it is worth noting that some reform measures have changed the structure of health financing and expenditure without leading to any real increase or decrease in spending. For instance, emergency ambulance and high-cost high-tech services were transferred from HIF to central government financing in 1998 (1997/9, 1997/20).

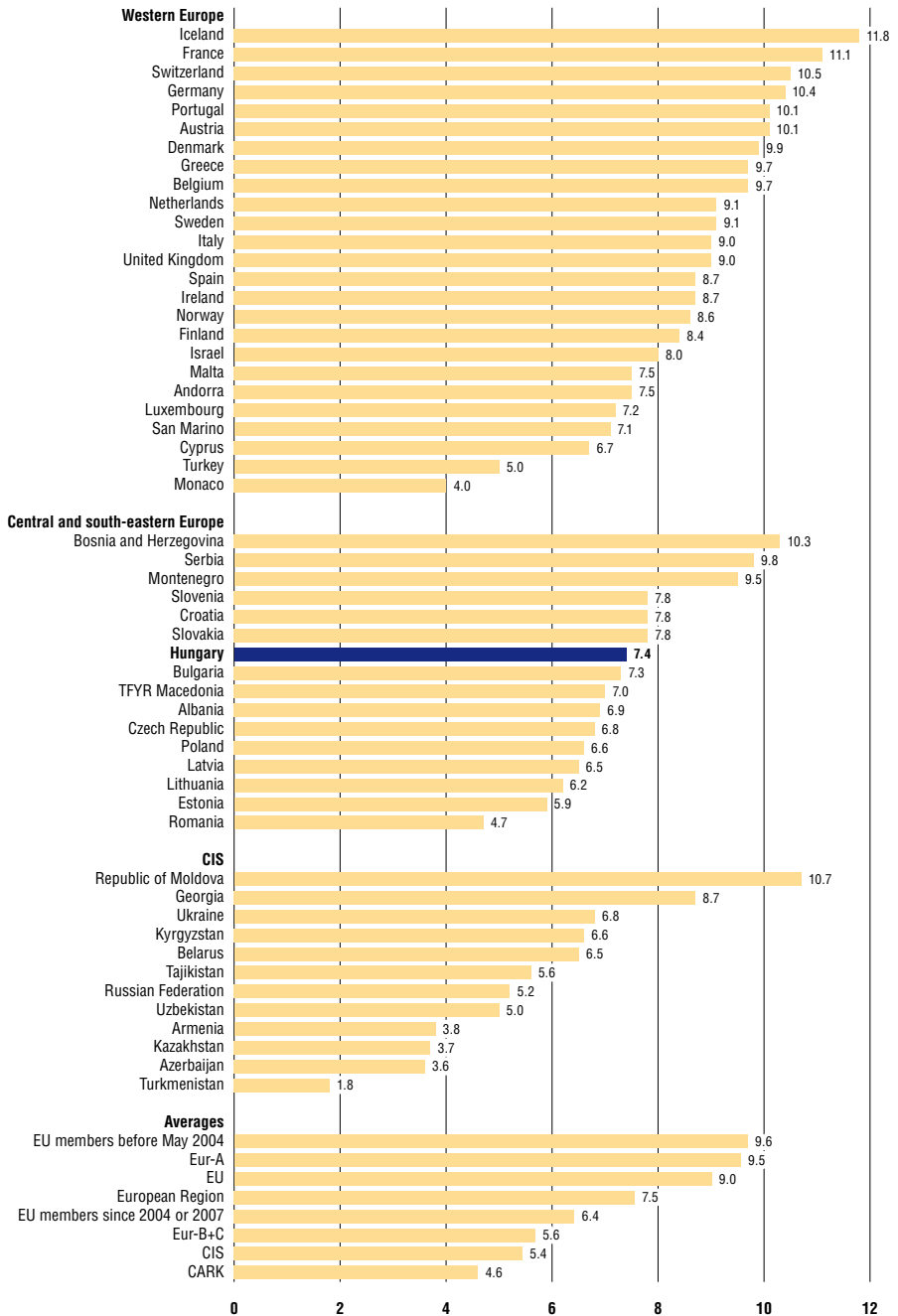
Fig. 3.2

Public sector health expenditure as a share (%) of total health expenditure in the WHO European Region, 2008



Source: WHO Regional Office for Europe, 2010.

Fig. 3.3
Health expenditure as a share (%) of GDP in the WHO European Region, 2008



Source: WHO Regional Office for Europe, 2010.

Table 3.2
HIF expenditure by main categories, 1995–2011

Expenditure category	1995	2000	2005	2010 ^p	2011 ^p
Total expenditure (current prices, billion NCU)	445.1	797.7	1579.9	1445.5	1462.3
Cash benefits (%) ^a	26.5	27.7	28.6	16.4	15.9
Health care (%)	62.0	69.7	69.7	80.4	81.29
Other (%) ^b	8.7	0.4	0.3	1.8	1.9
Administration (%)	2.8	2.2	1.5	1.4	0.9
Expenditure on cash benefits (current prices, billion NCU)	118.1	220.8	451.3	237.7	232.5
Expenditure on health care benefits (current prices, billion NCU)	275.9	556.3	1100.4	1161.5	1188.8
of health care benefits					
Curative services (%)	69.2	67.6	63.1	65.2	64.8
Pharmaceutical reimbursement (%)	25.7	27.1	31.7	29.7	28.9
Medical aids reimbursement (%)	3.9	4.1	4.0	3.9	3.8
Balneotherapy (%)	0.4	0.6	0.4	0.3	0.3
Other health care benefits (%) ^c	0.7	0.7	0.7	0.8	2.2

Source: NHIFA.

Notes: ^a As of 2007, disability pension payments were transferred to the pension fund; ^b Includes transfer payments to the pension fund and costs of real estate property businesses; ^c Includes travel reimbursement, mother-milk supply, cross-border services; ^p Planned costs.

Table 3.3
Trends in the expenditures of the curative service of the HIF by main categories, 1995–2011

Curative and preventive services	1995	1998	2001	2004	2007	2010 ^p	2011 ^p
Total (current prices, billion NCU)	190.7	298.9	410.0	654.6	718.7	757.6	770.1
Primary care (%)	10.7	11.0	10.0	9.2	10.1	10.3	10.5
Mother and child health services (%)	2.3	2.3	2.3	2.2	2.6	2.4	2.3
Dental care (%)	2.7	2.8	3.0	3.2	3.1	2.9	3.1
Care centers (%)	1.9	2.0	2.3	1.6	0.8	0.3	0.3
Transport of patients (%)	–	–	1.0	0.9	0.9	0.8	0.8
Ambulance service (%)	–	–	–	2.7	2.9	3.0	3.2
Dialysis (%)	2.0	2.5	2.8	2.5	2.9	3.0	3.0
Home special nursing (%)		0.3	0.4	0.4	0.5	0.5	0.6
– Outpatient specialist care, including CT. MRI and laboratory services (%)	15.6	16.1	16.9	17.4	17.0	18.1	18.1
– Inpatient acute services (%)	51.2	53.4	52.4	50.8	46.8	46.0	45.0
– Chronic hospital services (%)	6.0	6.3	6.3	5.8	6.5	7.5	8.1

Source: NISHR, 2011b; ^p Planned.

3.2 Sources of revenue and financial flows

Public expenditure on health in Hungary is financed mainly through a combination of SHI contributions and general tax revenue transfers to the SHI scheme. In addition, revenue from general and local taxation plays a significant role in financing capital costs, public health services and some expensive health technologies. Private sources of revenue include charities, NGOs and corporations, voluntary health insurance as well as a considerable share of OOP payments (see Fig. 3.4). In 2009, 58.8% of total expenditure on health was covered by the HIF (OECD, 2011). The revenue of the HIF is derived mainly from (a) SHI contributions, which, for employees, take the form of a proportional payroll tax that is split with employers; (b) general tax revenue transfers from the central budget; (c) direct payments from pharmaceutical companies (see sections 2.8.4 and 6.1.2); and (d) the hypothecated health care tax. This hypothecated health care tax was introduced in 1997 and consisted of two components: a lump-sum tax and a proportional tax. The proportional tax is levied only on income that is not subject to the SHI contribution (see also section 3.3.2). The lump-sum tax was eliminated at the beginning of 2010.

The share of total health expenditure financed through central and local governments in 2009 was 10.9% (Fig. 3.5), but this does not capture (a) the tax revenue transferred from the central budget to counter HIF imbalance (see section 3.3.3) and (b) the hypothecated health care tax, which is also transferred to the HIF. If, however, we consider the real sources of revenue and not the agents through which the spending is administered, then the share of total health expenditure financed through general and local taxes in 2009 rises to 35%, while the share financed through SHI contributions would be 32.5% (Fig. 3.5). Interestingly if this latter approach is used when looking at earlier expenditure data, the share of total health expenditure financed from general and local taxes in 2002 and 2003 turns out to be even higher than that financed from SHI contributions. Although this might seem a rather peculiar way to pool resources in an SHI system, it is very much in line with recent trends in Europe – that is, to move away from exclusive reliance on labour-related social insurance contributions and use a mix of revenue sources for financing the health insurance system. This development, however, did not follow an explicit taxation policy strategy in Hungary until the recent financial crisis, when the government decided to radically reduce the SHI contributions and compensated this loss of revenue by increased general tax revenue transfers to the HIF (see section 3.3.2).

Fig. 3.4
Financial flows

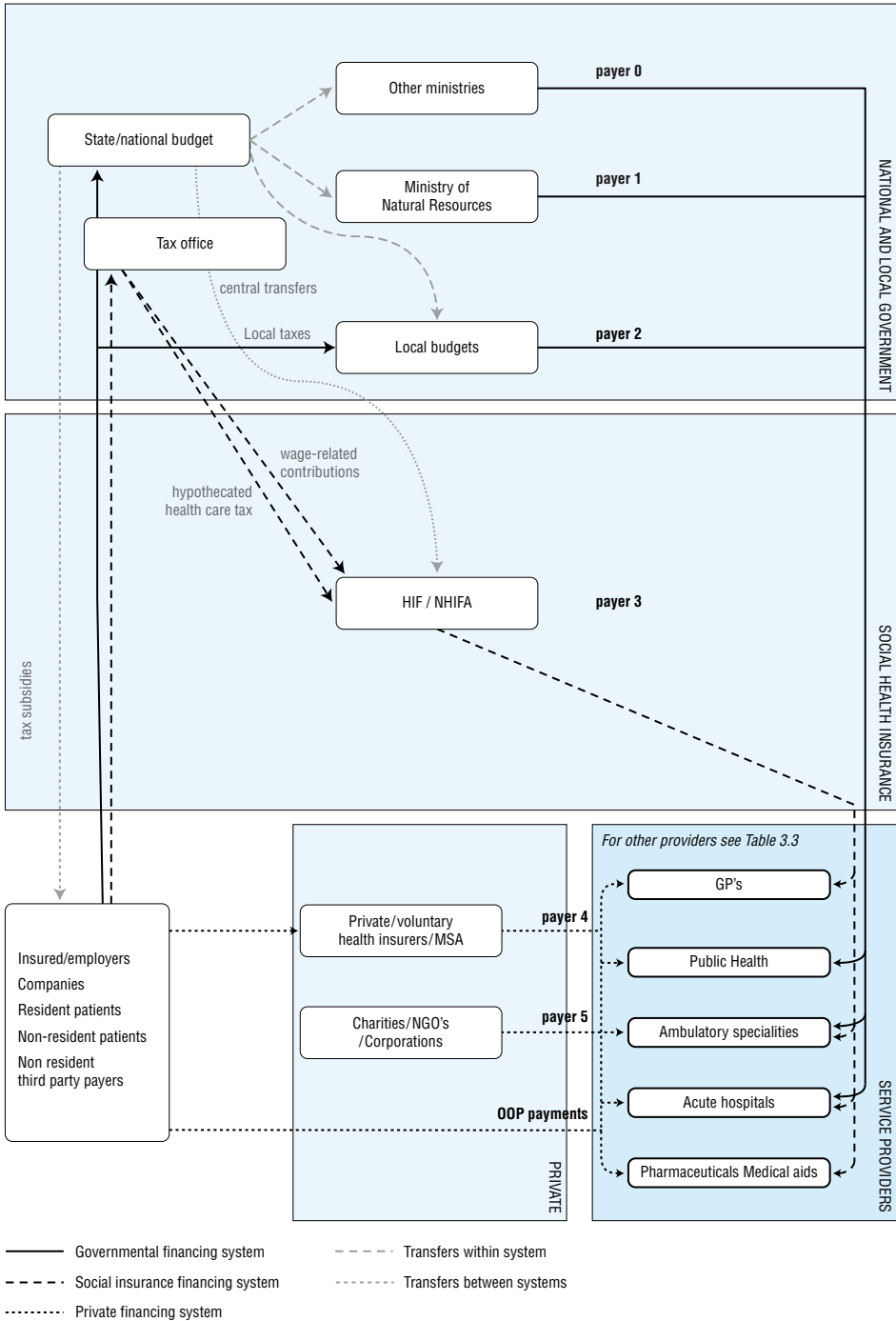
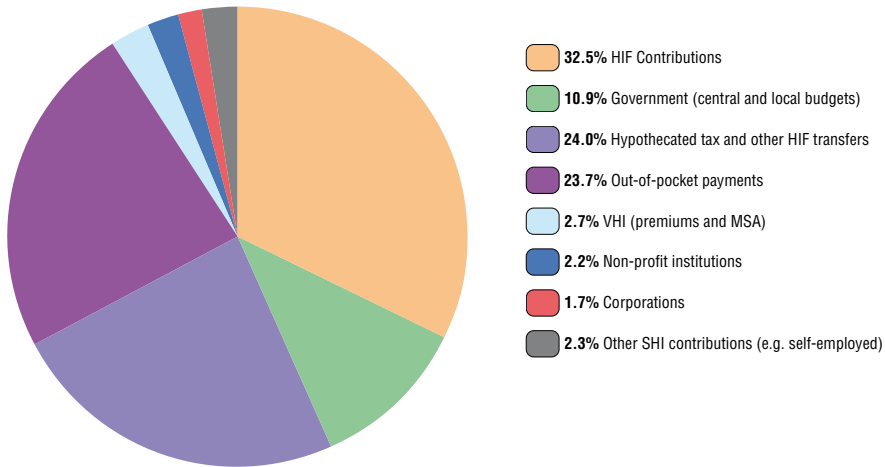


Fig. 3.5

Total expenditure on health according to source and administering agent, 2009



Source: Author's adaptation based on WHO NHA.

Whereas recurrent expenditure is financed by the HIF, nearly all capital investment related to outpatient and inpatient care is financed by the central and local governments. Nonetheless, the central government still pays for recurrent expenditure related to certain services (for example, high-cost high-technology treatments and public health) and covers co-payments for residents with very low incomes. Since the mid-1990s, governments in Hungary have used cuts in the SHI contribution rate as one of their main tools for boosting employment, but have failed to compensate the HIF adequately for the resulting shortfall in revenue, leading to a prolonged financial imbalance (see section 3.3.3). Private health insurance plays a fairly limited role in health care financing, with a share of 2.7% of the total health expenditure in 2009 (Table 3.1). Most of the expenditure under the private health insurance heading is actually not insurance, but individual medical savings accounts (MSAs) without any pooling across individuals beyond the family. The MSA scheme has benefited from tax subsidies, but in recent years these subsidies have been reduced and the scope of services that the MSA scheme can cover was also restricted. Overall, OOP expenditure continues to be the dominant form of private expenditure in Hungary (see section 3.4).

3.3 Overview of the statutory financing system

3.3.1 Coverage

Breadth of coverage

In accordance with the constitution (1989/4), Act CLIV of 1997 on Health Care (1997/20) stipulates that every individual has the right to life-saving or preventive health care to avoid serious or permanent damage to his or her health, as well as to relieve any pain or suffering caused by sickness. Furthermore, every individual has a right to health services that are appropriate, continually accessible, equitable and regulated in a properly defined legal framework (1997/20) according to health status. However, Hungarian citizens and residents are not covered for health care treatment by subjective right, except for emergency or life-saving measures.

Currently, Act LXXX of 1997 on Those Entitled to the Services of Social Insurance and Private Pensions and on the Funding of These Services sets out the rules for participating in the health insurance system and defines entitlement to in-kind and cash benefits. Participation in the system is compulsory for all citizens living in Hungary (that is, people with a personal identification card); opting out is not permitted. As a general rule, Hungarian minorities living in neighbouring countries are not entitled to health services in Hungary, but this does not mean that they were denied access to care in the past. Since 2007, a special commission of the Ministry of National Resources evaluates applications by Hungarian minorities living abroad and defines the package of health services they are entitled to.

The population in Hungary is divided into three main groups: (1) insured individuals who are entitled to all services covered by the NHIFA and who pay regular contributions based on their income, (2) individuals who are entitled to medical services but are not required to pay contributions, and (3) all other inhabitants with a personal identification card and permanent residence, who are obliged to pay a medical service fee (that is, a fixed-amount insurance premium) on a monthly basis (1997/8). Foreigners who work in Hungary for a longer period are not obliged to participate but may do so if they wish.

According to the provision of the legal framework, Hungary should have 100% coverage, but the report of the NHIFA to the National Assembly in 2009 shows that the health insurance status of approximately 4% of the population is unclear (Ministry of Health, 2009a). Health services are provided on the basis of a social insurance identification number (*Társadalombiztosítási*

Azonosító Jel; TAJ), which was initially issued to every citizen who applied for it. For many years, the regulation on contributions and their payment was not fully enforced: before 2006, patients could obtain health services simply by presenting the TAJ card to their health care provider, who was unable to check whether they still had a valid NHIFA registration and had actually paid the necessary health insurance contributions. In 2007, however, the government introduced a system to check the validity of the TAJ card. Providers have online access to the relevant database maintained by the NHIFA and can check the validity of the patient's card ad hoc. Patients will receive necessary care even if their cards are not valid, but they will also be informed that their insurance registration status is unclear and they need to contact the NHIFA. The Tax Office is also notified about such cases for further processing and eventually collecting unpaid contributions retrospectively (2007/2). It is important to stress that necessary care cannot be denied to patients with unpaid contributions. As a result, population coverage is virtually universal.

Scope of coverage

Providing universal and comprehensive coverage was the founding principle of the previous, state-run socialist health care system. Health services were free of charge except for very small co-payments for medicines, medical aids and prostheses. Although this was inconsistent with the scarcity of resources, the problem was neither admitted nor addressed. Rationing probably occurred through queuing, implicit waiting lists, the dilution of services and informal payments.

In the early 1990s, government reforms placed greater emphasis on structural transformations than on setting priorities related to health care benefits. Parallel to the establishment of the HIF, a list of services to be covered was defined in amendments to Act II of 1975 on Social Insurance (1992/1). The benefit package was almost exhaustive, with the exception of aesthetic and recreational purposes (1992/7). The HIF does not offer benefits over and above those specified in the established benefits package.

The NHIFA offers services in kind to the insured and other entitled persons, as well as cash benefits to the insured (Table 3.2), including sick pay and child care and maternity benefits. The responsibility for funding disability pensions used to lie with the NHIFA but was transferred to the PIF in 2008. In contrast, the responsibility for funding the child care fee, which is available to parents until the child is 2 years old, used to belong to the central government but was transferred to the NHIFA in two steps, in 2007 and 2008. The HIF covers treatment abroad as long as individuals have (a) received permission from the

NHIFA or (b) obtained this treatment in accordance with bilateral international treaties or the European Commission Regulation 883/2004, which deals with the provision of health care in EU Member States.

Before 2004, there was no systematic, formal or transparent process for deciding which services would be included in or excluded from the benefits package. With EU accession in May 2004, Hungary was obligated to adopt Council Directive 89/105/EEC. This regulation aimed to ensure that transparent measures are adopted by national authorities in the pricing and reimbursement of pharmaceuticals. Adopting this regulation, the government established the process of HTA to evaluate applications by pharmaceutical companies (2006/8). The NHIFA uses various criteria in the decision-making process, such as health needs, cost-effectiveness and budget impact (2004/4) in order to classify certain pharmaceuticals for different categories of reimbursement (see sections 2.7.2 and 2.8.4).

The first steps towards a less generous benefits package were taken during the economic crisis of 1995, when the HIF deficit led to calls for urgent action (see section 3.3.3). Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization subsequently curtailed both in-kind and cash benefits. The main item excluded from the benefits package was tooth-preserving dental services for adults. Subsidies for balneotherapy were also removed, a co-payment for patient transfer (i.e. ambulance) services was introduced, and sickness benefits were reduced (1995/5). In addition, employers became responsible for financing occupational health services (1995/8). The adverse effects of these measures – for example, a sharp drop in the use of dental services – forced the government in power from 1994 to 1998 to reconsider the exclusion policy and reintroduce dental services with some co-payments (1996/1) for adults. The next government abolished co-payments for tooth-preserving dental treatments in 2001, thus restoring the original situation (2001/10). Nevertheless, the share of OOP spending on dental services has remained very high, with total OOP expenditure in this category amounting to HUF 106 billion (€418.7 million) in 2007 and thus exceeding total NHIFA expenditure on dental services by a factor of five (OECD, 2010). OOP expenditure in this category represents 19.3% of the total private expenditure on health in Hungary.

Act LXXXIII of 1997 on the Services of Compulsory Health Insurance and related decrees define which health services are free of charge, which are covered but require some user charges, and which are excluded from HIF coverage. The Act defines a negative list based on the premise that, in principle,

health services are covered and exclusions must be stipulated (1997/9). Also in 1997, new legislation on health and health insurance was enacted to address the issues of rationing and priority setting in a more systematic manner. Act CLIV of 1997 on Health introduced the concept of waiting lists and stipulated that waiting list priority must be assigned based on uniform and explicit criteria, taking into account patient health status (1997/20). Act LXXXIII of 1997 has made it possible to deviate from the waiting list order only in cases where both the reason for and the importance of the outcome of the intervention have been attested to officially (1997/9). Thus far, central waiting lists have been set up for organ and tissue transplantation and positron emission tomography/computer tomography (PET/CT) services, which are managed by the National Blood Supply Service (NBSS; *Országos Vérellátó Szolgálat*). Waiting lists for all other services are to be set up by the providers contracted by the NHIFA in the event of persistent shortages in the capacity to provide the necessary care (1997/9, 2006/9). Outpatient institutions must keep ordered lists of patient access (appointment lists), based on the priority of service provision dates that is established. Between 2007 and the first half of 2010, the waiting and appointment lists were supervised by the Health Insurance Supervisory Authority (HISA) (2006/10, 2006/14) and in certain cases by the NPHMOS. Then, upon abolition of the HISA, this task was partly transferred to the NHIFA (2010/9, 2010/10, 2010/11).

Depth of coverage

Co-insurance and co-payments are required for pharmaceuticals, medical aids and prostheses, balneotherapy, dental prostheses, treatment in sanatoria, long-term chronic care and some hotel services in hospitals. Co-payments are also due if:

- non-emergency specialist services are obtained without a referral from an authorized physician, normally the family doctor;
- patients choose to visit a provider other than the one they were referred to (see also section 2.9.2);
- patients desire more services than those prescribed by their physician (1997/9, 1997/18).

Special rules apply to a few services, such as infertility treatments, for which the number of attempts covered by HIF is limited (1997/16). The costs of medical examinations required to certify an individual's fitness to drive or hold firearms are not covered (1997/18). Treatments for aesthetic or recreational purposes are explicitly excluded, as are those which have not proved effective

in improving health. The latter include services that are not included in the International Classification of Procedures in Medicine, introduced in 1976 by WHO. In addition, cosmetic surgery, massage, abortion or sterilization without medical indication, and the prostate-specific antigen test for screening purposes are not covered (1997/9, 1997/14). Since 2007, treatment for injuries resulting from extreme sport activities and vaccinations that are not part of the government's mandatory immunization programme are also not covered by public sources (1997/14).

3.3.2 Collection

General government budget

There is an increasing participation of the central government budget in financing the budget of the HIF, and the common assumption that countries with SHI rely predominantly on wage-related contributions to fund their health system no longer holds in Hungary.

According to the NHIFA, the total transfer from the central government budget, including deficit financing, is planned to be almost five times higher in 2010 (covering 47.5% of the HIF expenditure) than it was in 1997 (covering 10.9%). Hence the role of general taxes in funding of the HIF has become as important as the role of the wage-related contributions. From the perspective of the whole health care system, the share of tax funding among public sources was very high already in 2002 and 2003, when the share of tax funding (with 38.5%) exceeded the share of wage-related contributions (33.6%) in 2003, considering the deficit financing and hypothecated health care tax among tax sources in the budget of the HIF (Table 3.4).

The hypothecated health care tax was introduced (1996/9) in 1997 to supplement the resources of the HIF and was initially paid by employers for each employed person as a lump sum (Table 3.5). It was intended to compensate the HIF for social groups entitled to services but not paying contributions and the abolition of transfers from the PIF following the pension reform (1996/8, 1996/12). This measure had an insignificant impact on the resources of the HIF: as calculated by the authors based on NHIFA data, its share combined with the remaining contribution of the central budget (once the PIF transfer was abolished) reached 19.6% of the HIF budget for services excluding cash benefits in 1997 compared to 21.2% before the reform. This is an example of a change in the revenue mix without substantial impact on the overall income of the HIF budget.

Table 3.4

Sources of revenue as a percentage of total expenditure on health, 1995–2009

	1995	2000	2005	2008	2009
Public expenditure	84	70.7	72.3	71.0	69.7
HIF ^a	67.2	59.3	61.0	59.2	58.8
Government ^a	16.8	11.4	11.3	11.8	10.9
Wage-related contributions ^b	52.2	34.9	36.1	37.1	32.5
General and hypothecated health care tax ^b	20.8	34.9	34.7	31.2	34.9
Other health insurance contributions ^b	11.0	0.9	1.5	2.8	2.3
Private expenditure					
OOP payments ^a	16	26.3	23.8	23.8	23.7
Voluntary health insurance ^a	–	0.2	1.1	2.2	2.7
Non-profit institutions ^a	–	2.8	1.6	1.9	2.2
Corporations (1)	–	–	1.2	1.1	1.7

Sources: ^a OECD, 2010 and WHO, 2011; ^b Authors' estimate.

The government in power between 1998 and 2002 added a proportional component to the hypothecated health care tax as of January 1999. The 11% proportional tax was levied on types of income previously exempt from HIF contributions, such as dividends, in-kind allowances and letting property. Furthermore, the lump-sum component of the hypothecated health care tax was increased from HUF 1800 (€6.8) in 1997 to HUF 4500 (€17) in 2002. However, the government in power between 2006 and 2010 reduced it again to HUF 1950 (€7.7) in 2006, then abolished it completely in 2010. The proportional component is still in effect.

A new type of hybrid tax, the simplified contribution payment, was launched in 2005, applicable for persons or entrepreneurs working in the media or arts (2005/6) up to a certain income ceiling. Instead of the regular HIF contributions and income tax, the employees and employers in these occupational groups pay an overall (15% employee and 20% employer) contribution, which covers the entirety of their tax and social security obligations. Eleven percentage points of this employer contribution is earmarked as a health insurance contribution.

Among other public sources of financing are general and local taxes, other contributions for persons seeking employment and persons classified as being disadvantaged regarding employment, paid by the central government budget, as well as special taxes to be paid by pharmaceutical companies and wholesalers (2006/8). These revenue sources supplement the budget of the HIF to a small extent.

Collection of health insurance contributions

Since 1990, compulsory health insurance contributions have been the primary source of health care financing in Hungary (1989/6). The contribution is calculated as a percentage of gross wages and is therefore mildly regressive. It is determined by the National Assembly and split between employer and employee. In 2010, the HIF contribution amounted to 8% of an employee's gross wages, with an employer share of 2% and an employee share of 6% (Table 3.5). There used to be an upper threshold for the employee share of the contribution (1997/8), but this was eliminated in January 2001 (2000/8). In the third quarter of 2006, however, a *minimum* contribution base was introduced, which in 2009 amounted to two times the minimum wage.

Table 3.5

Social insurance contribution and hypothecated health care tax, 1995–2010

	1995	1998	2001	2004	2007	2010
Social insurance contribution						
Total (% of gross salary)	54	49	42	40.5	43.5	41.5
– employer	44	39	31	29	29	26
– employee	10	10	11	11.5	14.5	15.5
Of which:						
Health insurance contribution						
Total (% of gross salary)^a	23.5	18	14	15	15	8
– employer	19.5	15	11	11	8	2
of which: benefits-in-kind	–	–	–	–	5	1.5
of which: benefits-in-cash	–	–	–	–	3	0.5
– employee	4	3	3	4	7	6
of which: benefits-in-kind	–	–	–	–	4	4
of which: benefits-in-cash	–	–	–	–	3	2
Hypothecated health care tax, Lump sum (NCU/month)	–	2100	4200	3450	1950	0
Hypothecated health care tax estimated in % of the gross salary	–	3.7	4.9	3.0	1.5	0.6
Total (% of gross salary)^b	23.5	21.7	18.9	18.0	16.5	8.6
Ceiling on employee contribution Thousand NCU/year	–	2100	4200 ^c	–	–	–

Source: Act (1975/1); Act (1996/9, 1997/8, 1998/19).

Notes: ^a Without hypothecated health care tax; ^b Including the estimated hypothecated health care tax; ^c eliminated in January 2001.

Special rules apply to the self-employed, who must pay contributions either based on the activity-specific standard income set by the government in advance or on the official minimum wage. Small farmers either pay contributions based on the current minimum wage or, below a certain level of income, they pay health insurance contributions at 20% of their revenue and get benefits-in-kind

but no cash benefits (1997/8). In order to qualify for more extensive benefits, they can choose to pay the full contribution rate (employer's and employee's combined) based on a special income statement to the Tax Office.

Provision for non-contributing groups has been shared between the social insurance system and the government since 1992: the central government pays the contributions for most of the non-contributing groups but not pensioners (1992/1). In reality, while payments by the PIF reached 20.2% of the expenditure on benefits-in-kind of the HIF, the contribution of the central budget for the non-contributing groups only amounted to 1%, which made practically no difference in the budget of the HIF (NHIFA, 2008).

Unpaid HIF and old age insurance contributions combined peaked at 4.3% of GDP in 1994, but still amounted to 2.5% of the GDP in 2000. In fact, some authors estimate a shadow economy of 25.1% of GDP in Hungary, which is at the lower end of the range for transition economies of central and Eastern Europe, but higher than in Slovakia and the Czech Republic, as well as than the average for OECD countries (Schneider & Klinglmair, 2004).

High HIF contribution rates have certainly provided an incentive for avoidance and evasion, including payment arrears, non-payment and under-reporting of income. Successive governments have attempted to address these problems in several ways. The interventions had three main directions: decreasing the HIF contribution rate, widening the contribution base and stronger enforcement of the payment of contributions.

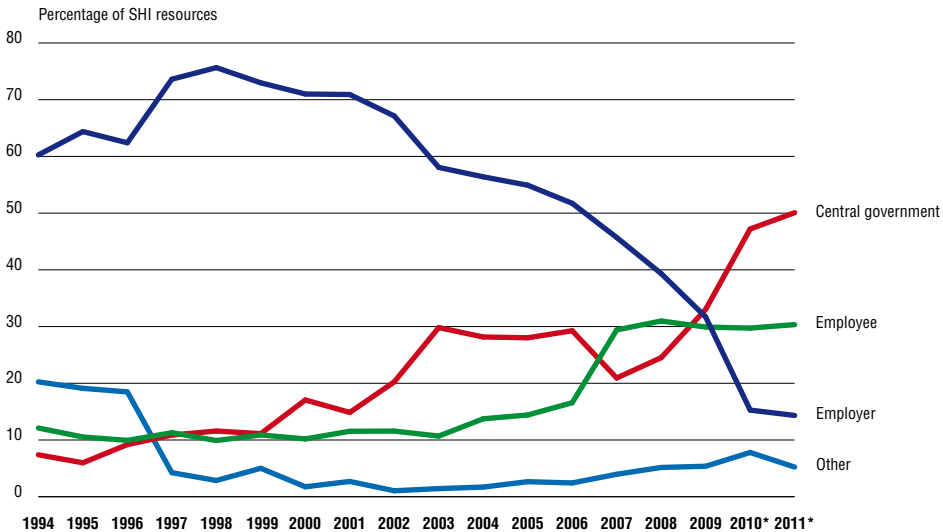
In 1996, the HIF contribution of the employers was decreased by three percentage points, which was the starting point of an enduring trend in the radical decrease of the employer contribution rate coupled with the more rapidly increasing deficit of the HIF, throughout the following decade. This policy aimed at improving international competitiveness, boosting economic growth and stimulating the employment level. The potential consequences on HIF revenue were not addressed in a systematic manner.

In 1998, contribution rates were decreased further and contribution collection was transferred from the NHIFA to the more authoritative Tax Office, with the aim of making collection less susceptible to tax avoidance, whereas the governance structure of the HIF and NHIFA were reorganized. The employer share of contributions was decreased by another four percentage points to 11% in 1999 (and remained at this level until 2006), while the employee contribution had been lowered by 1% in 1998 (Table 3.5). The government abolished the ceiling for the employee health insurance contribution (2000/8) and added a

proportional component to the hypothecated health care tax (see above). The government in power between 2002 and 2006 basically upheld this policy as did the next administration, which further reduced the employer contribution rate from 11% in 2006 to a symbolic 2% in 2010. At the same time, the employee contribution rate increased from 4% in 2006 to 6% in 2010. Over the last 15 years, this policy has resulted in a steep increase in the ratio of employee to employer contribution shares. In the late 1990s, employers provided 75.6% and employees 9.9% of HIF revenue, whereas, in 2011, shares are expected to be around 14.3% and 30.3% respectively, with a parallel increase of the share of the central government to 50.1% (Fig. 3.6).

Fig. 3.6

Main sources of HIF revenue in Hungary as a % of total revenue, 1994–2011



Source: Author's calculations based on NHIFA data.

Notes: * Estimated or projected.

It was expected that increased employment would shrink the shadow economy and increase HIF revenues. Defending their law amendment (2009/5) which decreased the employer contribution rate by three percentage points in 2009, the government argued that a one percentage point decrease in the contribution rate would increase employment by 0.15%. However, evidence from the employment database of the HCSO (HCSO, 2010c) shows that the employment ratio of the population in the 15–64 age group increased from 53.6% in 1998 to 56.0% in 2000 and to 56.7% in 2008, that is, the employment ratio increased only by 3.1% between 1998 and 2008 and by 0.7% between 2000 and 2008. Thus, despite the efforts and measures by successive governments, up to 2010 the level of employment remains nearly as low as in the late 1990s.

Overspending in the pharmaceutical budget, high unemployment and decreasing real wages certainly contributed to the persistent fiscal instability of the HIF, at least in the early phase of economic transition, but the evasion of health insurance contributions stemming from the size of the shadow economy and the substantial, uncompensated decrease of the contribution rate seem to be the core weaknesses of the revenue collection function since the mid-1990s.

3.3.3 Pooling of funds

Although the collection and pooling functions are separated from each other in the Hungarian system of health financing, there is no complicated mechanism to distribute resources from the collecting agency (the Tax Office) to the main pooling agency (the NHIFA), the latter of which is also the single payer in the health insurance system. The Tax Office must transfer the collected payments on a daily basis to the account of the HIF, which is administered by the Treasury, and has to report on the outcome of the collection regularly to the NHIFA (1998/27). Given that there is a single National Risk Pool, no risk-adjusted allocation methods are applied.

The annual process of setting the HIF budget is administered by the Ministry of National Economy,² which starts planning by issuing detailed guidelines to the other ministries and government agencies by mid-April in a given year. These include target numbers for the sub-budget level of HIF expenditures and other macroeconomic parameters. The planning process follows a top-down approach, in which needs assessment plays a fairly limited role, while target numbers for the next year are based on the current year, without taking into account realistic calculations of the cost of services in the benefits package. The final version of the budget approved by the government for HIF expenditure in the 2010 financial year differed only slightly from the one originally proposed by the Ministry of National Economy, underlining the weakness of the Ministry of National Resources to influence budget allocation for health. The NHIFA does not bear financial responsibility for any imbalance in the HIF budget and the state has to cover expenditures even if they exceed revenues (1975/1, 1997/8).

The Ministry has been planning the HIF budget with a substantial deficit since 2003. The fact that this has been possible highlights the irregularity of state budget planning regulations. The same regulation stipulates that, when financial data analysis and the trends in the macroeconomic context and HIF expenditures forecast fiscal imbalance, the government is obliged to prepare recommendations to the parliament for ensuring financial stability through

² Before the reorganization in 2010 the Ministry of Finance.

increasing revenue, decreasing expenditure or modifying the scope (breadth, depth or height) of benefits (1992/1, 1997/8). Subsequent governments have failed to address the chronic imbalance of the HIF budget in a systematic and transparent manner.

Since the inception of the HIF, its expenditures have always exceeded its revenues with the exception of some fiscal years (1995, 2007 and 2008). This gap has been covered retrospectively at the end of each fiscal year through deficit financing by the government budget. HIF revenues decreased from 7.8% of the GDP in 1993 to 5.5% of the GDP in 2005 (see also Table 3.6), while expenditures only fell from 8.5% to 7.2%. The gap between revenues and expenditures peaked in 2005 at 23.8% of total HIF expenditure (amounting to HUF 375 billion or €1.48 billion or 1.7% of GDP). The peculiarity of the budget management stewardship by the Ministry of National Economy is illustrated by the fact that 91% of the gap between revenues and expenditures in 2005 was a planned deficit approved by parliament in 2004 (NHIFA, 2008), while the rest was due almost exclusively to overspending in the pharmaceutical sub-budget. As a result of effective cost-containment measures since 1997, such overspending was not apparent in the inpatient and outpatient health services sub-budgets.

Table 3.6

Revenues, expenditures and balance of the HIF, 1995–2011 (selected years)

Expenditure category	1995	1998 ^b	2001	2004	2007	2010 ^c	2011 ^e
Total HIF revenues (current prices, billion HUF)	422.9	561.5	884.7	1100.1	1676.0	1376.1	1370.9
– as % of GDP	7.3	5.4	5.8	5.3	6.6	5.0	–
Total HIF expenditure (current prices, billion HUF) ^a	445.1	632.2	915.0	1443.8	1648.6	1445.5	1462.3
– as % of GDP	7.7	6.0	6.0	6.9	6.5	5.3	–
HIF expenditures on health care (current prices, billion HUF)	282.0	460.4	628.2	1014.2	1095.8	1161.5	118.8
– as % of GDP	4.9	4.4	4.1	4.9	4.3	4.3	–
HIF balance (current prices, billion HUF) ^a	-22.23	-70.73	-30.28	-343.65	27.41	-69.41	-91.4
– as % of total HIF expenditure	-5.0	-11.2	-3.3	-23.8	1.7	-4.8	-6.2
– as % of GDP	-0.4	-0.7	-0.2	-1.7	0.1	-0.3	–

Sources: GDP: Ministry of Finance 2009/10, HCSO; HIF Revenues and Expenditures: NHIFA; Total and public expenditure on health: OECD, 2009b.

Notes: ^a Includes cash payments, payments for in-kind benefits and administrative costs; ^b Change in the methodology of data collection; ^c Estimated or projected.

The sudden improvement in the balance of the HIF budget in 2007 and in 2008 was the result of the combined effect of a change in budget planning and of measures to contain pharmaceutical expenditures. First, the parliament decided to reintroduce the obligation of the central budget to pay a certain

amount of contributions on behalf of the non-contributing groups by means of the newly established National Risk Pool, leaving the hypothecated health care tax, which has the same goal, intact. This measure, as in 1997, did not increase the financial resources of the HIF, since this budget transfer was calculated to eliminate the planned deficit of the HIF budget. Thus, only the timing and legal form of the central budget contribution changed, but not its amount. The strict cost-containment measures introduced in 2007 have yielded concrete and measurable results in decreasing the overspending of the pharmaceutical sub-budget of the HIF, although this was mainly achieved by increasing patient cost-sharing (2006/9).

While most public revenues are pooled by the HIF, there is some pooling fragmentation. The central and local governments are responsible for capital costs of providers and different municipalities may allocate more or less to health care facilities. This causes great variation in the physical infrastructure quality of the health service delivery system. Richer municipalities usually have better facilities, some poorer municipalities have accumulated debt in order to maintain a proper infrastructure, while others have simply ignored this obligation due to lack of funding. Any debts accumulated by local governments add to the overall government budget deficit, forcing the central government to formulate stricter regulations on the level of debt local governments are allowed to accumulate. Although the central government provides grants to support the development of infrastructure by municipalities, there is no explicit strategy for reducing the inequalities created by this fragmented pooling and resource allocation arrangement.

3.3.4 Purchasing and purchaser–provider relations

The organizational relationship between purchaser and providers is based on a contract model since 1990, when the NHIFA was established and the ownership of most public health care facilities was transferred to local governments (1990/1). Although the NHIFA is a single payer with a monopsonistic market power, it has very limited discretion over purchasing decisions, for example to set the terms of the contract and to contract selectively with providers. The National Assembly and the government regulate the most important elements of the provider contract in acts and decrees, including reimbursement price, capacities, quantity of outputs, payment methods and financing of capital costs. As pointed out in published comparative literature, active contracting does not actually take place in Hungary, but is often a formality for establishing the basis for provider reimbursement (Figueras, Robinson & Jakubowski, 2005).

On the one hand professional associations do not have negotiation rights on prices and outputs in the contractual process, on the other hand the NHIFA is obliged to contract the providers that are selected or approved through the capacity regulation processes of the government (see also section 2.8.2). Similarly, family doctors, who are for the most part private entrepreneurs, contract with the local government to provide services for the local population, and the NHIFA is obliged to conclude a payment contract with all those family doctors who have a local government contract. Physicians working in outpatient and inpatient facilities are mostly salaried employees and not contracted separately by the NHIFA, although they do have a contract for the outpatient prescription of pharmaceuticals (for the role of the NHIFA regarding pharmaceuticals see section 2.8.4).

Institutional health service providers have to contract with the NHIFA in order to become eligible for reimbursement. The contract defines provider capacities in terms of outpatient specialist consultation hours, and acute and chronic hospital beds. Based on these contracts, individual health care providers are then reimbursed from the sub-budgets by various methods of payment: family physicians are paid by adjusted capitation, outpatient specialist services by fee-for-service points, and acute and chronic inpatient services by HDGs (*Homogén Betegségcsoportok*, HBCs) and patient-days respectively. Until 2001, contracted capacities were determined per county and specialty by law according to a special formula of local health needs (on the basis of certain socioeconomic indicators of the local population), while the county consensus committees agreed on the distribution of contracted capacities across individual health care providers (1996/4). In 2001, Act LXIII of 1996 was repealed, and the actual contracted capacities became the basis of future contracting (2001/5). The law allowed greater flexibility for local governments to downsize and restructure capacities. At the same time, capacity extensions had to be approved by the then Ministers of Health and Finance. In 2006, the new government froze provider capacities on 31 December 2006, then downsized and restructured inpatient capacities (2006/12) (see more detail in 2.8.2).

As mentioned above, the NHIFA is not allowed to engage in selective purchasing, and its contracting process is not based on systematic health needs assessment. It has to contract with all providers who have a territorial supply obligation. Until 2007 the quantity and quality of outputs were not stipulated in the contract, except for a few high-cost, high-tech interventions, like liver transplantation, for which the annual number of procedures was set in advance. Since the beginning of 2004, the government has set output limits for inpatient and outpatient care by defining the number of HDGs and fee-for-service

points, which are paid for by the NHIFA, for each health care provider (see also section 3.7). Above the set quantities health care providers receive no additional payment. Quality control, on the other hand, is a task of the NPHMOS. The NHIFA has the right to monitor contracts, mainly by controlling the validity of providers' reports on output.

Private providers contracted by the NHIFA are family physicians, pharmacies, pharmaceutical wholesalers and traders, and providers of certain diagnostic services and kidney dialysis, dental care services, patient delivery transport services, district mother and child nurse and school health services, as well as a few outpatient specialist care and inpatient care providers. This latter group includes hospitals owned by churches or charities, which are fully integrated into the publicly financed health insurance system. There is one private profit-making hospital contracted only for the provision of same-day surgical procedures.

The participation of private providers in health service delivery in Hungary started with the dialysis services in the early 1990s, followed by diagnostic services as of 1996. Private providers were initially involved in the outsourcing of various types of medical services and then increasingly in ancillary services, such as laundry, catering, accounting and performance reporting. However, since the mid-2000s, the entire management of hospitals and outpatient specialist providers (polyclinics) can be subject to outsourcing (functional privatization, i.e. when only the management of the service provider has been contracted out).

The management of hospitals owned by local governments has been contracted out in many cases. Contracting out the provision of certain services and management is a widespread phenomenon, which started in the mid-1990s and has been evolving towards the corporatization of providers. Thus, a large number of private providers, with varying scopes and levels of services, can take part in the provision of health care services without a formal contract with the NHIFA. In the case of functional privatization, the private management company takes over NHIFA contracting from the local government, which remains the owner of the facilities. In hospital care, the first concession contract for operating a hospital was signed in 2004 and more followed. However, the flagship actor in the private health industry (Hospinvest) declared bankruptcy in 2009 and returned management rights to the owners, that is, the respective local governments, causing intensive public and media debate across the country. Its failure was a serious blow to the functional privatization model.

In 2009, the State Audit Office published a study on the contracting out of hospital services and on concession contracts for operational rights. The report concludes that in most cases the outsourcing process has been determined by private companies rather than by public authorities (State Audit Office, 2009b).

3.4 OOP payments

OOP payments in the Hungarian health care system can be divided into three main categories. First, patients pay user charges for services and products that are only partially covered by HIF (cost-sharing). Second, some products and services are not covered by HIF and are financed out-of-pocket (direct payments) and, third, some patients pay physicians and non-medical health professionals informally for services, even if these are covered by HIF (informal payments). This phenomenon, also known as under-the-table, envelope or gratitude payment, is a legacy of the state-socialist health services and has continued to play a role in the Hungarian health care system despite 20 years of continued health care reforms.

According to the OECD (2010), the share of OOP payments in total health expenditure increased from 16.0% in 1995 to 23.7% in 2009 (Table 3.1). In total, 56% of OOP spending in 2007 was on pharmaceuticals and medical aids, and 42.8% was on medical services. The overall magnitude of OOP expenditures has also been controversial: according to the National Health Accounts, the household budget surveys underestimate not only informal payments, but also total OOP payments (Table 3.7). The structure of OOP payments is similar if data reported by households are used: in 2007, 56% was spent on outpatient medical goods and 44% on health services, including informal payments. In any case, the various data sources agree that OOP spending increased more than twofold in real terms, and by 80% as share of GDP between 1993 and 2007, and within that informal payments at least stagnated both in real terms and as a share of total OOP expenditures.

Table 3.7

OOP payments on health care, 1993–2007

	1993	1995	2000	2005	2007
OOP expenditure (current prices billion NCU)	34.7	67.3	246.8	435.8	468.4
– as % of GDP	1.0	1.2	1.8	2.0	1.8
Share of OOP expenditure spent on					
– pharmaceuticals (%)	–	–	–	44.3	50.1
– medical aids and prostheses (%)	–	–	–	5.3	5.9
– health services (%)	–	–	–	50.5	42.8

Source: OECD, 2009b.

Notes: The share of OOP spending on different services was estimated using System of Health Accounts methodology.

3.4.1 Cost-sharing (user charges)

The concept of user charges was acknowledged as a possible source for financing health services as early as 1972 (1972/1) and some symbolic amounts were charged already, but user charges themselves were introduced in 1989 for a limited number of services, especially for pharmaceuticals (1988/3). Co-insurance and co-payments are currently required for (a) medical goods, such as pharmaceuticals (1995/1), medical aids and prostheses (2000/5) and dental prostheses and (b) health services, such as balneotherapy (1997/6), treatment in sanatoria (except for rehabilitation after acute illnesses), long-term chronic care and some hotel services in hospitals. Co-payments may also be required when patients fail to observe the rules of service utilization and seek specialist care without a referral (1997/9, 1997/18) (Table 3.7). The methods applied to determine the extent of co-payment differ depending on the group of services or products, but all decisions are made by the central government.

Medicines and medical aids and prostheses have set prices as basis for reimbursement, which are negotiated between the NHIFA and the producers or traders. The amount of user charges depends on the price subsidy provided by the NHIFA, either a fixed sum or a certain percentage of the agreed price (1997/9). The extent of the subsidy can differ for the same substance, depending on whether it is prescribed by a family doctor or a specialist (see also section 5.6). Outpatients must have a valid prescription from the medical doctor, and must purchase the medicine at a pharmacy with an NHIFA contract to be eligible for subsidy. It has to be emphasized that there are no user charges for medicines dispensed for hospitalized patients, given that inpatient care includes the cost of medications. Before 1990, drugs were heavily subsidized by the state and consumers paid only a symbolic amount. In contrast, patients paid one-fifth

of pharmaceutical expenditures of the outpatient sector in 1992, one-third in 2000 and 40% in 2007, according to National Health Accounts data. There is an exemption system in place for persons with very low income, who can get the necessary medications without user charges. Eligibility is based on means testing administered by local governments (1993/1) (see also section 5.6).

User charges for dental prosthetic treatments and above-standard hotel services can be determined by the providers themselves, within the limits of certain rules set by the Act LXXXIII of 1997. In contrast, the government centrally sets the amount of co-payments for long-term and chronic care, as well as for services that have been utilized bypassing the regular referral system (see also section 2.9.2). These fees equally apply to all providers. For instance, the co-payment for long-term chronic care has been around HUF 400 (€1.5) per day since 1998 (1997/18), which was equivalent to one and half litres of milk or one hour parking in the city centre of Budapest in 2010. Providers retain the revenue from any of these sources, but HIF reimbursement on these cases is reduced accordingly (1997/9).

In February 2007, health policy moved sharply towards introducing a flat co-payment in outpatient and a per diem in inpatient care (2006/9) in order to curb excess utilization. Exemption schemes were also implemented to protect vulnerable social groups based on their socioeconomic status and to reduce the public resistance in general towards these new types of user charges. Providers thus obtained an additional HUF 13.3 billion (€52.5 million), amounting to about 0.7% of total health expenditure (NHIFA, 2008). These measures became a point of substantial debate and were capitalized upon politically by the opposition parties. The referendum held on 9 March 2008 on user charges had a high turnout and overwhelmingly rejected the policy (2008/2). Thus, the new user charges were withdrawn, triggering the discharge of the Minister of Health, the subsequent collapse of the governing coalition and deep political crises within both governing parties.

3.4.2 Direct payments

Patients must pay the full price of services that are excluded from public financing, such as certification of health for the purpose of employment, sports or obtaining a driver's licence (1997/18). The same applies to services that are covered in principle but are actually delivered by a private provider who has not been contracted by the NHIFA. By the same token, providers contracted by the NHIFA are not allowed to charge extra for covered services (1997/9).

3.4.3 Informal payments

The third source of OOP expenditure comes from informal payments, which became widespread in the state-socialist health care system. Despite several official campaigns against them, the regime not only tolerated informal payments but also included them in the calculation of salaries of medical doctors and even required that they be taxed. Since 1989, providers have had to declare informal payments as part of their tax returns. The overall magnitude of informal payments is debated, since various surveys, reports and expert opinions have come to contradictory results.

At the lower end of the range are percentages calculated by the Hungarian Central Statistical Office (HCSO). These vary between 0.06% and 0.11% of GDP (HCSO, 1992, 1993, 1994) and are based on data obtained from a regular household budget survey and adjusted to compensate for various methodological issues. At the upper end of the range is a figure provided by the World Bank, which estimates that informal payments averaged 0.6% of GDP (that is, 7% to 11% of total health expenditure) between 1989 and 1996 (Orosz, Ellena & Jakab, 1998). Based on another survey, informal payments were estimated at approximately HUF 30 billion (€113.6 million) for the same year, which would account for 4.3% of total expenditure on health (Bognár, Gál & Kornai, 2000; Kornai, 2000; Gál et al., 2003). The magnitude of informal payments was thought to be even greater according to some expert opinions. For example, one report estimated the amount of gratuities at HUF 41.4 billion (€156.8 million) for 1996 (Orosz, Ellena & Jakab, 1998). Gaal et al. (2006) argue that the household budget surveys of the HCSO underestimated the scale of informal payments, but these surveys remain the only regular data collection for this type of OOPs in Hungary. They estimated that the true magnitude of informal payments most likely was between HUF 16 and 50 billion (€60.6 million and €189.4 million) in 2001, or between 1.5% and 4.5% of total expenditure on health. Although overall this does not seem to be a substantial amount, informal payments do have a profound impact on the behaviour of health workers, since the money is not equally distributed among them. There are physicians whose income from informal payments is considerably higher than their official salary and others who do not participate at all. Physicians, in particular specialists such as obstetricians and surgeons, receive the bulk of informal payments. These are more widespread in the inpatient sector than in the outpatient sector, and may differ by type of service, for example, cardiac surgery, hip replacement or home visit (Ékes & Bondár, 1994; Bognár, Gál & Kornai, 2000; HCSO, 1988; Kornai, 2000).

The data on OOP payments presented in Tables 3.4 and 3.7 include estimates of informal payments calculated by the HCSO. The practice of making informal payments for health services is deeply embedded in the Hungarian health care system and is therefore persistent. Although the relatively low salaries of medical doctors and other health workers have been a major contributing factor, eliminating informal payments will require concerted action to restore the lost confidence in public services.

3.5 Voluntary health insurance

3.5.1 Market role and size

In contrast to Germany, the voluntary health insurance system in Hungary has no substitutive, but only limited complementary and supplementary functions. Buyers opt for private health insurance either to cover services not included in the benefits basket or because they are dissatisfied with their publicly financed care options.

Data from the OECD shows a recent boom in the sector, especially in the case of voluntary mutual health funds, but should be interpreted with caution, because the data collection methodology does not clearly distinguish between the financing of private commercial insurance and that of mutual insurance funds. In 2009, voluntary health funds still constituted only 7.4% of private and 2.7% of total health care expenditure altogether, up from 0.6% and 0.2% in 2000 (Table 3.1). In 2008, the commercial profit-making insurers spent HUF 5.2 billion (€19.7 million) on cash benefits and reimbursement of health services, amounting to 0.27% total health expenditure (compared to 0.23% in 2000) (Hungarian Financial Supervisory Authority, 2010b; OECD, 2010).

Under the communist regime, voluntary health insurance was non-existent, with the exception of the Hungarian State Railway Employee voluntary supplementary insurance scheme, which has operated since 1930 and where members pay 0.5% of their salary. After the change of regime, Act XCVI of 1993 on Voluntary Mutual Health Funds created the legal framework for complementary insurance schemes on a non-profit-making basis, according to the model of the French *mutualité*. Initially, a smaller portion of the membership fee was a real health insurance premium, paid into a common fund or risk pool. The larger part of contributions went to individual accounts and could be used by the account holder only, making this rather an MSA scheme. As of 2003, the government abolished the risk-pooling element of the system, and

currently the system works as a pure MSA. By the end of 2009, there were 37 voluntary health funds in Hungary, according to data of the Hungarian Financial Supervisory Authority (Hungarian Financial Supervisory Authority, 2010a). They covered 900 000 residents in 2010 (approximately 9% of the population) compared to only 128 000 in 2001. Their expenditure on services rose from HUF 3.3 billion to 56.4 billion (€12.5 million to €203.3 million) in the same period. In 2008, their total expenditure on services amounted to HUF 39.9 billion (€151 million) (Hungarian Financial Supervisory Authority, 2010b), which corresponded approximately to 2.2% of total health expenditure.

3.5.2 Market structure

The market structure of the voluntary health funds is highly concentrated. The three largest funds (operated by large financial and private profit-making institutions) held 42.6% of membership and 39.4% of total financial assets (in comparison, 22 of the remaining 34 funds hold only a respective 4.3% and 4.1%) in 2009 (Hungarian Financial Supervisory Authority, 2010a).

3.5.3 Market conduct

The reason for private insurance not having taken root in the Hungarian health care system may lie with the nearly universal coverage of the health insurance system or the higher quality services that can be bought less expensively by informal payments, but this is a matter of debate (Mihályi & Petru, 2000; Kornai, 2000). Voluntary mutual insurance funds can both supplement and complement the NHIFA benefits package (1993/10), with services ranging from home care to pharmaceuticals, medical aids and recreational activities. In 2010, 75.7% of the expenditure on services was spent on reimbursement of pharmaceuticals and medical aids, 15% on supplementing services covered by the NHIFA and 6% on recreational and sport activities (Hungarian Financial Supervisory Authority, 2010b). Sixteen percent of all members did not pay their contracted monthly contributions in 2009 (Hungarian Financial Supervisory Authority, 2009) and administrative costs as a share of total expenditure on services amounted to 8.7%, much higher than for the NHIFA (Hungarian Financial Supervisory Authority, 2010b).

Private profit-making health insurance is even more limited. Some companies offer only insurance at the upper end of the market, but these are mainly income replacement cash-benefit policies for certain illnesses and not real indemnification insurance. There are new attempts to extend the private health insurance market by offering in-kind benefits in the form of

above-standard hotel services, but the outcome of these projects has not been fully analysed yet. In some cases it can be observed that the business plan is based on services, where the boundaries between public and private health care are not clearly defined.

3.5.4 Public Policy

Since 1995, the government has subsidized participation in voluntary health funds with a 30% tax rebate up to HUF 100 000 (€360.4) per year in 2010 (1995/14). However, the main revenue source of the voluntary health funds (87% of total revenue in 2009) are the monthly contributions paid by employers (up to 50% of the minimum wage and subject to tax exemptions for the benefit of the employee) (1995/14). Obviously, the supportive public policy has had a significant impact on extending both membership and revenue of voluntary health funds (Hungarian Financial Supervisory Authority, 2009).

3.6 Other financing

The change of regime opened the way for external and other sources to flow into the health sector in the form of governmental aid and loan programmes, voluntary donations and taxpayer donations.

3.6.1 Parallel health systems

Three large ministries have retained their health care facilities and are thus involved in the provision of care. The origin of these parallel systems dates back to the first half of the 20th century, when several private and public insurance funds employed physicians and owned health care institutions. The Ministry for National Economy, which among its many responsibilities runs the Hungarian State Railways, has its own comprehensive system of health service delivery within which railway workers and their dependants are given priority (1994/3). The number of providers and their capacities, however, were significantly reduced in 2007 (2007/7). The Ministry of Defence has its own inpatient and outpatient services, which are open to the general public, although special rules give priority to its employees. According to the general principles applied in health care financing, both ministries cover the capital costs of services, whereas recurrent costs are financed through the HIF. The Ministry of Public Administration and Justice provides health services to prisoners; this is entirely separate from the main system of provision.

3.6.2 External sources of funds

External sources have supported the reform process, especially in its early phase. In the area of health services, these included bilateral aid programmes, development assistance from the EU, USAID partnership programmes and a World Bank loan – the Health Service and Management Project – supporting the restructuring of the health care system. The largest was the seven-year World Bank project for the institutional development of public health, health services modernization and the establishment of health services management and public health training, among other things. The most important external projects have been financed by EU grants, initially designed to support the preparation of the country for EU accession and, after 2004, the economic and social convergence with more developed EU Member States. Under the “New Hungary Development Plan” (2007–2013) over HUF 400 billion (€1.44 billion) has been and will be invested in the development of human resources and health care infrastructure. In 2010, HUF 109 billion (€392.8 million) in EU funds was awarded mainly for developing infrastructure in health (Antonyi, 2011). Of this, 98% is absorbed by two of the three main development programmes, aiming to support investments almost exclusively in physical infrastructure. The third programme aims at developing human resources and health promotion.

3.6.3 Other sources of financing

Other private sources include enterprises financing and/or delivering preventive, curative and rehabilitative occupational health services to their employees. Voluntary donations channelled through charities have also begun to play a role since 1990. The size of the sector is more significant in terms of financing than that of profit-making private health insurance, but it is still a minor (2.2% in 2009) share of total health expenditure (Table 3.4). The government created a new opportunity for the expansion of the voluntary sector in 1996: taxpayers can decide which non-profit-making organizations receive 1% of their personal income tax (1996/13). All non-profit-making organizations that finance or carry out public benefit activities are eligible, except for political parties and organizations representing the interests of employers and employees. Since health care is a public benefit activity, non-profit-making organizations financing and/or providing health care are eligible. The government has extended this scheme by another 1% of income tax to be offered to churches, some of which own and operate institutions for health care provision (1997/12).

3.7 Payment mechanisms

3.7.1 Paying for health services

Under the former state-socialist system, hospitals and other health care institutions received a fixed, annual, line-item budget that was increased by a certain percentage each year. The size of the budget was not linked to performance but to input norms and it was subject to political influence. The reforms of the 1990s have brought about significant changes in inpatient as well as outpatient care. The payment system has become output-based and payment mechanisms are geared to the type of service instead of the type of institution. Patient capitation was introduced for family doctor services in 1992, while a fee-for-service point system for outpatient specialist care, a payment system based on HDGs for acute inpatient services, and payment per patient day for chronic care were established in 1993 (1992/4, 1992/8). Payment methods for various services are determined annually in the acts on the HIF budgets (1997/9), while detailed regulations are provided in governmental and ministerial decrees (1993/5, 1999/1). An overview of payment mechanisms is presented in Table 3.8.

Table 3.8

Provider payment mechanisms

	Ministry of National Resources	National Health Insurance Administration	Private voluntary health insurers	Cost sharing	Direct payments
Primary care	–	C, CP	–	–	X
Outpatient specialist care	–	FFS	FFS	–	X
Acute hospitals	–	HDG, IP	FFS	–	X
Inpatient long-term care	–	PD	–	X	X
Long-term nursing care	–	PD, FFS	–	–	X
Dentists	–	FFS	–	X	X
Pharmacies	–	FFS	–	–	X
Public health services	PF	C	FFS	–	X
Pharmaceuticals	–	FFS	FFS	X	X

GB: Global budget C: Capitation

CP: Case payment PF: Project financing

IP: Itemized payment PD: Per diem

FFS: Fee-for-service

In addition to the main payment methods, special rules apply to certain services, whose running costs are covered from separate sub-budgets of the HIF. Patient transfers are paid per kilometre plus a fixed fee per patient; home care is paid per home visit adjusted for the complexity of the case. Expensive prostheses, implants and some other medical devices (pacemakers etc.) are sometimes paid for separately, while the remaining costs of the intervention are covered by HDGs. This also applies for some expensive procedures and drugs (transplantations, extracorporeal liver dialysis, oncologic drugs, etc.).

The government in power from 1998 to 2002 piloted the CCS, a project aiming to address the shortcomings of incentives in the existing payment systems. The concept of the CCS was that health care providers be given the opportunity to take responsibility for the entire spectrum of care of a population group (initially up to 200 000 people) (1998/26). These care coordinator organizations could be hospitals, polyclinics or groups of family doctors and were assigned a virtual budget by the NHIFA based on the number of people in their catchment area multiplied by a risk-adjusted capitation fee. If the total cost incurred during the year was lower than the virtual budget, the difference was paid to the care coordinators and could be invested in improving services or used for remuneration purposes. The project was criticized mainly for lack of transparency as well as inequitable distribution (State Audit Office, 2008a) and was subsequently abolished in December 2008, despite documented successes during its first few years of operation.

Public health services

Public expenditure on public health services was 0.2% of GDP in 2008, which was 2.6% of total health expenditure (OECD, 2010). The central government and the NHIFA use different types of payment methods to finance these services: the NHIFA finances MCH nurse services through prospective capitation and fixed payments based on geographical considerations. Of the total public spending on public health, the share of NHIFA finance was 28% in 2008. The largest share (48% in 2008) in financing public health comes from the global budget provided by the Ministry of National Resources that gives a global budget to the NPHMOS, which covers services for communicable and non-communicable diseases (see also section 5.1).

The government spent 24% of total expenditure for public health services under the intersectoral NPHP (see also sections 5.1 and 2.6) that aims to coordinate and carry out various prevention and health promotion programmes. Within the NPHP, the Ministry of National Resources awarded grants and gave direct payments for prevention and health promotion activities amounting to

2.2% of total spending whereas other ministries and government agencies provided 22% of total expenditure on public health services (Ministry of Health, 2008). Finally, EU grants are increasingly used to finance public health services under the Social Renewal Operational Programme. However, in 2010, amounts awarded for health promotion (HUF 4.6 billion or €16.6 million total) were fairly limited compared to those allocated to health infrastructure (more than HUF 107 billion or €385.6 million) (Antonyi, 2011).

Tobacco and alcohol taxation is a significant source of income for the central government, but there is no specific allocation to public health services. The Ministry of National Resources recently recommended using excise tax to finance public health services as an alternative, but there has not yet been a government decision on this matter (Ministry of National Resources, 2010).

Primary/ambulatory care

Family doctors are financed with mixed payment methods that include prospective and retrospective elements. Capitation payment was introduced in 1992 for their services (1992/4). In 2009, the NHIFA paid 70% of the total expenditure on family doctor services through prospective capitation payments (NISHR, 2011b). People are allowed to choose their family doctors freely (see also section 2.9.2), and the number of registered individuals per practice (practice list) is the basis of general practice financing. The practice income is made up mainly of capitation payments with an additional fixed amount depending on the size and location of the practice as well as case payments for non-registered patients, which represented 29.4% of NHIFA expenditure on family doctors in 2009.

Capitation payments are based on the size of the practice list, which must be updated regularly by the family doctor to allow for any changes (for example due to death or migration). They are adjusted to the age composition of the patient pool and the qualification and work experience of the physician. The population is divided into five groups: for a person up to 4 years of age, family doctors receive 4.5 points; between 5 and 14 years 2.5 points; between 15 and 34 years 1 point; between 35 and 60 years 1.5 points; and over 60 years 2.5 points. Above a certain number of points (2400 for adult or child practice, and 2600 for mixed practice), the family doctor does not receive the full capitation payment, to prevent the negative impact of an unmanageable practice size on quality of care. Different limits apply if the practice is not single-handed. The total number of points is multiplied by 1.2 if the family doctor has a relevant qualification (specialization in family medicine or internal medicine for adult practices or paediatrics for child practices). The factor is 1.1 if the family doctor

has no relevant qualification, but has at least 25 years of work experience in primary care (1999/1). Family doctors receive the calculated practice income directly from the NHIFA, if they are a private entrepreneur with a valid contract. If they are a salaried employee of the local government, the NHIFA transfers the capitation payment to the latter, which is responsible for salary payment.

In 2009, the government introduced a performance bonus payment system for family doctors, based on quality indicators. Family doctor services have to reach a certain minimum score measured by the NHIFA by means of selected quality indicators in order to get rewarded. The government spent HUF 300 million (€1.1 million) for this purpose in 2010 but, as of April 2011, the Ministry of National Resources is scaling up the programme, revising its methodology and setting aside HUF 3 billion (€10.9 million) for potential financial rewards (Borbás & Mihalicza, 2011).

Outpatient specialist care

Most outpatient specialist services are financed by fee-for-service points, based on the German point system. Each procedure is assigned a number of points on the basis of its complexity and resource requirements. Providers report their monthly activity data with patient-level detail, including codes of procedures performed, to the regional branches/offices of the NHIFA. The payment process is carried out by central offices of the NHIFA. Up to the year 2000, performance points used to be added up nationally and the monetary value of 1 point was calculated by dividing the predetermined sub-budget (*kassza*) by the total number of points. Payment was made according to the points collected, multiplied by the calculated national monetary value of 1 point. These procedures allowed effective cost-containment. Between the second half of 2000 and 2003, the monetary value of 1 point was fixed in advance and part of the sub-budget was put aside at the beginning of each year to compensate for output increases and seasonal variations. The money value of 1 point was recalculated only if this reserve was exhausted.

Since the beginning of 2004 a new measure of volume regulation with degression was applied to contain output inflation (2003/25). Providers were eligible for full reimbursement for only 98% of their performance in the preceding year. If a provider in a given month produced more points than that, the excess points up to 5% were reimbursed at 60%, between 5% and 10% at 30%, and above 10% at 10% of the monetary value of 1 point. This system was in place until 2006, when the government introduced an even stricter cost-containment measure. Since 2007 excess points above the providers' own output limit are not reimbursed at all (see also section 6.1). A transition period

was allowed for outpatient specialist care providers. Initially they could retain 70% of their previous historical budget and only the rest of their income was calculated according to the collected fee-for-service points. The share of the historical budget decreased from year to year, until the entire income came from fee-for-service points produced.

Inpatient care

Inpatient services are reimbursed according to the type and severity of the case. Since 1993, an HDG-based retrospective payment system is used to reimburse acute-care, same-day surgery, certain types of treatment (such as chemotherapy) and emergencies (> 24 hours), with the exception of some tertiary care services, which are paid by the central government (see section 5.4 for more detail). 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 for the complexity of the case.

The essence of the HDG system is that it classifies inpatient cases into a manageable number of categories on the basis of their medical features, complexity and costs. The current version of Hungarian HDGs has 26 main groups, which are themselves divided into hundreds of smaller groups. Each group has an assigned weight (or number of points), which is higher for more complex and costly cases. Hospitals have to report their discharged cases monthly, and the reported cases are grouped into HDGs at the Department of Financing Informatics of the NHIFA (formerly known as Information Centre for Health Care, or Gyogyinfök), which operates the system. This procedure determines the hospitals' monthly output in terms of HDGs, and the NHIFA pays according to the total number of HDG points multiplied by the monetary value of 1 point, the so-called national base rate. The national base rate is set in advance by the NHIFA for one year and it applies to all hospitals equally. In order to facilitate cost-containment, the acute inpatient care sub-budget of the HIF is also capped nationally, and the same techniques have been used to prevent overspending as in the case of outpatient specialist services.

The current system has been developed over an 18-year period and HDGs are revised continuously to adapt to changes in medical practice and to support strategic purchasing (1998/2, 2001/1). It is worth noting that the HDG system has been used for implicit strategic purchasing, which means that cost weights were in some cases set higher or lower than the actual average cost of the services in the relevant HDG group in order to motivate providers to increase or decrease volume of a particular case or shift to alternative treatment modalities. For

example, generic drug prices were used for HDG calculation instead of actual cost data from hospitals or from the introduction of new, more cost-effective technologies.

The Information Centre for Health Care (Gyogyinfók) launched a pilot project to collect cost data in hospitals for the adaptation of the United States DRG system in 1986 (1987/1). The first version of HDGs was developed on the basis of cost data from 500 000 cases of 28 participating hospitals, and was introduced countrywide in July 1993 (1993/5). Initially, the base rate was unique to each hospital. It was calculated for each institution on the basis of its previous budget and output, and the differences were gradually decreased until the national average was reached in 1998 (1995/9, 1996/12). Government Decree No. 13/1998 (I. 30.) Korm. introduced the uniform national base rate in March 1998, with the provision that it can be recalculated if output exceeds budget reserves (1998/1). For a short period of time, the government used a supplementary fixed element in hospital financing, unrelated to hospital performance, which was eventually abolished in 1998 (1996/12, 1998/26).

These gradual changes allowed hospitals to phase in the new system of payment in a more acceptable and less disruptive way. It should be noted, however, that the transitional system of individual base rates (unique to each hospital), and of retaining parts of the historical budget put the most efficient hospitals at a disadvantage. For instance, in the case of the HDG payment system, individual base rates were calculated on the basis of the previous historical budget of each hospital, which was divided by the HDG points earned by the hospital in a pre-introductory period. This means that those hospitals that produced the most output (in terms of HDG cost weights) from the lowest annual budget had the lowest individual base rate.

The introduction of the output volume limitation for hospitals possibly led hospital management to introduce measures that further decreased hospital costs and therefore limited provision of services, thus lengthening waiting lists. In 2009, the Ministry of Health³ proposed amendments to improve the flexibility of capacity distribution between inpatient and outpatient facilities, and between inpatient curative care and inpatient long-term care (2009/5). The number of patients whose treatment will be covered will be redistributed each year on the basis of proposals by the HIF. If some allocated capacities are not utilized, they can be transferred to another institution.

³ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

In April 2009, the government decided to abolish the output volume limit for inpatient and outpatient specialist medical services, which had been in place since 2004, and to introduce a combination of a pre-fixed national base rate combined with a floating fee element (EMAFT). This sparked a very serious debate between the government and the hospitals and intense protests on behalf of the latter that escalated in September 2009. Finally, the government and the representatives of the hospitals agreed that, instead of replacing the output-based payment system with a predetermined global budget, the government would abolish the EMAFT system and reintroduce the previous output volume limit in the financing of specialist medical services.

Pharmaceutical care

There is a unified system of free pricing for all pharmaceuticals regardless of prescription status. For reimbursed medicines, the price proposed by traders is evaluated by the NHIFA, using external and internal reference pricing as well as HTA for the evaluation of cost-effectiveness. The NHIFA finances pharmacies and wholesalers with regressive and/or fixed mark-ups. Every hospital has the autonomy to purchase the necessary medical products by tendering or public procurement, once the product in question has been evaluated and assigned a coverage status by the NHIFA. The cost of drugs for hospitals is financed by the NHIFA through HDG payments. Patients are required to pay co-payments for pharmaceuticals reimbursed by the NHIFA up to a certain percentage of consumer prices and/or are reimbursed based on reference pricing (see section 2.8.4 for more detail).

3.7.2 Paying health workers

In the state-socialist health care system all physicians, nurses and midwives were salaried public employees, and private practice was allowed only on a part-time basis (1972/2). Public employment with salaries has remained the dominant form of medical practice throughout the years of continued health care reform, with the exception of entrepreneur family doctors, who contract with both the NHIFA and local governments and are paid on a capitation basis. Some medical doctors run private practices, usually as second jobs, and are paid per on a fee-for-service basis by their patients, free from central regulation. Most specialists are salaried public employees, who are guaranteed a minimum level of salary according to a pay scale (1992/5) based on qualifications and years of experience, but the number of specialists who work as private entrepreneurs contracting with health care providers is increasing, especially in the outpatient specialist care sector. Most clinical specialists still receive informal payments from patients, but these are too unequally distributed to

be considered official salary supplements. They do, however, provide some material incentive for doctors to stay in the profession, especially for certain specialties (e.g. gynaecology, surgery).

The majority of personnel, including nurses and midwives, continue to be salaried public employees. In 2010, health care workers' salaries ranked strikingly low among those of full-time employees of the 20 main sectors of Hungarian economy (see Table 3.9). This is closely linked with the human resource crisis in the health system, which endangers the sustainability of current performance even for the near future: according to the NISHR, the number of health care workers dropped in public institutions (see more in 4.2.1).

Table 3.9

Average monthly gross wages of employees in health care and in the national economy, HUF

	2006	2008	2010
Health care	165 000	185 000	176 000
– as % of average in national economy	96.2%	93.3%	87.0%
Industry	163 000	188 000	207 000
– as % of average in national economy	95.3%	94.7%	102.2%
Financial services	402 000	432 000	433 000
– as % of average in national economy	234.4%	217.2%	214.0%
Public administration and defence	223 000	268 000	243 000
– as % of average in national economy	130.2%	134.7%	12.2%
National economy in average	171 000	199 000	203 000
– as % of average in national economy	100.0%	100.0%	100.0%

Source: HCSO, 2011.

Notes: €1 = 265.43 HUF (August 2011), Central Bank of Hungary.

Despite repeated mentions in policy papers by the Ministry of National Resources since the beginning of 2000s, that the low wages of the health workers should be a top priority of health policy agendas, no effective policy has been formulated on this matter and no modification of the strict cost-containment strategy towards the health sector has taken place. The single exception was the – on average – 50% raise in public sector salaries in the fall of 2002, just before the local government elections. This significant increase brought the official salaries in the health sector closer to the industry average in following years but health care wages have been levelling off again since 2005 (HCSO, 2010c).

Obviously, there are differences in wages among health professionals. Medical doctors earn far higher wages than nurses or other health workers, but still have far lower monthly gross earnings than the financial sector average,

even with extra payment for being on-call. At same time, nurses – even with extra payments – earn 19% less than the national average (Table 3.10) (NISHR, 2011a).

Table 3.10

Structure of average monthly gross wages of full-time employees of hospitals and outpatient care centres in the fourth quarter of 2010, HUF

	Doctors		Nurses		Other employees		Total	
	Gross wage (HUF/month/capita)	%	Gross wage (HUF/month/capita)	%	Gross wage (HUF/month/capita)	%	Gross wage (HUF/month/capita)	%
Base payment	241 278	66.2%	113 593	67.7%	106 371	75.3%	126 136	69.5%
Payment allowance and other supplements	59 266	16.3%	42 419	25.3%	23 896	16.9%	37 771	20.8%
Bonus	8 164	2.2%	3 192	1.9%	3 003	2.1%	3 714	2.0%
Overwork payment	17 813	4.9%	5 460	3.3%	4 358	3.1%	6 478	3.6%
On-call payment	37 812	10.4%	3231	1.9%	3571	2.5%	7452	4.1%
Gross wages	364 332	100.0%	167 895	100.0%	141 198	100.0%	181 551	100.0%

Source: NISHR, 2011a.

4. Physical and human resources

4.1 Physical resources

4.1.1 Capital stock and investments

According to statistics from the HCSO, Hungary had a total of 175 hospitals in 2009. Altogether, these hospitals had 71 489 beds, of which 71 064 were in operation (HCSO, 2010d). These statistics, which are based on the NHIFA annual report for 2009, require some clarification (NHIFA, 2010).

First, the total number of hospitals does not include institutions without an NHIFA contract (i.e. the one private, profit-making hospital and one of the two hospitals owned by the Ministry of Public Administration and Justice, the so-called prison hospital at Tököl). Adding the 708 beds operated by these two institutions to the total number of beds cited above brings the total inpatient capacity in 2009 up to 72 197 beds.

Second, although same-day surgery is considered acute inpatient care in Hungary and is paid through HDGs, it can also be performed by outpatient specialists (see section 5.4). As a result, the 175 or 177 hospitals cited above include 22 polyclinics that do not have any contracted inpatient capacities.

Third, according to the minimum standards of health service provision set by the Minister of Health (now known as the State Minister for Health) in 1996 and 1997, inpatient care providers with less than 80 beds should not be classified as hospitals (2003/15). There were 30 such providers in 2009.

Thus, if we exclude the 22 polyclinics, as well as the 30 providers with less than 80 beds, there were in reality only 125 hospitals that year. Here, it is important to note that so-called daytime hospitals are also not included in the NHIFA report; these hospitals represent an emerging form of care that is

currently used mainly in the long-term treatment of psychiatric patients (see section 5.7). The care these hospitals provide should not be confused with same-day surgery.

Table 4.1 provides simple descriptive statistics on the number of 155 inpatient care providers and their capacities. The average capacity was 470 beds, and the total number of beds operated by each provider ranged from 10 to 2166. The largest provider was Semmelweis University in Budapest, and the smallest were two hospice and chronic care providers, each of which had 10 beds. About 70% of all providers had fewer than 500 beds. Larger hospitals (that is, hospitals with more than 1000 beds) include four universities with medical faculties, four municipal hospitals, the Military Hospital in Budapest, 13 large county hospitals, and a large municipal hospital in Borsod county. Six inpatient care providers had only acute beds, whereas 45 had only chronic capacities (although 8 of these 45 also provided same-day elective surgery). The rest had a mixed profile with both acute and chronic beds. The average acute capacity was 415 beds, while the corresponding figure for chronic care was 186 beds in 2009. The largest chronic care provider in 2009 was a municipal hospital in Budapest, with 795 chronic beds.

Table 4.1

Number and size of inpatient care providers in Hungary, 2009

Type of provision	Size of inpatient care providers (in beds)								
	Other providers		Hospitals						
	10-19	20-79	80-149	150-249	250-499	500-999	1000-1499	1500-1999	2000+
Acute care									
Number of providers	0	18	17	11	30	20	9	1	1
% of providers	0.0%	16.8%	15.9%	10.3%	28.0%	18.7%	8.4%	0.9%	0.9%
Cumulative number	0	18	35	46	76	96	105	106	107
Cumulative %	0.0%	16.8%	32.7%	43.0%	71.0%	89.7%	98.1%	99.1%	100.0%
Chronic care									
Number of providers	8	32	38	31	29	8	-	-	-
% of providers	5.5%	21.9%	26.0%	21.2%	19.9%	5.5%	-	-	-
Cumulative number	8	40	78	109	138	146	-	-	-
Cumulative %	5.5%	27.4%	53.4%	74.7%	94.5%	100.0%	-	-	-
Total									
Number of providers	7	23	13	19	44	23	13	9	1
% of providers	4.6%	15.1%	8.6%	12.5%	28.9%	15.1%	8.6%	5.9%	0.7%
Cumulative number	7	30	43	62	106	129	142	151	152
Cumulative %	4.6%	19.7%	28.3%	40.8%	69.7%	84.9%	93.4%	99.3%	100.0%

Source: Authors' calculations based on NHIFA, 2010.

In 2009 more than 26% of inpatient care capacity was concentrated in Budapest, which had 108.8 beds per 10 000 population, or about 50% more than the nationwide average (Table 4.2). Even though there had been some excess capacity in Budapest in the early 1990s, these figures no longer represent unjustified disparities in the geographical distribution of hospital beds for two reasons: first, Budapest serves the population of the surrounding counties as well (mainly Pest county, but to a lesser extent also Komárom-Esztergom, Fejér, Nógrád and Heves counties). When Pest county is taken into account, which together with Budapest forms the region known as Central Hungary, the number of hospital beds per 10 000 population exceeded the nationwide average by only 6% in 2009. Second, Budapest accommodates the majority of care capacities at the highest level of specialization (for example, at the National Institutes of Health), and the institutions at this level have a catchment area that encompasses the entire country.

At the regional level, geographic inequalities have generally decreased over the past 20 years, although this does not mean that capacity currently matches health care needs perfectly. The Southern Great Plain region showed the greatest deviation: in 2009, its capacity in terms of hospital beds was about 10% lower than the country average and the health status of its population was worse than the nationwide average. Although capacity in the Northern Great Plain region deviated less from the nationwide average, the health status of the population in this region was even worse than that in the Southern Great Plain region. It is important to note that whereas both the Northern Hungary and the Southern Transdanubia regions were above the country average in terms of hospital beds, the health status of their populations was substantially worse than the country average, which also implies regional disparities (HCSO, 2010a). Even though inpatient care capacity shows even larger disparities at the county level, this is not necessarily a source of concern, given that the utilization of health services is not confined by the geographical borders of the counties.

Table 4.2

Geographic distribution of inpatient beds per 10 000 population in Hungary, 1990–2009 (selected years)

County/Region	1990	1995	2000	2005	2006	2007	2008	2009
Budapest	153.5	147.4	136.4	132.9	132.7	115.3	109.5	108.8
Pest	52.0	48.2	40.6	34.5	34.2	30.1	29.7	29.3
Central Hungary	120.9	113.6	100.1	93.0	92.3	80.2	76.4	75.7
Fejér	74.1	66.0	68.3	63.8	64.1	60.2	60.2	60.3
Komárom-Esztergom	87.3	75.5	65.8	65.7	67.0	61.0	61.2	61.6
Veszprém	101.3	96.5	85.4	86.3	87.1	84.0	84.3	84.6
Central Transdanubia	87.1	79.0	73.3	71.8	72.5	68.2	68.4	68.6
Győr-Moson-Sopron	106.2	90.9	84.4	77.9	77.7	72.1	71.2	71.0
Vas	102.9	92.5	74.7	72.1	72.4	69.7	69.9	70.3
Zala	104.9	93.3	90.6	86.4	85.9	71.1	71.4	71.3
Western Transdanubia	104.9	92.0	83.6	78.8	78.7	71.1	70.9	70.9
Baranya	104.8	97.8	91.7	87.0	86.5	80.7	81.1	79.0
Somogy	94.3	87.9	72.2	71.9	72.1	71.0	71.5	71.9
Tolna	87.6	69.3	66.7	68.1	68.6	65.9	66.6	67.3
Southern Transdanubia	97.0	87.2	78.8	77.1	77.2	73.7	74.3	73.7
Borsod-Abaúj-Zemplén	92.9	81.1	73.3	74.4	75.6	73.6	73.5	75.3
Heves	125.4	87.1	80.8	79.9	80.3	68.9	68.5	69.5
Nógrád	95.4	75.1	74.9	75.5	76.1	70.1	71.0	72.6
Northern Hungary	101.5	81.6	75.4	76.0	76.9	71.8	71.8	73.3
Hajdú-Bihar	79.9	77.6	77.6	78.4	78.6	68.7	68.9	69.1
Jász-Nagykun-Szolnok	88.1	73.4	69.7	65.9	66.9	64.0	63.9	65.3
Szabolcs-Szatmár-Bereg	83.8	73.2	70.8	70.3	70.9	68.4	69.1	69.7
Northern Great Plain	83.6	74.8	72.9	72.0	72.6	67.4	67.7	68.3
Bács-Kiskun	81.9	76.6	69.3	64.8	64.7	55.9	56.3	56.5
Békés	79.5	79.2	70.6	72.6	73.3	64.4	65.4	67.6
Csongrád	103.6	96.9	83.5	80.2	80.3	71.7	71.5	71.6
Southern Great Plain	88.0	83.7	74.1	71.9	72.1	63.4	63.7	64.4
Country total	100.9	91.2	82.6	79.6	79.7	72.1	71.2	71.4

Source: In part authors' calculations based on HCSO, 2010f.

The general condition of the hospital infrastructure has been an issue for some time because sufficient public resources have never been invested in the refurbishment of buildings and equipment. A typical hospital has a large number of separate, often old and outdated buildings, usually located on different sites. According to a survey carried out in 2004 with the participation of about 50% of hospitals (that is, 75 providers with altogether 44 499 beds), the mean age of hospital buildings was 50.5 years (with a range of 45 to 62 years), and the average number of buildings per hospital was 22 (Papp & Eöry, 2004). Furthermore, in certain regions there were as few as 18 to 25 beds per building. In 2005 the 109 municipal hospitals had 3157 buildings (29 per hospital) on 337 sites (on average more than three sites per hospital) (State Audit Office, 2005).

The 2004 survey estimated that over HUF 187 billion (€760 million) would have been needed at the time to modernize the buildings of the participating hospitals, whereas only HUF 11 billion (€41.7 million) had actually been spent on reconstruction over the three previous years. Of the latter amount, more than 40% came from central government grants, less than 30% from the owners (that is, local governments), about 14% from providers' own resources, and the remainder from other grants and donations (Papp & Eöry, 2004). The State Audit Office of Hungary, which examined the use of central government grants for hospital reconstruction in 2005, found that the 22 surveyed hospitals had spent HUF 3.4 billion (€13.5 million) on building renovations between 1996 and 2004, which corresponded to an average of 0.7% of the gross book value of their real estate per year (State Audit Office, 2005).

The Directorate of Medical and Hospital Engineering of the Institute for Healthcare Quality Improvement and Hospital Engineering (formerly the Institute of Medical and Hospital Engineering) keeps a registry of real estate and of the energy use of inpatient care providers. Both publicly and privately owned hospitals are obliged to participate in collecting data every three years on their various sites, buildings and organizational units, as well as on energy procurement and use. Even though the database and various reports on hospital facilities are used by the State Secretariat of Healthcare and other governmental organizations, the State Audit Office regularly points out that health care investments have not been based on a comprehensive sector development strategy and that investment decisions have lacked coordination as a result, fostering parallel development, especially in the area of medical equipment. Because investment decisions have been guided instead by local economic interests, the structural transformation necessary to meet population health care needs and ensure the long-term sustainability of health care capacities has not been prioritized (State Audit Office, 2005).

Since the introduction of the purchaser-provider split model in Hungary, the financing of health services has been based on the separation of capital and recurrent expenditure. Whereas HIF financing covers recurrent expenditure only (1992/8, 1997/19), capital expenditure (both maintenance and new investments) is the responsibility of the owners of health care facilities, based on the principle known as the maintenance obligation (1997/20). This system of separate financing for capital and recurrent costs applies to the vast majority of health services, including inpatient and ambulatory care. The only exceptions are certain services such as public health and emergency transportation, which are financed entirely from the government budget (see sections 5.1 and 5.5). In theory, the owners of health care facilities (mainly the local governments of

municipalities and of counties, and to a lesser extent the central government and private entities) must finance the investment in and maintenance of infrastructure, buildings and equipment from other sources. In practice, however, hospitals have used NHIFA revenue for investment purposes, and in 2000 the government decided to take a less rigid stance and relax regulations in this regard (1999/12). It is not surprising that providers have been allowed to use NHIFA revenue to cover capital expenditure, since the maintenance obligation has placed a substantial burden on local governments, which usually have a relatively weak revenue base and are in need of central government support.

Local governments have four other sources of revenue for investment and capital stock maintenance: (1) transfers of national tax revenue (for example, part of the personal income tax), (2) local taxes, (3) central government grants in the form of earmarked and target subsidies and (4) other conditional capital grants from national sources (mainly the Ministry of National Resources) and international sources (mainly EU structural funds). In principle, local governments should use the first two sources to cover the capital expenditure on health care facilities. In practice, however, only a few local governments can afford to pay for expensive medical equipment or for refurbishing hospital wings or entire buildings. The central government has thus offered conditional and matching grants under Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (option 3 above), which also determines the components of the system and the application process.

The first component is a conditional capital grant (earmarked subsidy) for large-scale projects, usually for the renovation or extension of existing buildings with a cost exceeding HUF 250 million (€900 000). Its upper limit and local contribution share are not specified (2006/2). Local governments submit project proposals to the ministry responsible for local governments (as of June 2010 the Ministry of Interior), which makes a priority list while taking into account recommendations from the relevant ministry (for example, in the case of health care projects, the ministry responsible for health, that is, the Ministry of National Resources with its State Secretariat for Healthcare; see section 2.3.3). Subsequently, the National Assembly decides on the submitted proposals.

The second component is a target subsidy (that is, a matching grant), which allows local governments less discretion because both its purpose and conditions are predetermined by the National Assembly (1992/9). In the health sector, local governments can apply for target subsidies to purchase medical equipment, such as X-ray machines or dental equipment. The local share required varies each

year: for example, for the 2011–2012 period, local governments can apply for a matching grant of over HUF 1 million (€3630) to purchase anaesthesiology and intensive therapy equipment, with a minimum local share of 25% (2009/7).

The third component of the system used to be a budget that had been devolved to the county councils for regional development, which decided on the allocation of funds among various applicants. Target-type decentralized grants (*céljelleget decentralizált támogatás*, or CÉDE) were introduced in 1997 (1997/13), but were eliminated in 2006 when EU funding became the main source of capital grants in the health sector (2006/9).

For the 2007–2013 budget period of the EU, Hungary is the recipient of €22.4 billion from the various structural and cohesion funds, out of which the government decided to spend €1.8 billion on various health care infrastructure development projects, including the renovation of hospitals, polyclinics and primary care surgeries, and on the building of new polyclinics and health centres in primary care (2006/4). In preparation for the grant agreement between Hungary and the EU, major changes were implemented in the existing capital financing system. Not only was the decentralized component (that is, the CÉDE) of the earmarked and target subsidy system eliminated in 2006, but the National Assembly also suspended new conditional capital grants and authorized the government to harmonize actual investment decisions and ongoing projects with upcoming EU funding (2006/11). Since 2008 the scope of matching grants has been limited to a specific health care purpose (2007/10). There is no doubt that EU funds have become almost the only source of capital investment, although local governments must still make efforts to provide the required local share. Providers often have to contribute from their own resources (for example, income from paying services or donations to hospitals founded by charities). It is worth noting that private providers are also eligible for the various public grants if they supply services to the population of a local government under the territorial supply obligation.

Other important capital financing options are the various capital grant programmes run by the Ministry of National Resources/State Secretariat for Healthcare to replace medical equipment or to support providers in meeting minimum standards. These programmes also shrank during the phasing in of EU funds. For the most part, the health sector did not participate in the large-scale public–private partnership (PPP) investment programmes initiated by the government in power from 2002 to 2006. The only health care related examples are two higher education PPP projects at Semmelweis University, Budapest.

Table 4.3 shows the distribution of EU structural and cohesion funds in the health sector up to April 2011. Of the total funding awarded, almost three-quarters has been allocated to the inpatient care sector, less than 5% to primary care and less than 1% to health promotion. On the other hand, special emphasis has been placed on the development of medical rehabilitation, emergency care and blood supply and on the development of disadvantaged subregions, for which a disproportionately large number of projects and the corresponding funds have been approved. There are also 22 cross-border collaborative development projects under implementation with five neighbouring countries, and further projects have been planned with Croatia and Serbia (Ministry of National Resources, 2011).

Table 4.3

Sectoral distribution of funding for EU-funded health care projects (in million HUF and euro) in Hungary, 2007–April 2011

Sector	Projects awarded	Funding awarded (million) HUF		Projects contracted	Funding contracted (million) HUF		Projects implemented
Primary care	274	12 524	47.0	272	12 437	46.7	148
Outpatient specialist care	71	47 821	179.4	70	47 750	179.1	36
Inpatient care	70	204 571	767.5	52	146 353	549.1	5
Health promotion	281	2 764	10.4	267	2 633	9.9	23
Education & training	32	863	3.2	30	790	3.0	4
Employment	68	2 531	9.5	68	2 531	9.5	4
IT	3	4 374	16.4	3	4 374	16.4	1
Other	2	1 239	4.6	2	1 239	4.6	1
Total	801	276 686	1 038	764	218 107	818.3	222

Source: Ministry of National Resources, 2011.

Given that capital investment in health care has been chronically underfunded in Hungary, the influx of EU funds has been indispensable. Between 1994 and 1999, public investment in health care was almost halved in real terms and, as a share of GDP, decreased from 0.46% to 0.39% between 1996 and 2003 (State Audit Office, 2005). The central government has always been in a position to control its expenditure and investments through the system of earmarked and target subsidies, despite the dominance of local governments in the ownership of health care providers. Between 1991 and 2004, local governments received HUF 184 billion (€697 million) in earmarked subsidies, mainly for the renovation of existing inpatient care facilities, but the total amount of capital grants showed a decreasing trend in real terms between 1996 and 2003. According to the findings of the State Audit Office of Hungary, funding for capital costs has

been unstable, has not been related to the health care needs of the population and has not been based on an approved health sector development plan (State Audit Office, 2005).

4.1.2 Infrastructure

In 2009, local governments owned 78% of all hospital beds in Hungary, almost 20% of which (15.2% of all beds) were in Budapest. Of the total number of approved beds, university clinical departments had 9.7%, the National Institutes of Health had 5.9% and health care institutions of other ministries had 2.5%. In addition, 3.8% of all hospital beds were owned by churches and charities operating hospitals with a territorial supply obligation and therefore eligible for HIF financing (HCSO, 2010f). Private non-profit-making organizations operate in several fields of inpatient care, the majority of beds being provided for internal medicine, paediatrics, psychiatry and follow-up care (NHIFA, 2010).

Over the past 15 years, Hungary has followed the general European trend of reducing the number of acute hospital beds both through real reductions and bed reallocations to different types of services (Fig. 4.1). There were two major waves of bed reductions – the first between 1995 and 2001 and the second in 2007 – as part of fiscal stabilization packages prompted by very high deficits. In general, the average length of stay (Fig. 4.2) and hospital admissions rates have also decreased since 1990, as have occupancy rates (Fig. 4.3). For more information on trends in the mix of beds in the Hungarian health care system see sections 5.4, 7.3.2 and 7.5.2.

Fig. 4.1

Trends in the mix of beds in the Hungarian health care system, 1990–2009 (selected years)

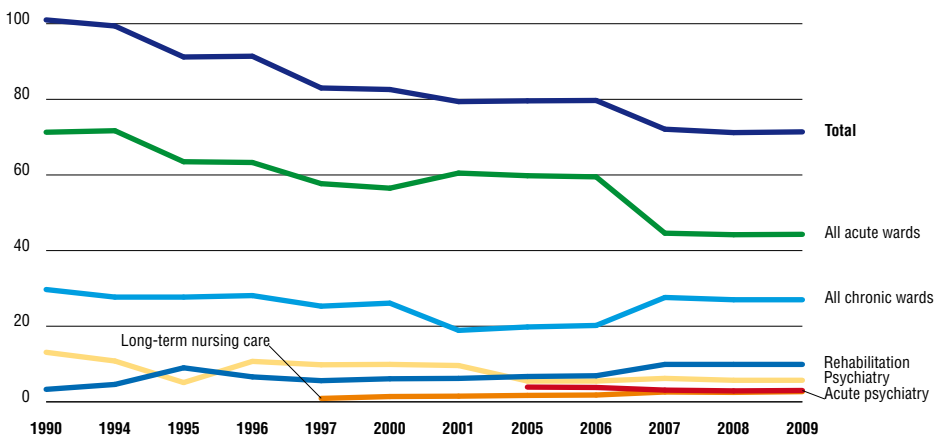
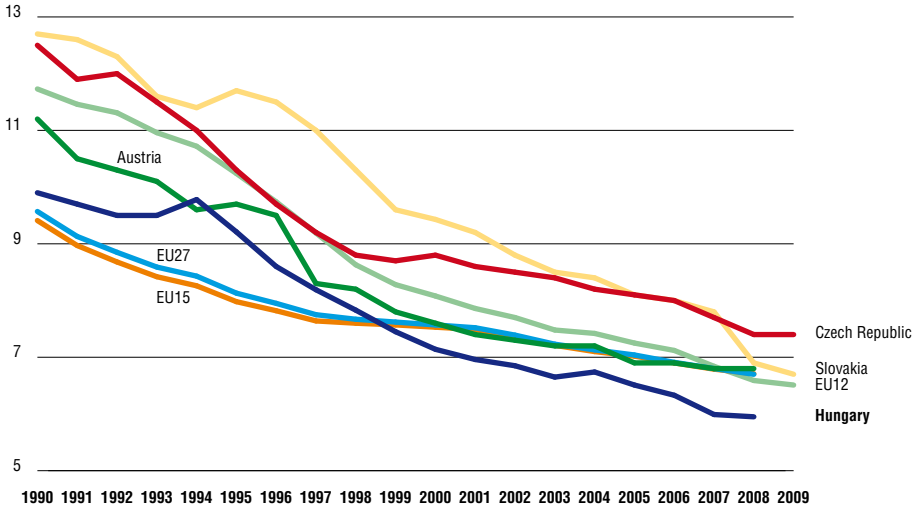


Fig. 4.2

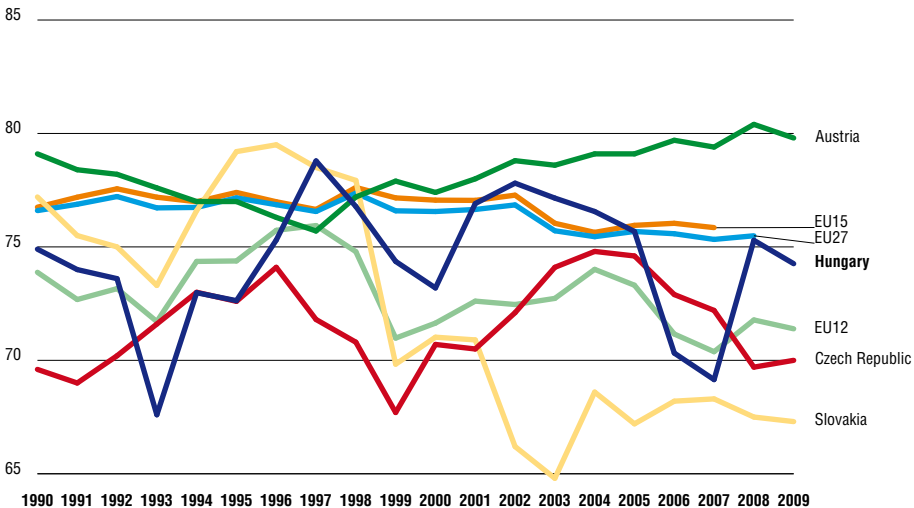
Average length of stay in acute-care hospitals in Hungary and selected countries, 1990–2009 (or latest available year)



Source: WHO Regional Office for Europe, 2011.

Fig. 4.3

Bed occupancy rate (%) in acute-care hospitals in Hungary and selected countries, 1990–2009 (or latest available year)



Source: WHO Regional Office for Europe, 2011.

One of the main legacies of the Semashko-style system in place during the communist era was an oversized hospital sector, which came to be considered inefficient and inequitable (see section 7.5.2), leading to calls for restructuring and downsizing. In the first phase of reforms in the mid-1990s, the government introduced a DRG-based hospital payment system for acute inpatient care and per diem payments for chronic inpatient care, as well as a three-member structure for top hospital management, according to which a financial director, medical director and nursing director managed the institution together. These measures did not produce significant structural reorganization in the hospital system, but it has to be noted that a uniform base rate was not introduced until 1998 (1996/14).

The next government attempted to address the issue more directly. First, as part of the restrictive package of 1995, the Ministry of Welfare¹ became responsible for bed reduction decisions by determining the capacities to be contracted for under the territorial supply obligation by local governments. A total of 8000 beds was removed from the system in 1995 (1995/5), but the decision-making process was found to be unconstitutional by the Constitutional Court (1995/13), which ordered the government to develop a more systematic method for applying the territorial supply obligation. The 1996 Capacity Act determined the maximum number of beds and outpatient consultation hours per specialty and per county based on a formula that aimed at representing the health needs of local populations (1996/4). The Act was expected not only to reduce the number of beds considerably but also to produce a more equitable geographical distribution. Its implementation was left to the county consensus committees summoned by the NPHMOS and comprising representatives of local health care providers such as hospitals, the local branches of the Hungarian Medical Chamber and county offices of the NHIFA (see section 2.2). In counties where beds had to be reduced based on the formula, the county consensus committees had to agree which provider would give up how many beds. As a result, the number of beds decreased by another 9000 in 1997, and remained at around 80 beds per 10 000 population until 2006. The government also endorsed cost-effective forms of care, including same-day surgery and home care. For instance, in 1996, a separate HIF sub-budget was created for home care services, for which HIF expenditure was also increased (see also section 5.8).

As a result of all these changes, the number of acute hospital beds was reduced by 20% between 1992 and 1997 and the number of hospital beds for chronically ill patients was also reduced by 17%, according to national statistics.

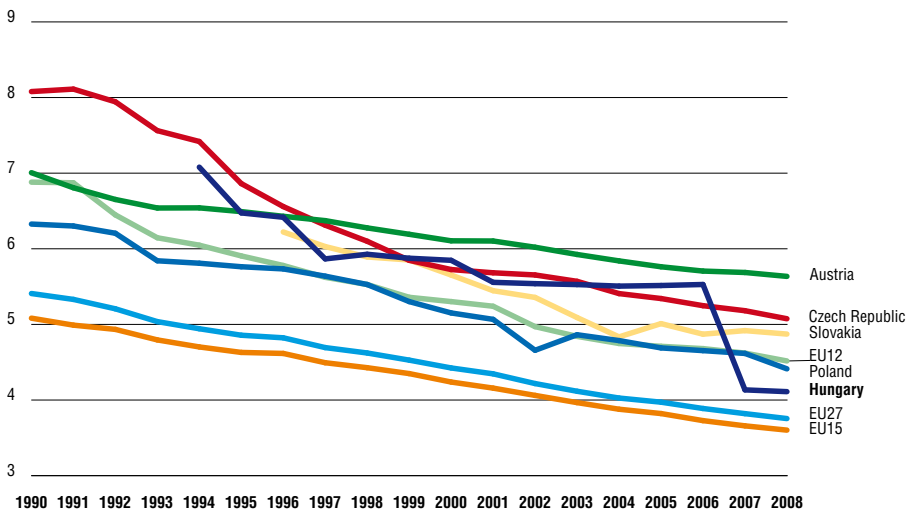
¹ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

The next major wave of downsizing in acute inpatient care capacities took place in 2007 (2006/12). More than 25% of acute beds were removed from the system, with a parallel increase in the number of chronic beds. Six hospitals were closed, twelve remained without acute beds, and one or more acute wards were closed in thirty-three other hospitals.

The number of acute hospital beds per 1000 population in Hungary ranked above the EU15 and EU27 averages in 2008, but below numbers for neighbouring countries with similar economic development, such as the Czech Republic and Slovakia (Fig. 4.4). Capacities for long-term nursing care in both the inpatient and outpatient setting are still considered insufficient and thus unable to meet the needs of the ageing population (see also section 5.8).

Fig. 4.4

Beds in acute hospitals per 1000 population in Hungary and selected countries, 1990–2008



Source: WHO Regional Office for Europe, 2011.

4.1.3 Medical equipment, devices and aids

The operation and licensing of medical equipment (including medical aids and prostheses) is run by the Authority for Medical Devices of the State Secretariat for Healthcare (2000/4). The Authority replaced the Institute of Hospital and Medical Engineering, which was renamed and continues as an organization of

quality control and audit in this area (1990/2). The registration and licensing system was harmonized with the practice of the EU (1999/7), along with that for pharmaceuticals.

Minimum standards for health care institutions (regarding personnel, equipment and buildings) were introduced as a rationalization measure in 1996 and 1997. Buying new and replacing obsolete equipment falls to the owners of facilities, who can either pay from their own sources or apply for a conditional or matching grant. Various capital grant programmes are run by the Ministry of National Resources for replacing medical equipment or supporting providers in meeting minimum standards. EU capital grants have also played an increasing role in the funding of medical equipment in recent years (see also section 4.1.1 above). In 2008, there were 28 magnetic resonance imaging (MRI) units, 71 CT scanners and 6 PET units functioning in hospitals and ambulatory units (European Commission, 2011).

4.1.4 IT

In 2010 the rate of regular internet users in Hungary was 61%, only slightly below the EU27 average (65%). It has increased almost by 200% since 2004 (21%). At the same time, the share of individuals using the internet to seek information with the purpose of learning was 31%, only 1% lower than the EU27 average (European Commission, 2011). The recent government action plan states that a broadband connection is available for 97% of the population but only 19.7% use it, and that 55% of the population own a personal computer. There are 11 million mobile phone subscriptions, which is about 10% more than the size of the population (Ministry of National Development, 2010).

The use of IT in the health sector has developed gradually. It is largely attributable to the introduction of new payment techniques in 1993 and subsequent important requirements for financial administration and reporting, such as ad hoc provider checks of patients' health insurance status and eligibility for services since 2007. The development of IT in the health care context was supported by a strategic vision of the Ministry of Health, Family and Social Affairs in 2003, which was based on a recommendation of the Ministry of Telecommunications (Ministry of Health, Family and Social Affairs, 2003). The implementation of the strategy, which aimed primarily at increasing the number of informed individuals and communities, was found to be only moderately effective (WHO, 2006). Nevertheless, one of its successful initiatives was the establishment of a web- and telephone-based health information centre available around the clock, which offers quality information not only to citizens but

also to providers. The current government IT strategy, now coordinated by the Ministry of National Development, aims to improve IT capacities in the health system. Some of the initiatives of the 2003 plan – such as the establishment of electronic prescribing and medical records, and the creation of systematic mechanisms to keep registration databases updated and transparent – were not implemented. The new action plan will put them into practice, along with other initiatives that include, for instance, the horizontal integration of provider IT systems in order to increase interoperability and to reinforce patient data transfer between providers, starting in the second quarter of 2011 (Ministry of National Development, 2010).

Regarding the current level of IT use in primary care, a study of the European Commission based on 2007 survey data ranked Hungarian family doctors as solid average performers among EU countries with regard to eHealth utilization. They ranked ahead of all central and eastern European countries except Estonia. Almost all family doctors in Hungary regularly used IT to store administrative and medical files, but effective IT solutions (for example, for transferring lab results or for electronic prescriptions) are not in use due to a lack of technical prerequisites. Only 35.7% of primary care physicians in Hungary had broadband internet access in 2007, which was well below the European average (47.9%). They used their computers for consultation purposes (84%) and to access decision support systems (93%), but were reluctant to develop practice web sites. Indeed, only 9% of primary care physicians in Hungary had a web site for their practice in 2007, which was one of the lowest rates in the EU (European Commission & Empirica, 2008).

4.2 Human resources

4.2.1 Health workforce trends

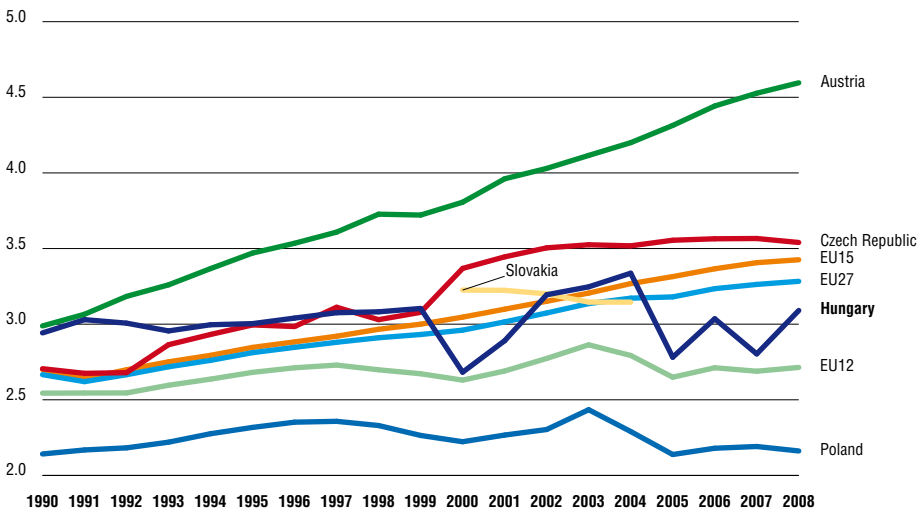
As can be seen in Fig. 4.5, Hungary had 3.1 active physicians per 1000 population in 2008. This was higher than the figure for Poland and the EU12 average, but below those for the EU27, EU15, the Czech Republic and Austria. Although the per capita number of physicians in Hungary in 2008 appears in the figure to be no higher than it was a decade earlier, frequent changes in data collection methodology and in the organization responsible for updating the registration database make it difficult to analyse trends with any precision. Between 2000

and 2007, the task of collecting and maintaining data on physician registrations was the responsibility of the Hungarian Medical Chamber. Since then, the task has fallen within the remit of the OHAAP.

Other sources of data help provide a clearer picture. Using payroll data from 44 089 individuals working in 130 public institutions to estimate the number of health professionals, the quarterly report of the NISHR from 2011 found that the absolute number of physicians working in inpatient and outpatient care had dropped substantially between 2003 and 2010, falling from 19 503 to 16 913 (NISHR, 2011a). Here it is important to note that this source did not take account of physicians who may have switched from the status of a public employee to that of a private entrepreneur while continuing to work in the same hospital. Because private entrepreneurs do not appear on the hospital payroll, a large number of switches to the status of private entrepreneur could make a decline in the total number of physicians appear artificially large. Another factor to consider is that increased professional mobility may contribute to the overall decline in the numbers of physicians in the near future (see section 4.2.2).

Fig. 4.5

Number of physicians per 1000 population in Hungary and selected countries, 1990–2009 (or latest available year)



Source: WHO Regional Office for Europe, 2011.

Physicians in Hungary are unevenly distributed, both in terms of geography and specialties. Excluding counties with medical universities, the average number of practising physicians was lowest in Békés County, with 1.5 physicians

per 1000 population in 2008. Five additional counties also had fewer than 2.0 physicians per 1000 population that year (Ministry of Health, 2009c). Out of a total of 35 169 medical posts in 2008, some 4% were unfilled, implying both regional disparities and differences among specialties. For instance, there was not only a shortage of public health physicians (19% of available posts vacant), but also of physicians working in acute inpatient care (13% of available posts vacant) (Ministry of Health, 2009c). In contrast, traditionally there have been very few persistent vacancies in family physician and family paediatrician posts in primary care districts. In 1999 about 99% of these posts were filled (HCSO, 1999), and unpublished data from the NHIFA indicate that this percentage was roughly the same in 2007.

The share of jobs occupied by physicians working as private entrepreneurs in all sectors was 43.4% in 2009 (Table 4.4), which was a substantial increase from the 36.5% figure reported for 2005 (HCSO, 2010d).

Table 4.4

Number of physician posts according to sector and share of private entrepreneurship, 2009

Sector	Total number of physician posts	Share (%) of private entrepreneurship
Acute inpatient care	10 629	10.5
Outpatient care	8 856	50.2
Family doctors	6 907	84.5
Dental services	4 698	66.4
University and college education	1 438	0.3
Occupational health services	949	59.5
Rehabilitation	602	8.1
Outpatient dispensary care	376	21.3
Chronic inpatient services	368	10.3
Ambulance services	318	20.4
Public health and epidemiology	255	0.0
Transfusion services	150	12.7
Medical research	107	5.9
Other	1 504	-
Total	37 156	43.4

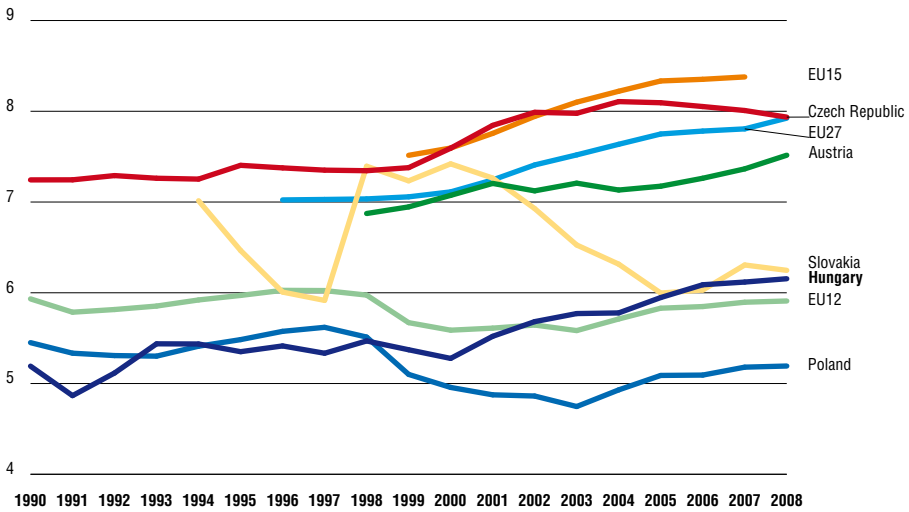
Source: HCSO, 2010d.

The number of nurses per 1000 population in Hungary has increased steadily, rising from 5.3 in 2000 to 6.2 in 2008. This latter figure was slightly higher than the EU12 average, but far below the averages for the EU15 and even EU27 (Fig. 4.6). In total, some 4% of posts for nurses and other ancillary health professionals were unfilled in 2008 (Ministry of Health, 2009c). It is important

to note that the number of nurses graduating each year in Hungary has dropped from almost 6000 in 1993 to less than 4000 in 2008 (WHO Regional Office for Europe, 2011).

Fig. 4.6

Number of nurses per 1000 population in Hungary and selected countries, 1990–2008 (or latest available year)



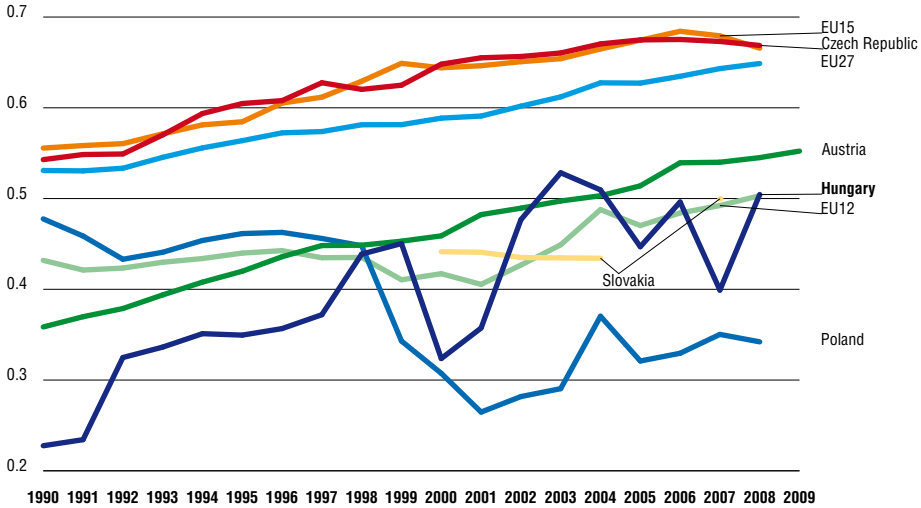
Source: WHO Regional Office for Europe, 2011.

In contrast to physicians, the per capita number of dentists in Hungary increased by 56% from 2000 to 2008, a phenomenon attributable to the far better remuneration possibilities in private business. In 2008, Hungary had 0.5 dentists per 1000 population, which was about the same as in the EU12 as a whole, but far below averages for the EU15 and EU27 (Fig. 4.7).

The per capita number of pharmacists rose 20% between 2000 and 2008. In 2008, Hungary had 0.6 pharmacists per 1000 population, which was higher than the EU12, but much lower than EU27 and EU15 (Fig. 4.8).

Fig. 4.7

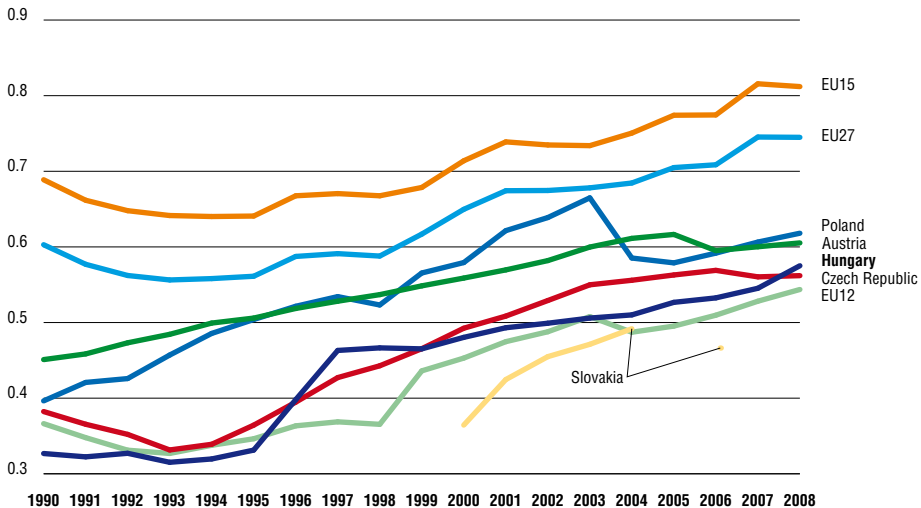
Number of dentists per 1000 population in Hungary and selected countries, 1990–2009 (or latest available year)



Source: WHO Regional Office for Europe, 2011.

Fig. 4.8

Number of pharmacists per 1000 population in Hungary and selected countries, 1990–2008 (or latest available year)



Source: WHO Regional Office for Europe, 2011.

The salaries of health workers, especially of physicians, have remained low compared to those in other sectors of the economy and in western Europe, even after the change from the Semashko-style health system in place during the communist era (see also section 3.7.2). The practice of informal payments was and has continued to be widespread, but these are not evenly distributed among health professions or medical specialties. As a result, well-paying specialties such as surgery or gynaecology became particularly attractive to new entrants, while other specialties, such as diagnostics, public health and the paramedical professions began to exhibit general shortages well before Hungary joined the EU in 2004. The shortage of nurses and health care support personnel has forced physicians, including specialists and family doctors, to carry out nursing and administrative duties in addition to their regular responsibilities (Gál et al., 2003; Orosz & Holló, 2001). Moreover, low salaries and informal payments have kept medical doctors working well after the age of retirement because state pensions have been too low to enable decent living standards. Altogether 8.2% of practising physicians were over the age of 61 in 2007 (Ministry of Health, 2009c).

Successive governments have failed to formulate effective policies to tackle these problems. Although the share of physicians working as private entrepreneurs has been increasing steadily, public employees with low salaries still form the majority. The health workforce is ageing, affecting physicians and nurses alike, and Hungary is a net donor country regarding health care worker migration (see section 4.2.2). Together, these factors have created a human resource crisis in health care, which requires increased attention by the government to avoid the collapse of the single-payer health insurance system.

4.2.2 Professional mobility of health workers

Health professionals who intend to leave the country to work abroad must have their diploma certified by the OHAAP. The process is lengthy, and applicants must pay a fee. Because data on the actual number of health professionals leaving Hungary are lacking, the number of certification requests can be used to estimate outflow. Of all health professionals applying for certification in Hungary between 1 May 2004 and 31 December 2009, an estimated 4901 were physicians, 1316 were nurses, 749 were dentists and 226 were pharmacists (Eke, Girasek & Szócska, 2011). Here it should be noted that these numbers include both applicants who were residing in Hungary during this period and those who were not. Of those not resident in Hungary, the vast majority are likely to have been individuals who were already living and working in another EU Member State and required retrospective certification from their employer after Hungary

joined the EU in 2004 (Eke, Girasek & Szócska, 2011). Altogether 43.6% of applicants between 1 May 2004 and 31 December 2009 held a general medical degree only and 56.4% were specialists. Salary levels (see sections 3.7.2 and 4.2.1) were the main push factor for mobility (Eke, Girasek & Szócska, 2011).

In terms of inflow, a total of 639 foreign physicians, 1585 foreign nurses and 82 foreign dentists registered with the OHAAP between 2004 and 2008 to practise in Hungary. The majority of these individuals were members of Hungarian minorities from neighbouring countries (Eke, Girasek & Szócska, 2011).

In short, there has been a net inflow of nurses and a net outflow of physicians and dentists since 2004. It is important to note that whereas the outflow appears to be increasing substantially, the inflow is diminishing. For example, the number of foreign nurses who registered to practise in Hungary in 2008 was only 45% of the number in 2005 (Eke, Girasek & Szócska, 2011).

4.2.3 Training of health care personnel

Health care professionals can be trained at the secondary, post-secondary and higher education levels, supervised by the State Secretariat for Education, and by means of professional training supervised by the State Secretariat for Healthcare. Physicians and pharmacists are trained at four universities, into which the faculties of the previously five medical universities have been integrated (Medinfo, 2000). Undergraduate education takes six years for physicians, five years for dentists, and four and a half years for pharmacists. In addition, universities can offer postgraduate and continuing education courses. Postgraduate professional training of medical doctors is carried out under the so-called central trainee system, which is a centrally determined residency programme supervised and financed by the Ministry of National Resources.

Non-medical health professionals, such as nurses and assistants, are trained at several levels. Practising nurses used to be trained for four years at secondary-level vocational schools, but nurse training has been harmonized with EU requirements and elevated to the post-secondary level, where a three-year training course leads to a diploma in nursing. This basic nursing education can be followed by clinical specialization courses in the form of on-the-job training in various nursing specialties, such as oncology. Nine colleges of nursing offer a four-year baccalaureate diploma in nursing, and graduates can continue in postgraduate programmes (Ministry of Health, Social and Family Affairs, 2002). There are qualified health workers who enter directly into higher education courses, including highly qualified nurses with diplomas, MCH

nurses, midwives, emergency ambulance officers, dieticians, physiotherapists, sanitary inspectors and optometrists. Further training of qualified health workers is offered by health faculties of universities and in the two training institutions of the State Secretariat for Healthcare, which is part of the Ministry of National Resources. One of these training institutions, the Institute for Basic and Continuing Education of Health Workers, operates the registration system for non-medical health professionals (1998/12).

Before 1989, Hungary had no training courses in public health or health services management. Later, the Ministry of Health² supported the establishment of the School of Public Health at the University of Debrecen and the Health Services Management Training Centre at Semmelweis University. Both schools offer Master of Science training curricula for medical graduates and other professionals. The Health Services Management Training Centre offers continuing education programmes for hospital managers. As a regional partner of the World Bank Institute, the Centre also offers an international course on Health Sector Reform and Sustainable Financing, designed to provide an intensive training opportunity for senior decision-makers in the region.

4.2.4 Doctors' career paths

The careers of physicians in Hungary follow three main paths: professional, academic or managerial. Generally, these paths are separate, but for some practising physicians they are not. For instance, in a county hospital, a head of department who both treats patients and directs the work of subordinate physicians can be involved in the teaching of medical students and medical residents (and be granted an honorary academic title for doing so) (2005/7).

The professional, the managerial and, to a certain extent, the academic career paths have a general regulatory framework based on Act XXXIII of 1992 on the Legal Status of Public Employees. This framework applies equally to all public employees, including physicians and other health workers, and there is a related governmental decree for implementing the provisions of the Act in health care institutions (1992/5, 2008/12). The Act defines the public employee career path in relation to a guaranteed minimum salary (Articles 60–80). The pay scale has 10 categories, numbered from A to J, and in each category there are 14 grades. Public employees are classified in the lettered categories according to qualifications, educational and academic attainment (highest level of education, specializations, doctoral and other academic degrees, as well as membership in the Hungarian Academy of Science) (1992/5). Category A requires either an

² As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

elementary education or vocational training, whereas Category J requires either a university degree plus a specialization and a doctoral degree, or membership of the Hungarian Academy of Science (Article 61). In each category, the grade level is determined by the years of service (Articles 62 and 64). The public employee is upgraded by one grade for every three years in service (Article 65). In 2010 the guaranteed minimum salary in grade 1 of category J was HUF 154 000 (about €555) per month, and in grade 14 this is multiplied by 1.8725 (2009/6). Special rules apply to heads of organizational units and organizations (managerial path), and to teachers and researchers at institutions of higher education and at research institutes (academic path). Since 2009 managers have been divided into two groups: (1) appointed directors (*kinevezett vezető*), who are full-time managers, and (2) acting managers (*megbízott vezető*), who carry out their managerial duties part-time in addition to their regular professional work (1992/5, 2008/5). In a health care service delivery organization, this means that acting managers (for example, heads of departments) are allowed to treat patients whereas appointed directors are not. Individuals in the former category receive a so-called managerial allowance, which supplements the basic public employee salary, and managers in the latter category have an entirely different pay scale, which consists of two levels (manager and higher-level manager) in three categories (secondary education, higher education 1 and higher education 2). In 2010 the base salary was HUF 120 000 (about €433) per month, the highest category had a multiplier of 2.4, and the base managerial allowance was HUF 20 000 (about €72) (2008/5, 2009/6).

The governmental decree mentioned above regulates only the amount of managerial allowances in the various managerial positions of health care organizations (2008/12). The highest allowance, which is 300% of the base managerial allowance, is for the directors working for providers of health care services at the national level and members of their governing bodies (2010/2). There are no higher-level managerial positions specified by the decree, however, for which the rules of the appointed directors must be applied. Health care delivery organizations that provide publicly funded health services must have a four-member top management team, including the chief executive officer and three deputies, the medical director, the nursing director and the financial director. Outpatient providers do not have a nursing director, and long-term or nursing care providers do not have a medical director (2003/11). Applicants for the top management positions of publicly funded health service delivery organizations, including the chief executive officer and the medical and nursing directors, are required to hold a degree in health services management and have a minimum of five years' experience to be eligible for the chief executive officer

(CEO) post or three years' experience to be eligible for either of the other two posts. Applicants whose degree course is in progress or who commit themselves to obtain the degree within five years are exempted. Exemptions can also be granted by the owner of a health care delivery organization (2002/4), but this has to be approved by the professional governing body of the institution in question. The members of this professional governing body include the medical director, the nursing director (or senior assistant) and the heads of medical departments or the senior consultants in a matrix hospital (2003/11).

The academic career path is regulated in detail in Act CXXXIX of 2005 on Higher Education, but the pay scale of the various positions is contained in Annex 2 of Act XXXIII of 1992 on the Legal Status of Public Employees. There are two to three grades in each category, and the salary is determined relative to the university professor grade 1 (100%). An assistant professor (university trainee) grade 1 earns 37% of this salary, whereas a university professor grade 3 earns 106%. The base salary in 2010 was HUF 437 300 (about €1576) per month (2009/6). Aside from general university positions, there is a separate career path for academics who work mainly on research projects. Positions consisting of at least 90% research must be defined as scientific research positions, but individuals in these positions have to take part in teaching activities as well. The starting position is the junior scientific assistant, and the most senior position is the research professor with a guaranteed salary 40% and 100% of the university professor grade 1 respectively (2005/7).

The professional career path for physicians and other health care professionals is not regulated in detail by the aforementioned acts or decrees. Act XXXIII of 1992 on the Legal Status of Public Employees has no provisions specific to health care, and the related governmental decree, which regulates the health care-specific implementation of the provisions of the Act, deals only with the classification of various health professionals (physicians, paramedical workers, nurses and assistants, and non-medical jobs) into the various categories of the public employee pay scale; the categorization of managerial positions and the extent of managerial allowance as described above; and the definition and extent of health care-specific supplementary allowance (diagnostic, assistant, traumatology, intensive therapy, infectology, psychiatric and nursing allowances). For instance, recent graduates of medicine, dentistry and pharmacy are classified into category H; medical doctors, dentists or pharmacists who recently qualified in their specialization are classified into category I; clinical specialist psychologists are classified into category I; and dietitians, diploma nurses or physiotherapists are classified into category F (2010/2).

In general, the career path of a physician working in a general hospital begins with the residency period and, after passing their specialization exam, the new specialist becomes a so-called departmental or ward doctor (2009/2). After several years of medical practice, the physician can be promoted to the position of an adjunct doctor (*adjunktus*), who is the deputy of chief doctors, and finally to a chief doctor. The chief doctor title is recognized by law and can be granted to specialists who have at least 10 years of medical practice and have received an evaluation of “excellent” in accordance with the rules of performance assessment, described by Article 40 of Act XXXIII of 1992 on the Legal Status of Public Employees. Chief medical doctors receive what is known as a “titular allowance”, which was 50% of the base allowance in 2010 (2008/5). Chief medical doctors can be promoted further along the managerial career path, as described above. Physicians in general hospitals may also participate in the teaching of medical students and medical residents. Universities are allowed to acknowledge their educational activity by granting honorary academic titles, including the title of “titular associate professor” and of “titular professor” (2005/7).

The general principle underlying Act XXXIII of 1992 on the Legal Status of Public Employees is that, for the various groups of public employees, a guaranteed minimum salary is defined, and employers are able to exceed this minimum. As of early 2009, these deviations are allowed only if the performance of the public employee is evaluated and found excellent or very good (2008/5).

The career paths of other health care staff are regulated within the same legal framework and according to the same principles as the career paths of physicians.

5. Provision of services

Health care delivery is based on the constitutional obligation of the state to make health services available to all eligible residents. At the heart of the system is the territorial supply obligation, which divides responsibility for service delivery among local governments according to geographical areas and levels of care: municipalities are responsible for providing primary care and county governments are responsible for providing specialist health care services within their respective jurisdictions.

There are cases in which municipalities are allowed to provide outpatient specialist and inpatient care. Indeed, according to the principle of subsidiarity, county governments may not refuse to pass on the responsibility for service provision to the municipalities if the latter are willing to accept it. Furthermore, the territorial supply obligation determines the size of health care providers' catchment areas, which can vary with different levels of care and types of services. For instance, there are municipal hospitals that provide secondary care not only to the inhabitants of the municipality concerned, but also to the neighbouring population. Similarly, large county hospitals provide tertiary care in certain medical specializations to the population of more than one county.

To understand fully how the delivery system operates in Hungary, however, two further distinctions must be made. First, the territorial supply obligation does not require local governments to deliver health services themselves; they are allowed to outsource service delivery to private providers, who deliver the services in a health care facility and with equipment owned by the local government. Referred to as “functional privatization”, this arrangement is the predominant form of service provision in primary care and has become increasingly common in secondary care since the late 1990s. Second, whether public or private, the owners of health care facilities that provide services under the territorial supply obligation are responsible for keeping the assets in working order – that is, for covering the capital cost of services. This principle

is referred to as a maintenance obligation and has special relevance in cases where service delivery has been outsourced. The types of primary, secondary and tertiary services whose provision must be ensured by local governments are defined in Act CLIV of 1997 on Health. The provision (and direct financing) of certain services, however, is the responsibility of the central government. These include public health, emergency ambulance services and blood supply.

5.1 Public health

Public health services are the responsibility of the central government, in particular the State Secretariat for Healthcare, which is part of the Ministry of National Resources (see section 2.3.3). The State Secretariat for Healthcare provides these services through the NPHMOS. The NPHMOS was formed in 1991 on the basis of the State Supervisory Agency for Public Hygiene and Infectious Diseases, which had its origins in the late nineteenth and early 20th centuries, when the state assumed responsibility for public health, social medicine and health administration services, to be provided by civil servants known as medical officers. As part of the Semashko-style health system in place during the communist era, the sanitary stations of the State Supervisory Agency implemented successful compulsory immunization and public hygiene programmes, which led to substantial improvements in the health status of the population but failed to respond adequately to the transition that made chronic non-communicable diseases the number one public health problem (see section 1.4). By establishing the NPHMOS in 1991 (1991/1), the government aimed to address this shortcoming. Although the duties of the NPHMOS were expanded according to modern concepts of public health, the successful public hygiene and infectious disease control structures already in place were preserved. At the same time as the NPHMOS was established, several health administration duties were deconcentrated, including compulsory registration, licensing and the professional supervision of health care providers.

The administration of the NPHMOS is divided into three levels: central, regional and subregional (*kistérség*; for more details on organizational structure see section 2.3.3). The NPHMOS is responsible for controlling, coordinating, supervising and delivering public health services and for supervising the supply of pharmaceuticals and the delivery of personal health services (2006/22). The central office, also known as the Office of the Chief Medical Officer, is responsible for planning and coordinating health promotion and prevention programmes at the national level. It directs and coordinates public health,

epidemiology, health promotion and health administration, including the registration, licensing and professional supervision of health care providers and pharmacies. In turn, the regional offices are responsible for implementing these tasks either directly or through their subregional offices. To perform these duties, the regional offices employ medical officers, pharmacy officers and MCH nurse officers. Each of these groups of professionals is directed by a national and a regional chief officer.

In terms of the organization and financing of health care, the most important health administration duties of the NPHMOS are to take decisions on the modification of specialist capacities and to designate the borders of health care providers' catchment areas within the framework of the territorial supply obligation. These tasks were assigned to the regional offices of the NPHMOS (and, in cases of inter-regional redistribution, the National Chief Medical Officer) in late 2008, when the previous system of capacity planning and distribution was found to be unconstitutional by the Constitutional Court.

The work of NPHMOS is supported by nine National Institutes of Health, which carry out methodological, scientific, educational, administrative, professional supervisory and expert consultancy tasks in various domains of public health and personal health services (2006/22). The National Institute for Epidemiology is responsible for the supervision of immunobiological preparations and diagnostics, epidemiological and clinical microbiology and for the surveillance of communicable diseases based on a system of compulsory reporting by medical practitioners (1998/6, 2010/5). The National Institute for Health Development is responsible for prevention, health education and health promotion. The Institute coordinates the NPHP and organizes lifestyle counselling, as well as education and information provision programmes. The National Institute for Environmental Health controls and coordinates activities that monitor, evaluate and maintain the quality of air, water and soil, while the Frédéric Joliot-Curie National Research Institute for Radiobiology and Radiohygiene and the National Institute for Food and Nutrition Science supervise and control the areas corresponding to their names. The National Institute of Chemical Safety deals with toxicology and chemical risk evaluation (2010/6). The Institute operates the Health Care Toxicology Information Service, which maintains a database registering dangerous substances, provides information around the clock by telephone or in writing to health professionals, authorities and the general public, and also collects and analyses data and prepares an annual report on cases of poisoning reported by health care providers.

In the area of personal health services, there are three National Institutes with methodological, supervisory and coordination roles. The National Institute for Child Health collects and analyses data on children's health; conducts research; performs methodological and administrative tasks; provides information and education; and assists in organizing, financing and ensuring the quality of provision in children's health care. The National Institute of Primary Health Care is responsible for supervising the provision of primary care and monitoring the health status of the population based on reports submitted by primary care providers. The main task of the National Centre for Health Care Audit and Inspection (NCHAI) is to supervise the activities of health care providers by monitoring the quality of their health services, as well as their adherence to legal regulations, clinical guidelines and professional norms, through regular inspections and clinical audits (2010/6). In addition to managing, coordinating and controlling the work of the system for supervising health care professionals (2005/2), the NCHAI is also responsible for the surveillance of non-communicable diseases and for running the National Register of Congenital Disorders. The NCHAI has three specialized centres: the Centre for Rare Diseases, the National Centre for Psychiatry and the National Centre for Addictive Disorders (2010/6).

Until 2007 the areas of occupational health and food safety also fell within the remit of the NPHMOS. As part of its plan to introduce managed competition to Hungary's single-payer health insurance system, the government in power from 2006 to 2010 began to shrink considerably the scope of its public health and health administration functions. The HISA was established and the agencies of occupational health and food safety were put under the control of other ministries (see subsection *A third attempt to introduce managed competition to the health insurance system* and subsection *The Health Insurance Supervisory Authority* in section 6.1.1). Since 1995, employers have been responsible for financing occupational health services (1995/8). Whereas larger employers maintain and run their own services, smaller employers can contract with occupational health care providers on a private basis. The NPHMOS used to exercise control over occupational safety, supervise occupational health care at the employer level and provide specialist occupational care through the National Institute of Occupational Health. With the exception of professional supervision, these functions, together with the National Institute of Occupational Health, were transferred in 2007 to the Labour Inspectorate of the Ministry of Social Affairs and Labour (2006/15).

A similar reorganization was implemented in the field of food safety. The rationale behind the changes in this instance was to concentrate the supervision of the entire food chain – from the production of raw materials to the consumption of meals – in one authority. The former task of the NPHMOS to supervise the preparation and consumption of food was relocated to the Central Agricultural Office under the Ministry of Agriculture and Rural Development¹ (2007/8). The National Institute for Food and Nutrition Science remains under the NPHMOS, but food inspection duties have been transferred to the Central Agricultural Office.

Other actors participate in the delivery of public health services, especially in the primary care sector. For instance, the NPHMOS, through the National Institute for Epidemiology, plans, directs and coordinates the compulsory immunization programme and supplies the vaccines through its regional and subregional offices, and family doctors and the school health services carry out the actual vaccinations (1998/6). The District MCH Service provides pre- and postnatal care, as well as prevention and health education for families and schools, and is coordinated and supervised by senior MCH nurses from the NPHMOS (1997/10). These well-organized, accessible and good-quality programmes have likely played a key role in achieving Hungary's excellent immunization record.

Other public health services have been less successful, especially health promotion and other prevention programmes. The NPHP aims at reducing morbidity and mortality rates for the most important public health problems – that is, cardiovascular disease and cancer – through a comprehensive action plan, including health promotion, prevention and screening, as well as improving health care services in priority areas (2003/1). However, the financial resources allocated to the implementation of this programme have decreased year by year, and its budget in 2007 was two-thirds less than in 2003 (Ministry of Health, 2008).

A breast cancer screening programme was established in 2002, whereby women between 45 and 65 years of age are invited to visit providers with screening facilities once every two years (1997/17, 2003/8). More than half a million women, some 41% of all those eligible, participated in programme during its first year. Participation has, however, remained between 40% and 50% since this time. Screening for cervical cancer was launched in 2003, whereby women between the ages of 25 and 65 are invited to visit providers with screening facilities once every three years (2003/8). Participation in this

¹ As of 2010 the Ministry of Rural Development.

programme has been much lower, with only 5% of eligible women having taken part (Ministry of Health, 2008). In 2006, two further screening programmes – for occult gastrointestinal bleeding and prostate cancer – were introduced on a pilot basis for people aged 50 to 70 years, but these were terminated in 2009 (2005/11, 2009/3).

At present, the only compulsory screening programmes in Hungary are those for infants and children, including screening for congenital disorders and examinations of the sensory organs and blood pressure on an annual basis (1997/17). Compulsory screening for adults can be ordered only in special cases (1998/6).

In addition to these regular screenings, there are also on-off or short-term initiatives, such as the “Screening for Life Programme” conducted by the Ministry of Health in 2007.² As part of an all-day health fair, screening teams measured and recorded participants’ blood pressure, blood glucose and BMI, as well as any dental, ophthalmological, paediatric or orthopaedic conditions. They also screened for COPD and melanoma, and provided self-examination training. A variety of pilot programmes have also been implemented, including screening for colorectal cancer among people aged 50 to 70 years and for labial and oral cancer, and for increasing the effectiveness of cervical screening with the involvement of MCH nurses (Ministry of Health, 2009b).

5.2 Patient pathways

To demonstrate how the Hungarian health system operates from the point of view of the patient, this section describes in detail the pathway taken by a patient with a typical case of chronic heart failure, including the first point of contact, the diagnostic processes and, ultimately, the treatment and care received. It is important to note that there may be significant deviations from this example due to professional and regional disparities.

- A 50-year-old male patient consults his family doctor, with whom he is registered, and complains of fatigue, difficulty breathing, swelling around the ankles and waking up during the night and needing to urinate. The progression of symptoms has been continuous, and it is the patient’s first visit with these complaints. The visit is free of charge.

² As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

- The family doctor performs several basic examinations, such as blood pressure, blood sugar and ECG, which are available on site in his practice. For laboratory testing, the patient is either referred to the laboratory responsible for the family doctor's primary care district (through the territorial supply obligation), or the blood sample is taken on site and sent in by the doctor's office. A referral from the family doctor is necessary for performing the tests.
- Once the patient has returned with the results, the doctor evaluates them and makes a diagnosis. If further diagnostic or treatment measures are beyond his competence, he refers the patient to an outpatient specialist, which in the case of our example patient is a cardiology unit.
- With the family doctor's referral slip in hand, the patient visits the provider who delivers cardiology outpatient services under the territorial supply obligation. This provider is located either within an independent outpatient clinic or an outpatient unit attached to a hospital. Although patients are entitled to choose their health provider and doctor in accordance with the provisions of Act CLIV of 1997, the right to free choice is constrained in many ways within the health insurance system by other regulations and by user charges. Providers of secondary care are not allowed to refuse treatment to patients within their catchment area, but may do so for patients outside their catchment area who are seeking elective interventions. If a provider has enough capacity, however, patients living outside their catchment cannot be turned down either. Within hospitals, patients may freely choose their physician, albeit subject to the provider's operational rules (1997/20). The choice of an inpatient care provider and physician is subject to a 30% co-insurance, with a ceiling of HUF 100 000 (about €360) (2006/9, 2006/17, 2007/4).
- In cardiology, a specialist coordinates the care, makes the final diagnosis, determines the appropriate treatment, and decides which level of care (inpatient or outpatient) is required for the patient. In Hungary, it is typical for inpatient and outpatient care to be integrated – that is, they use the same human resources and infrastructure within the same organization. This being said, there are also a number of independent polyclinics.
- After the patient has completed specialist treatment, the specialist prepares a discharge note, with which the patient returns to his family doctor. From this point onwards, the family doctor is responsible for coordinating the patient's care according to the treatment plan recommended by the specialist. Because the specialist's attestation of the diagnosis is valid for six months only, patients undergoing long-term

therapy must visit their specialist at least once every six months. Unfortunately, there is no seamless national information system for medical documentation accessible to providers at every level of care; family doctors can only obtain secondary care treatment documents that are handed over to them by the patient..

All the services mentioned above, with the exception of the free choice of hospital and physician and any outpatient medication, are currently covered by the HIF and are therefore free of charge. Certain outpatient specialist services do not require a referral from a family doctor (see section 5.3).

5.3 Primary care

In Hungary, municipalities are responsible for ensuring the provision of primary care to the local population (1990/3), including family doctor services (through family physicians and family paediatricians), dental care, out-of-hours services, MCH nurse services and school health services (1997/20).

Family doctor services, at least in larger municipalities, are provided to adults by family physicians and to children by family paediatricians. In smaller municipalities, family physicians care both for adults and children in so-called mixed practices. Family doctors are required to have a qualification in the specialization of family medicine, which was introduced in 1992.

Local governments are responsible for ensuring that family doctor services are available to their population. They have the right to designate the primary care districts for family doctor services within their territory. To be eligible for HIF financing, family physician practices must care for at least 1200 residents over the age of 14 years and family paediatrician practices must care for at least 600 children aged 14 year or younger (1999/1). Primary care districts, which must cover the entire territory within the local government's jurisdiction (for example, a municipality), serve as the basis of the territorial supply obligation. People do not have to register with a provider in their primary care district. Since 1992 people have been allowed to choose their family doctor freely, but may only switch to a new family doctor once a year. Family doctors are not allowed to refuse patients who live in their primary care district, but may refuse applicants from other districts (1992/3). Municipalities can decide whether to deliver family doctor services themselves (by hiring family doctors as public employees) or to contract with family doctors working as private entrepreneurs. The latter is the most common arrangement in primary care and is known as

“functional privatization”. In these cases, the practice itself owned and equipped by the local government, but family doctors receive capitation payments directly from the NHIFA.

To work in a primary care district with a territorial supply obligation, family doctors must purchase a special licence (known as a “practice right”, or *praxisjog*), which was introduced in 2000 and was granted to all family doctors working in primary care districts with a territorial supply obligation (2000/1). According to this system, if a municipality advertises a family doctor post, the applicant has to buy this licence from the retiring family doctor or the doctor’s relatives to become eligible for the post. In this way, the central government intended to ensure that practices are bought and sold, while at the same time allowing local governments to remain responsible for ensuring the provision of primary care. Local governments retain discretion to decide in what form and by whom primary care will be provided. New entrants therefore still require the approval of the local government, as well as the capital to purchase a licence.

Family doctors are meant to act as gatekeepers in the Hungarian health care system. With the exception of certain specialist services, physician referrals are mandatory for obtaining higher-level care (1992/3), and patients are generally obliged to pay user charges if they bypass the referral system. Patients have direct access, however, to specialists in dermatology, ear, nose and throat diseases, obstetrics and gynaecology, general surgery, traumatology, ophthalmology, oncology, urology and psychiatry.

In 2009 there were 4971 family physicians and 1548 family paediatricians practising in Hungary, and the average number of inhabitants per practice was 1738 and 938, respectively (HCSO, 2010f). Looking at referrals made by family physicians, it is clear that they have not been effective gatekeepers. Between 1990 and 2008, the number of non-diagnostic referrals to providers of outpatient specialist care increased more than four times, and the number of patients per family physician referred to inpatient care increased by 78% (HCSO, 2010f). One of the reasons for these large increases may be that there is no incentive in the current, capitation-based payment system for family doctor services to provide definitive care and avoid unnecessary referrals. On the other hand, family physicians regularly complain about their overloaded schedules, excessively complicated regulations, onerous administrative requirements, and the overutilization of health services by patients.

The annual number of consultations per family physician increased by 31% from 1990 to 2006 (HCSO, 2010f). This was one of the government’s arguments for introducing user charges in February 2007 (2006/9). At the same

time, given that a substantial part of patient–doctor encounters in primary care take place for the purpose of obtaining a referral, the government rationalized prescribing regulations in order to reduce family doctors’ workload. Moreover, the requirement that family doctors prescribe only one month’s worth of medication at a time for patients with chronic disease was changed so that three months’ worth of medication could be prescribed. As a result of these measures, the number of consultations decreased by 15% from 2006 to 2007. After user charges were eliminated in April 2008 (see section 6.1.1), the number of consultations increased by 5% that year and by more than 8% in 2009 (HCSO, 2010f).

In addition to family doctor services, municipalities are also obliged to provide MCH and school health services. The District MCH Service is staffed by highly qualified nurses, trained at higher education level. They provide preventive care and health education to pregnant women, women in childbed and children under the age of 6 in geographic areas that are determined by the local government and cover no more than 250 persons in need of care (2004/6). MCH nurses are employed by the local government and work autonomously in the facilities provided by it, or they make on-site visits to families and schools. The work of district MCH nurses is coordinated and supervised by senior MCH nurse officers at the county level and by the chief MCH nurse at the national level (see section 5.1). MCH nurses also provide school health services together with physicians as a preventive service for children between 3 and 18 years of age. Based on the number of pupils to be cared for, school health services can be provided on a part-time or full-time basis. Finally, as their name implies, school MCH nurses and physicians are employed directly by a given school (1995/11).

Emergency care (out-of-hours services) and primary dental care services are also provided in the primary care setting (see sections 5.5 and 5.12).

5.4 Specialized ambulatory care/inpatient care

The provision of secondary and tertiary care is shared among municipalities, counties, central government and, to a minor extent, private providers. The various providers perform a wide range of activities depending on the level of care (secondary or tertiary), the number of specialties covered (single or multiple specialties) and the type of care (chronic or acute, inpatient or outpatient).

In general, counties are responsible for providing secondary and tertiary care to the local population. In practice, however, municipalities also provide specialist care on the basis of the principle of subsidiarity. County governments usually own large multi-specialty county hospitals, which provide secondary and tertiary inpatient and outpatient care to people with acute and chronic illnesses, whereas municipalities own polyclinics (multi-specialty institutions providing exclusively outpatient specialist care), dispensaries (single-specialty institutions providing only outpatient care, typically to the chronically ill) and multi-specialty municipal hospitals (providing secondary inpatient and outpatient services for acute and chronic illnesses). Outpatient care at the municipal level is provided in hospitals or in a separate building of a previously independent polyclinic later integrated into the hospital.

The central government also owns hospitals, which provide acute and chronic inpatient and outpatient care. These are divided among the Ministry of Interior, the Ministry for National Economy, the Ministry of Defence, the Ministry of Public Administration and Justice, and the Ministry of National Resources. Being part of universities, university hospitals fall within the remit of the State Secretariat for Education, which is part of the Ministry of National Resources. The single-specialty clinical departments of the medical faculties provide both secondary and tertiary care. The State Secretariat for Healthcare, which is also part of the Ministry of National Resources (see section 2.3.3), has single-specialty providers known as the National Institutes of Health, which deliver highly specialized tertiary care only, and a few state hospitals, which are mainly sanatoria that provide medical rehabilitation.

The territorial supply obligation applies to all public providers, but the size of their catchment area depends on the type of care provided and on the estimated number of people in need. The same health care institution can have different catchment areas for different types of care. In general, secondary outpatient care services have been assigned the smallest catchment area, but these are still larger than primary care districts. Tertiary care is offered at least on a regional basis, which includes the population of more than one county. Highly specialized tertiary care services, which are provided to patients with rare diseases, have the largest catchment area, namely the whole country (see also section 2.8.2) (1990/3, 1997/20).

A small private sector is also involved in the provision of specialist care, but providers usually have no contract with the NHIFA and users must therefore pay out-of-pocket. So far, there have been two main exceptions: specialist services with a shortage of public capacities, such as kidney dialysis or MRI,

and hospitals owned by churches or charities; these private non-profit providers are integrated into the main system of financing and service delivery (NHIFA, 2010). As part of the government's plan to rationalize the service delivery structure, the NHIFA has contracted with private profit-making providers for the provision of same-day surgery as well (see also section 5.4.1).

5.4.1 Outpatient specialist services

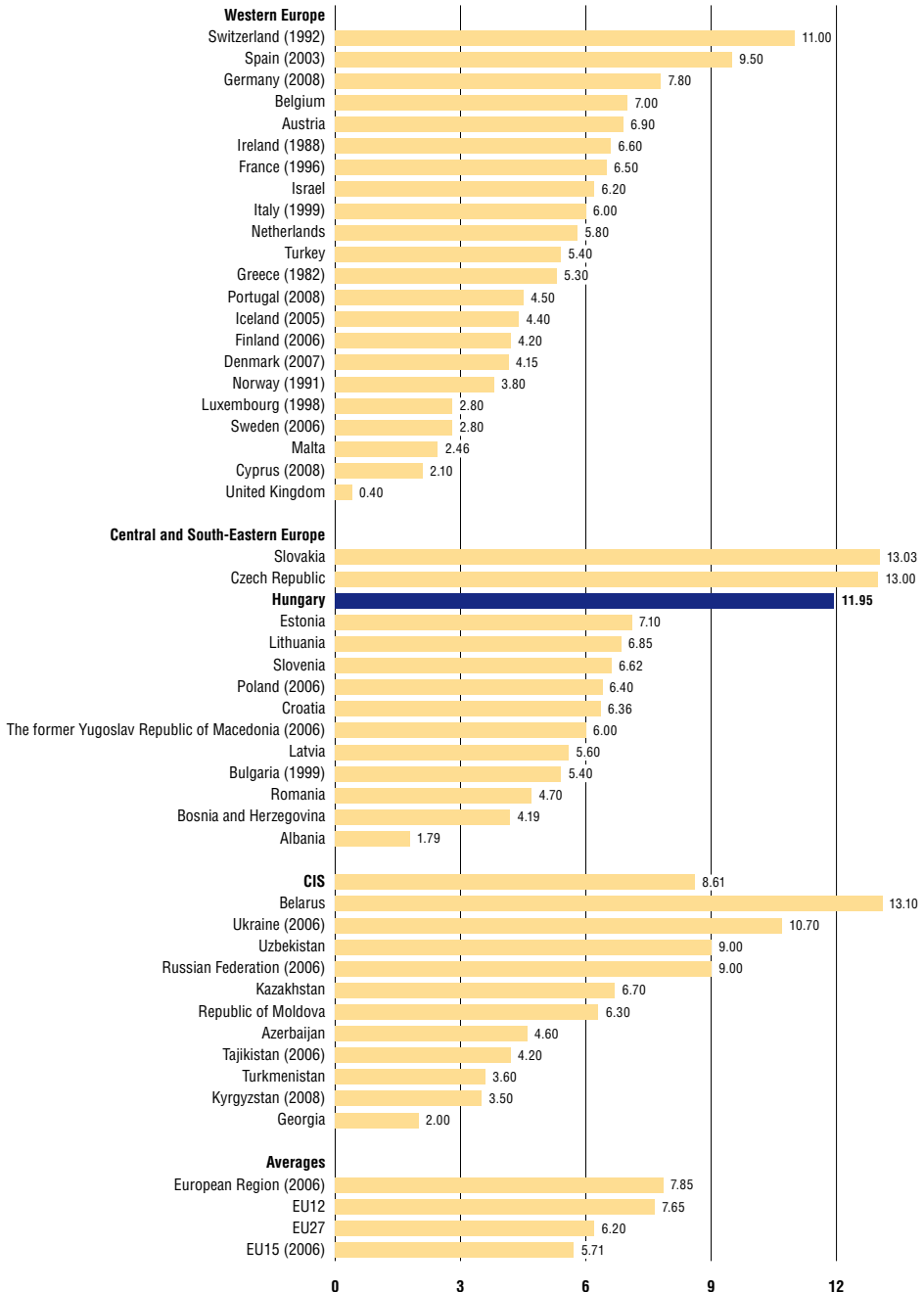
According to the aforementioned provider typology, outpatient specialist services are provided by polyclinics, dispensaries, municipal hospitals, county hospitals, clinical departments of universities, National Institutes and health care institutions of other ministries (for example, the Military Hospital – State Health Centre under the Ministry of Defence).

Initially, polyclinics employed specialists who worked exclusively in outpatient care. In the early reform phase in the 1990s, the objective was to integrate polyclinics partly into hospitals and partly into primary care. Instead of the three-pronged organization of the Semashko-style health care system during the communist era, integration would have made a two-pronged system of primary care and specialist care. The integration policy did not work, however, leaving several polyclinics that are still organizationally independent.

Dispensaries were established during the communist regime. They provide outpatient care to chronically ill patients with pulmonary, dermatological and sexually transmitted diseases, people with alcohol and drug addiction, and patients with psychiatric disorders. In addition to this chronic outpatient specialist care, dispensaries implement screening programmes in their respective specialties and, additionally, for hypertension, diabetes, cancer and kidney diseases. In 2008 there were 170 dispensaries in Hungary for pulmonary disease, 125 for dermatological and venereal diseases, 135 for psychiatric disorders and 66 for addiction treatment (HCSO, 2010f).

As can be seen in Fig. 5.1, each person in Hungary had an average of 11.95 outpatient contacts in 2009, which was third among the countries of central and south-eastern Europe after Slovakia (13.03) and the Czech Republic (13.00), and almost twice the EU27 average. High utilization rates in the outpatient specialist sector would not be undesirable if unnecessary hospitalization was avoided as a result. However, acute hospital admission rates in Hungary are also high (17.94 per 100 inhabitants compared to 15.66 for the EU27 average in 2008), albeit following a decreasing trend after the output of hospitals and outpatient specialist providers was limited by the government in 2006 (WHO Regional Office for Europe, 2011) (2006/5).

Fig. 5.1
 Outpatient contacts per person per year in the WHO European Region, 2009 (or latest available year)



Source: WHO Regional Office for Europe, 2011.

5.4.2 Inpatient services

In 2009 Hungary had 153 hospitals with an inpatient care contract with the NHIFA and a total of 71 800 approved hospital beds (NHIFA, 2010). Generally, these hospitals provide inpatient care at the municipal, county, regional or national levels, according to their level of specialization, which usually coincides with the hospital's catchment area. Hospitals that provide care in more than one medical specialty, however, can have different specialization levels for different specialties and consequently different catchment areas. Moreover, a hospital can have different catchment areas for the same specialty, as do clinical departments of university medical faculties, which have a local catchment area for secondary care and a national catchment area for tertiary care within the same specialty.

The principle of the Hungarian health care delivery system is that patients must receive care at the lowest level of specialization that can provide adequate treatment, and may be transferred to hospitals with higher levels of specialization only if necessary (1997/9). Where a patient ends up in the hospital system depends on the frequency of the disease, the severity or complexity of the case, and the cost and complexity of the treatment.

Municipal hospitals usually offer main specialties, such as internal medicine, obstetrics and gynaecology and surgery. According to the minimum legal requirements, a hospital at the first level of specialization is obliged to cover internal medicine, surgery and one other specialty, together with the basic diagnostic facilities (ultrasound, X-ray, ECG, laboratory) (2003/15). Municipal hospitals have the lowest level of specialization and the smallest catchment areas. County hospitals usually cover the whole spectrum of secondary care, providing additional specialties, such as haematology, immunology, cardiology and psychiatry for the population of an entire county. For the basic specialties, county hospitals usually have a local catchment area with the lowest level of specialization and another catchment area covering the whole county, within which they accept more severe or complex cases from municipal hospitals. County hospitals may also provide tertiary care, such as open-heart surgery, for the population of a region comprising more than one county. Finally, clinical departments of university medical faculties and National Institutes provide care of the highest level of specialization for the whole country, but university clinical departments have local catchment areas as well.

The owners of health care providers are required by law to supervise the management of their institutions (1997/20). There are no detailed regulations governing the way that hospital management operates. Hospitals that provide

care under the territorial supply obligation are required to set up a hospital supervisory council, whose members can be delegated by NGOs, providers and local governments. This council does not have management rights but can formulate opinions and proposals supporting the operation of the providers; it also represents the interests of the resident population.

In 2003 the Ministry of Health, Social and Family Affairs³ regulated some aspects of the management structures in public hospitals (2003/11). According to this regulation, the management of public hospitals must consist of a director and deputy directors in a typical pyramid-shaped hierarchical structure. The deputy directors are responsible for areas such as medical, nursing and business operations. In addition, there is a professional management board, whose members consist of medical and nursing directors, as well as the heads of every professional department. This board must meet for at least two sessions per year and can formulate recommendations to the director of the hospital. The consent of this board is necessary for some management issues, including the strategic professional plan of the institution and its quality management policy.

5.4.3 Day care

Day care in Hungary is defined using a 24-hour limit after hospital admission, which means that patients who are admitted late in the day and spend the night in hospital can also be considered day-care cases. At the same time, minor surgical procedures that do not need any postoperative supervision and emergency cases are not classified as day care (NHIFA, 2003). A special type of intermediate care known as daytime hospital treatment (for example, mental health treatment and rehabilitation services that do not require an overnight stay) is also not considered day care (see section 5.7).

The organizational, infrastructural and human resource requirements of day care are regulated by a ministerial decree (2002/20), whereas further regulations to be observed by service providers are defined in a rule-book published by the NHIFA (NHIFA, 2003). The State Secretariat for Healthcare also has a protocol on outpatient surgery, which was developed by the Professional College of Surgery and the Society of Multidisciplinary One-Day Surgery. Although the ministerial decree has opened up the provision of day-care services to polyclinics, the requirements are stricter than those for inpatient care. For example, physicians must have at least five years of experience providing

³ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

inpatient care and have performed a larger number of operations, and patients within a polyclinic's catchment area must be able to access its services within 30 minutes by car.

In the first phase of payment reforms in the mid-1990s, parallel to the introduction of the Hungarian adaptation of the DRG system, 13 diseases and 13 interventions were defined that could be treated/performed in the outpatient setting by inpatient care providers (1994/1). Since then, several modifications have been made in terms of the clinical, organizational, regulatory and payment frameworks of day care so as to improve its implementation, which has been recognized as too slow by policy-makers. In particular, measures were taken to shift more and more potential day cases from the hospital into the ambulatory care setting. Between 1994 and 2010, the scope of eligible interventions has been modified (in most cases expanded) many times, most recently in May 2010 (2010/3).

In late 2010, a total of 340 interventions (mainly surgical procedures, but also some diagnostic and other therapeutic services) were eligible to be performed on a day-care basis; these spanned the fields of general surgery, orthopaedics, gynaecology, gastroenterology, cardiology, urology, proctology, dermatology, ophthalmology, otorhinolaryngology and neurology (1993/6). Day care is paid by HDGs and these are separately defined in a ministerial decree (see section 3.7.1 for information on Hungarian DRGs) (1993/6).

The government also supported the expansion of day-care capacities by means of various projects, the EU structural funds' sponsorship of infrastructure development and the provision of extra financing for increased cases attended to (in 2003 and 2007). In the 2003 pilot project, eight service providers, five public and three private, were contracted for 16 750 extra cases to be treated over a two-year period between 2004 and 2005 (2003/2). In 2007, 5% of the financial resources freed as a result of the 2007 downsizing of acute inpatient care capacities were reallocated to the provision of day-care services (2007/3). Altogether 104 providers submitted applications to the tender of the NHIFA, and 22 500 HDG points and 66 964 cases were distributed among the 47 winners. In addition, the Ministry of Health⁴ distributed extra output volume points (expressed in HDGs) for day-care cases in 2008 from the so-called "ministerial pool" (a certain percentage of the total output volume in a given year has been set aside for the Ministry to distribute at its own discretion). Infrastructural development was also supported by the government with conditional and matching grants, most importantly for the refurbishment of existing polyclinics

⁴ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

under the Regional Operative Programmes, and the building of new polyclinics under the Social Infrastructure Operative Programmes of the New Hungary Development Programme, financed by EU structural funds (2006/6). In the former, day care was optional, while in the latter it was a compulsory component. Most of these new capacities are to be operational in 2011.

In addition, the government in power from 2006 to 2010 used special payment arrangements to support day care. Since 1 June 2008, hospitals have been allowed to convert a portion of their billable fee-for-service points (that is, the maximum number of points for which a provider is eligible for SHI financing) for outpatient specialist care to HDG points (2008/3). This measure was not entirely successful, as only a fraction of fee-for-service points was converted (70% and 40% of fee-for-service points remained unused in 2008 and 2009 respectively) (State Audit Office, 2010). As a result of the aforementioned measures, the number and share of day-care cases have been increasing, especially in the past four years. Nevertheless, there is still no specific strategy with exact targets for day care in Hungary, and the proportion of same-day surgery is still very low compared, for example, to the UK, Finland, Denmark and the Netherlands (State Audit Office, 2010). Only 10.8% of elective surgical procedures were performed as day cases in 2008 (OECD, 2010). In 2009 a total of 129 469 day-care cases (121.4 cases per 10 000 inhabitants) were reported in Hungary (HCSO, 2010f), and some two-thirds of publicly financed health care providers reported offering day-care services (NHIFA, 2010).

5.5 Emergency care

Emergency care is built around primary care (family doctors, out-of-hours services), polyclinics, inpatient care facilities (night duty), emergency medical services provided by the National Emergency Ambulance Service and, as a recent development, A&E departments of hospitals at different levels of specialization, as well as a web- and telephone-based medical counselling service known as DrInfo.

Act CLIV of 1997 on Health defines and differentiates between out-of-hours services (night duty, Article 93) and emergency medical services (medical rescue, Articles 94–96). Emergency medical services are provided to patients in need of immediate care and include (a) the care provided by an authorized provider at the place of the incident, (b) transportation to the closest service provider who can provide adequate care and (c) the care provided during transportation (Article 94). A few special kinds of emergency medical services

are also mentioned in this Act, including guarded patient transportation; urgent transport of medical teams to carry out life-saving interventions; the transport of life-saving medical equipment, drugs and organs for transplantation; the provision of stand-by emergency services to secure the place of accidents, mass catastrophes and mass events (e.g. pop concerts, festivals, sport events); and the transfer of people incapacitated by alcohol consumption from public places to a health care institution for 24-hour observation (Article 94). In Hungary emergency medical services are provided by the state and everybody is entitled to them, irrespective of citizenship and health insurance status (Articles 95 and 96). Detailed regulations, professional standards and requirements on licensing, procedures and documentation regarding emergency medical services are set out in a ministerial decree (2006/1).

The organizational structure and main tasks of the National Emergency Ambulance Service are described in a government decree. The CEO is appointed by the Minister of National Resources on the basis of the recommendation of the State Minister for Health, and the service is organized on a territorial basis: the national office supervises seven regional offices and the Hungarian Air Ambulance Public Company (established in November 2005), whereas the regional offices supervise more than 200 ambulance stations (2006/18). There are 26 emergency dispatch centres under the supervision of 7 regional centres, which have recently been separated organizationally from the ambulance stations. Based on the caller's information, the emergency dispatch centres are responsible for sending the appropriate vehicle according to the seriousness of the case. The emergency ambulance fleet has ten types of differently equipped vehicles, ranging from EA motorcycles to mobile intensive-care units and emergency ambulance helicopters (2006/1).

The National Emergency Ambulance Service was established in 1948, and for 40 years it was the sole organizer, coordinator and provider of emergency rescue and patient transportation in Hungary. During the 1990s, new emergency ambulance providers entered the area of emergency rescue, especially for neonatal care, while, more recently, the government in power from 2006 to 2010 decided to liberate the market of patient transportation and allowed private providers who met certain criteria and requirements to contract with the NHIFA (2007/12). Since the beginning of 2008, the National Emergency Ambulance Service has no longer taken part in ordinary patient transportation and its coordination has been transferred into the newly established National Patient Transportation Services.

The restructuring and development of emergency care have been a health policy priority of successive governments for the past 20 years because the system inherited from the Semashko-style health care system was somewhat fragmented and uncoordinated. Emergency care under that system had three different entry points: single-handed family doctors on duty, hospital night duty and the National Emergency Ambulance Service. As the interface between them was not ideal, complicated cases would easily end up in the wrong department, causing treatment delays (State Audit Office, 2009a).

Development projects have targeted the infrastructure, organization and coordination of services. Infrastructure development has been supported by conditional and matching grants, both from local sources and from EU structural funds. For the period from 2007 to 2013, a total of HUF 35 billion (about €1.3 million) has been allocated to various projects, including the modernization of the ground and air ambulance services, the renewal of emergency medical dispatch and the establishment of new (and upgrade of existing) A&E departments. The main directions of organizational development have been the centralization of out-of-hours services (that is, elimination of single-handed, stand-by out-of-hours services by the end of 2006) (2005/9), the establishment of one-stop A&E units in hospitals as a single entry point/interface for emergency care patients, and the development of a common dispatch service for all three local emergency care providers (Emergency Ambulance Service, hospitals and family doctors' out-of-hours services). The last of these three developments, however, has progressed slowly: by 2009 only 7% of the centralized out-of-hours services had been integrated into a common emergency dispatch service (State Audit Office, 2009a). In certain areas, the National Emergency Ambulance Service has taken over the provision of out-of-hours services, while in other areas such services are provided around the clock, which has the advantage of meaning that family doctors are not interrupted by emergency calls during regular surgery hours (State Audit Office, 2009a). The development of emergency care services has been supported by payment reforms as well. Bonus payments for centralization and the establishment of common emergency dispatch services have supported the reorganization of out-of-hours services, while the government has introduced a fixed fee component in the payment of hospital A&E departments.

In 2009 the State Audit Office published a report on the efficiency, accessibility and, to a certain extent, the quality of emergency care. In the absence of a comprehensive performance measurement system, the report focused mainly on the availability and distribution of capacities, some activity measures and the assessment of whether emergency care providers had met the

professional minimum standards set by the Minister of State for Health (then known as the Minister of Health) (State Audit Office, 2009a). According to the report, the 2007 restructuring of inpatient care did not eliminate disparities in the distribution of emergency care capacities, but the reorganization of family doctor out-of-hours services was showing substantial progress. The report also noted that single-handed stand-by services had been successfully eliminated by 2006 and that 80% of family doctor out-of-hours services had been centralized by 2008. The number of population per out-of-hours service unit had increased from 8300 in 2004 to 28 500 in 2008. According to the report, minimum professional standards had generally been met, although a common emergency dispatch system with the National Emergency Ambulance Service and the local A&E units was present in only 5% of cases (State Audit Office, 2009a). Utilization based on payment reports showed large variations: the proportion of actual emergencies out of 911 calls and visits to A&E units ranged between 3% and 100%.

The report also showed that progress had been made in the development of A&E departments, as the share of emergency cases admitted through these departments had increased from 61% in 2006 to 78% in 2008, paralleling a general increase in the effectiveness and efficiency of emergency care. Nevertheless, the proportion of emergency cases using other entry points remained (and undoubtedly still remains) high, with the distribution of A&E capacities showing large regional disparities (that is, an almost tenfold difference between the lowest and highest figures) in 2008. The audit of the NPHMOS in 2008 found that only 22 out of the 45 A&E units met all the required professional standards, with staffing shortages being the most frequent problem (State Audit Office, 2009a).

One of the key performance indicators often emphasized by decision-makers is the time needed to reach the site of the emergency, the target value having been set at 15 minutes. In an evaluation of the performance of the National Emergency Ambulance Service, Burány (2007) found that this target was reached in only 78.5% of cases in 2006 and, despite reform efforts, had hardly improved between 2000 and 2006 (attributable mainly to staff shortages).

Given that emergency care is still under reorganization and development in Hungary, patient pathways, from the first contact with the health care system to the completion of treatment and discharge, can vary to a large extent depending on the socioeconomic status of the patient and the location where the incident took place. Most experiences with the implementation of various reform measures have yet to be evaluated by the State Secretariat for Healthcare.

5.6 Pharmaceutical care

The pharmaceutical industry, from production to marketing, distribution and consumption, is comprehensively regulated in accordance with EU regulations (see section 2.8.4 for more details). There are three groups of actors in the supply chain of pharmaceuticals: producers, wholesalers and retailers. After two major waves of privatization and liberalization over the past 20 years – the first in the early 1990s and the second after 2006 – the pharmaceutical industry was mostly privately owned as of April 2011, with only a small segment of the supply chain in the public sector.

During the communist era, pharmaceutical companies were owned by the state and supplied not just most of the domestic market, but exported to countries of the former socialist bloc. In the early period of economic transition, the market was liberalized and, by the end of 1996, all but one Hungarian pharmaceutical company were privatized, with the state retaining a small share (between 5% and 27%) in three other companies (Antalóczy, 1997). Since then, state ownership has continued to decrease. In 2010 there were close to 200 producers in the market, which by and large can be classified into three groups: (1) companies that have local manufacturing plants in Hungary and typically produce generics; these companies are represented by the Hungarian Pharmaceutical Manufacturers Association; (2) large international companies that mainly produce original pharmaceuticals outside Hungary; these companies are represented by the Association of Innovative Pharmaceutical Manufacturers, which has 23 members; and (3) approximately 30 smaller manufacturers of generics without local production. The market share of these three groups, according to the pharmaceutical sub-budget of the HIF, is 23%, 58% and 12%, respectively (Government of the Republic of Hungary, 2010b).

Since the majority of the wholesale and retail industries were privatized in the 1990s, substantial market concentration has taken place. In 2010 three wholesalers covered around 90% of the pharmaceutical trade market: Hungaropharma (between 35% and 40%), Phoenix (40%) and Teva (10%). Another company, Euromedic Pharma, is a major partner of hospital pharmacies (Government of the Republic of Hungary, 2010b). Hungaropharma is owned by the three main Hungarian pharmaceutical manufacturers (Richter Gedeon, Egis and Béres) and, to a small extent, by pharmacies.

The pharmaceutical retail market has two main segments: (1) retail units serving the general public (called open-access public units) and (2) retail units serving inpatient care (called closed-door units). The two segments can and do overlap in everyday practice, for example in inpatient care. Four types of pharmacies are distinguished by law (2006/8):

1. *Public (open-access) pharmacies* (called community pharmacies in the academic literature). This is a general type of pharmacy that provides the full scope of pharmaceutical services, dispensing prescription-only medicines, magistral preparations, non-prescription (over-the-counter) medicines and nutritional supplements to the public. It must be managed by a pharmacist with the right to operate a pharmacy and to carry out managerial functions. A range of staffing, material and IT requirements are specified by law (2007/3).
2. *Branch pharmacy*. This type of pharmacy operates as an affiliate unit of a community pharmacy and can be established in areas without public pharmacies. Professional requirements and other standards are less stringent for these pharmacies.
3. *Institutional (hospital) pharmacy*. The main function of this type of pharmacy is to supply medicinal products for inpatient care in a hospital, but hospital pharmacies can have community pharmaceutical retail units, as well. Originally, these units were classified as restricted (or “closed access”) pharmacies because they were allowed to serve only discharged patients and hospital staff. These restrictions were eliminated, however, in 2006 (2006/8).
4. *Single-handed pharmacies (pharmacy run by a physician)*. These are actually not pharmacies in the strict sense of the word, but rather a service provided by a family doctor whose office is located in a remote area lacking a community or branch pharmacy. Family doctors are allowed to supply pharmaceuticals only to patients who are enrolled in their registry, with the exception of emergency cases. Single-handed pharmacies run by physicians have contracts with community pharmacies in order to administer the pharmaceuticals prescribed and sold.

The number and main types of pharmacies are shown in Table 5.1.

Table 5.1

Number and main types of pharmacies in Hungary, 2000–2010 (selected years)

Type of pharmacy	2000	2006	2008	2009	2010 (23 August) ^a
Public	1 999	2 010	2 351	2 412	2 441
– branch pharmacy	604	650	652	655	650
– single-handed pharmacy	298	278	253	248	250
Institutional (hospital)	147	143	130	130	122
– with a community retail unit	46	73	71	74	80

Sources: HCSO, 2010f; ^a Government of the Republic of Hungary, 2010b.

Note: Single-handed pharmacies are translated in the HCSO, 2010f publication as “magistral pharmacies”, but this is incorrect because these pharmacies do not dispense magistral products.

In addition to the types of pharmacies shown in Table 5.1, there are three other categories of pharmaceutical retail (Government of the Republic of Hungary, 2010b). First, the over-the-counter market was liberalized in 2006 by allowing the sale of certain over-the-counter drugs outside of pharmacies (2006/8). In 2010, about 470 types of over-the-counter medicines were available in about 600 retail units (mostly petrol stations, supermarkets, drug stores and beauty shops); only 1% of total over-the-counter retail sales took place in such locations, however. Second, through the active inpatient care sub-budget of the HIF, the NHIFA is the direct purchaser of certain very expensive drugs (e.g. target therapies in oncology such as trastuzumab, bevacizumab and pemetrexed), which are supplied to hospitals by the manufacturers on a contractual basis, as part of which the NHIFA stipulates the number of patients that can be treated. Approximately 3–4% of the pharmaceutical sub-budget of the HIF is spent this way. Third, only a very small fraction of pharmaceutical retail takes place through the internet and home delivery, which is still operated by pharmacies.

Before 2006 the ownership and market structure of pharmaceutical retail was developed based on the ethical model of corporate responsibility. Privatization was guided by Act LIV of 1994 on the Establishment and Rules of Operation of Pharmacies, according to which only self-employed private entrepreneurs and limited partnerships were allowed to operate community pharmacies, with the additional requirement that the unlimited liability partners of the limited partnerships must be pharmacists with at least a 25% share (Article 36). Community pharmacies had to be established and managed by pharmacists with a special licence, the so-called personal right (*személyi jog*) (Article 15), a concept similar to the “practice right” in primary care (see section 5.3). In partnerships, one of the unlimited liability partners had to be a pharmacist in possession of this special licence (Article 29). With these measures, the government aimed to ensure that pharmacists had a decisive role

in the management of community pharmacies and that the pharmaceutical retail system would not be dominated by profit-making investment interests alone. By the end of 1997, all previously state-owned pharmacies serving the general public had been privatized according to this model (HCSO, 1999).

Act LIV of 1994 also restricted the establishment of new pharmacies by requiring a minimum of 5000 inhabitants per community pharmacy, and a minimum distance of 300 metres (and 250 metres for towns with a population of more than 100 000) between new and existing pharmacies, from which the Office of the Chief Medical Officer (see section 2.3.3) was allowed to deviate only with the approval of the Chamber of Pharmacists (see section 2.3.10) (Article 5). The NPHMOS designated an indicative catchment area as part of the registration and licensing system, but this did not restrict the choice of consumers in any way (Article 6). Table 5.1 shows that this model contained the number of new pharmacies very effectively: between 2000 and 2006 only a handful of new pharmacies were established. The government in power from 1998 to 2002 strengthened the pharmacist-owned retail system by increasing the minimum ownership share of pharmacists from 25% to 50% (to be achieved by 31 December 2006) and excluding pharmaceutical manufacturers and wholesalers from ownership (2001/10). The plans were not realized, however, because the government in power from 2006 to 2010 rewrote the respective regulations based on a liberal model of corporate responsibility, eliminating most of the restrictions on ownership (no limitations regarding the type of business entity, no minimum share of pharmacists stipulated, manufacturers and wholesalers not excluded, pharmacy chains not prohibited), and relaxing the criteria for establishing new pharmacies (no population and distance restrictions for new pharmacies undertaking the provision of extra services for at least three years, such as longer opening hours, night duty, internet-based ordering and home delivery) (2006/8).

The new regulations entirely changed the dynamics of the pharmaceutical retail market. Between 2006 and 2010, the share of community pharmacies increased by more than 20% due to a higher concentration in cities and larger villages. At the same time, the supply for villages with less than 1000 inhabitants worsened. Moreover, pharmacy staff were unable to cope with the increased number of retail units and longer opening hours. As a result of the relaxed ownership regulations, both horizontal (the establishment of pharmacy chains) and vertical (acquisition of ownership by manufacturers and wholesalers) integration took place. It is estimated that in 2010 some 15–20% of pharmacies operated in chains (Government of the Republic of Hungary, 2010b).

The government that took office in 2010 has returned to the original, ethical model of corporate responsibility. In June 2010 the licensing of new pharmacies was suspended and further mergers were banned (2010/9). Moreover, in December 2010 a new act was passed endorsing the gradual reacquisition of ownership by pharmacists: Act CLXXIII of 2010 on the Amendment of Certain Health Care Related Acts brings the operation of pharmacies under the personal responsibility of pharmacists in order to enable them to contribute to efficient therapies and prevention programmes and to support healthy lifestyles (Articles 77 and 83). The minimum share of pharmacists' ownership in already functioning pharmacies must now reach 25% by 2014 and 50% by 2017 (Article 84). Actors in the pharmaceutical supply chain are not allowed to own newly established pharmacies, and mergers are banned for chains that consist of more than four pharmacies (Article 84). As for the pharmacies already owned by wholesalers, the shares must be adapted to the stipulated limits, but currently operating pharmacy chains may be maintained. As of May 2011, no offshore company will be allowed to hold shares in pharmacies (Article 87).

The demographic and geographical criteria for establishing new pharmacies have also been changed. A community pharmacy can only be established based on national tenders. In the case of municipalities with less than 50 000 inhabitants, the minimum demographic criterion is 4500 persons per pharmacy (including the new one) and the minimal geographical distance between pharmacies is set at 300 metres. In the case of bigger towns, the numbers are 4000 persons and 250 metres. The restrictions do not apply if the given municipality has no established pharmacy (Article 69). During the evaluation of tenders, priority is given to pharmacies that intend to provide additional services, such as longer opening hours, out-of-hours services, running a branch pharmacy or providing home delivery (Article 68). These changes aim to ensure that new pharmacies meet local needs and contribute additional services. The new provisions also regulate pharmacies' promotional activities, prohibiting such activities for reimbursed medicines and restricting them to the provision of health care services in the case of non-reimbursed drugs (Article 59).

In 2009 a total of 5301 pharmacists and 7536 pharmaceutical assistants worked in community pharmacies, whereas another 430 pharmacists and 790 assistants worked in hospital pharmacies (HCSO, 2010f). According to the concept of pharmaceutical care introduced in 2009 (2008/9), pharmacists are expected to provide health information and prevention activities, supervise and monitor drug treatment, work to minimize side effects and avoid harmful

drug interactions (2009/6). It is estimated that about 15% of pharmacies in 2010 took part in some form of pharmaceutical care programme (Government of the Republic of Hungary, 2010b).

The regulation and supervision of the pharmaceutical supply system is shared between the Ministry of National Resources (responsible for the regulatory framework), the National Institute of Pharmacy (responsible for manufacturers, wholesale distributors and clinical trials), the NPHMOS (responsible for retail trade – that is, pharmacies; see also section 5.1), and the NHIFA (responsible for HIF coverage of pharmaceuticals).

The manufacturing of pharmaceuticals for human use must be authorized and the products must be granted marketing authorization (that is, a licence) by the National Institute of Pharmacy. The price that is ultimately to be used as the basis for subsidy (that is, the agreed price) is subject to a negotiation process, whereas the wholesale and retail margins are regulated. The price of over-the-counter pharmaceuticals is not regulated. Hospitals buy pharmaceuticals directly from wholesalers or are supplied directly by the manufacturers, which are contracted by the NHIFA, as for example is the case for special, very costly pharmaceuticals. Prices are negotiable but may not exceed the wholesale price set in the case of subsidized pharmaceuticals (2007/1).

The HIF covers some pharmaceuticals partially and some in full. The process of including pharmaceuticals in the benefits package follows the requirements of the Transparency Directive of the European Commission (89/105/EEC) introduced in 2004 (see section 2.8.4 for more details) (2004/4). In 2010, there were 5513 products on the list for the drug benefits package, but not all of them were subsidized. The method for determining the extent of subsidies and user fees depend on several factors, including the severity of the condition, the indication and the type of prescription and pharmaceutical. In most cases, patients must pay user fees for prescribed pharmaceuticals in outpatient care, but inpatient care includes the cost of pharmaceuticals (at least according to the regulations) (see section 2.8.4).

The rules for prescribing pharmaceuticals were set forth in 2004 and 2005. In principle, every physician and dentist is entitled to prescribe pharmaceuticals by using their personal stamp along with their signature at the bottom of a prescription (2005/3). Under the so-called *pro familia* label, physicians can prescribe pharmaceuticals for themselves and their immediate family members (2004/5). Certain medicinal products, however, can be prescribed only by specialists. Family doctors can prescribe these pharmaceuticals (typically for chronic diseases) for up to three months if the relevant specialist has endorsed

the use of pharmaceutical treatment for a given patient (2005/4). Only one pharmaceutical is allowed per prescription (2004/5). The prescription must include information about the patient and the prescriber, the name of the pharmaceutical or its active ingredient, its quantity and its dosage (indicated daily dose) (2004/5). The prescribed quantity may not exceed the quantity necessary for one month's treatment, with the exception of patients with chronic conditions to whom pharmaceuticals can be prescribed for up to three months or, in exceptional cases, up to one year (2004/5).

There are two major types of reimbursement: indication-related and fixed. In the first category, the indication for a certain substance needs to be confirmed by a specialist. Some pharmaceuticals for less severe chronic conditions are covered up to 90%, 70% or 50% of the agreed retail price, while medications for the more severe, life-threatening diseases are covered 100% (however, in most cases a minimum patient co-payment, the so-called package fee, of approximately €1 must still be paid). In the second category, all indications determined in the licence of a medication are covered, either up to a fixed amount (through the reference pricing system) or on a percentage basis (80%, 55% or 25% of the agreed price). The reference pricing system is used for products with identical active ingredients or similar therapeutic effects. In the case of products with identical active ingredients, the basis for reimbursement is the daily treatment cost of the reference product, which is the product available on the market for at least six months with the lowest daily treatment cost and with a market share exceeding 1% (as expressed in days of treatment). All pharmaceuticals containing the same active ingredient receive the same subsidy per daily dose. The reference pricing system also applies to products with different active ingredients but similar therapeutic effects (2004/4). Further information on reimbursement can be found in section 2.8.4.

There is a system of exemptions from user charges for pharmaceuticals, medical aids and prostheses, and rehabilitation services for social service beneficiaries (1993/1). When this system was introduced, eligible individuals received all pharmaceuticals on a special list free of charge, with no consumption or spending limits. In 2006 the government introduced new rules to tackle abuse of the system. Eligible individuals are now granted a monthly personal budget of up to HUF 12 000 (about €45) to cover user charges on recurrent health expenditure associated with chronic diseases; these individuals also have an addition budget of HUF 6000 (about €24) for acute problems (2005/8). The range of accessible medicines is no longer restricted, but any spending above the budget ceiling must be paid out-of-pocket. Entitlement to user charge

exemption can be direct (for example, for abandoned children, or for people on regular social cash benefits or on disability pensions), or means-tested (that is, based on patient household income and pharmaceutical expenditure) (1993/1).

Pharmaceutical expenditure in Hungary has three main components: (1) SHI subsidies for pharmaceuticals prescribed in the outpatient care setting, (2) private (mainly OOP) spending on pharmaceuticals prescribed in the outpatient setting, and (3) hospital spending on pharmaceuticals as part of inpatient care that is covered by the HIF (the amount of privately funded inpatient care is negligible). Detailed information on financing can be found in the corresponding sections of Chapter 3. Total expenditure on pharmaceuticals and other medical non-durables in 2007 was \$434 at PPP per capita, which was slightly below the OECD average of \$461 (also at PPP). It is important to note that this figure includes user charges, but does not include expenditure on pharmaceuticals prescribed in the inpatient care setting, which makes international comparisons difficult. The share of public expenditure on pharmaceuticals in 2007 was 58.5%, which is close to the OECD average (57.7%); this being said, the range for this indicator was very wide among the OECD countries, from 21.3% for Mexico to 83.3% for Luxembourg. Between 2001 and 2006 the share of public expenditure on pharmaceuticals in Hungary rose from 61.2% to 67.2%. This upward trend was reversed by the cost-containment and cost-shifting measures of the government in power between 2006 and 2010 (2006/8).

An analysis of pharmaceutical consumption shows that almost two-thirds of spending from the pharmaceutical sub-budget of the HIF was attributable to three main treatment groups: cardiovascular (26%, or HUF 71 billion, about €280 million), oncological (23%, or HUF 64 billion – about €253 million) and neurological/psychiatric (14%, or HUF 38 billion – about €150 million) (Government of the Republic of Hungary, 2010b). The international comparison of defined daily dose (DDD) rates confirms this pattern. Among those countries for which data were available in 2006, there were three areas in which Hungary deviated significantly from the OECD averages: pharmaceuticals for cardiovascular disease (Hungary 613 DDDs vs OECD 456 DDDs), for hypertension (Hungary 23.7 DDDs, the highest among OECD countries, vs. OECD 7.8 DDDs) and anxiety disorders (Hungary 53.1 DDDs vs. OECD 30.7 DDDs) (OECD, 2009b).

5.7 Rehabilitation/intermediate care

Rehabilitation is defined in Hungary as all organized activities whose primary aim is to support the reintegration of temporarily or permanently disabled people into the community by restoring or preserving their remaining abilities. A complex intersectoral service, rehabilitation requires the coordinated actions of health care services, psychological services and the educational, occupational and social sectors. Medical rehabilitation aims to improve and substitute for impaired abilities through physiotherapy, sport therapy, speech therapy, psychological services, occupational therapy and medical devices (including medical aids and prostheses, as well as training in their use). Some alternative treatments provided frequently by medicinal spas and sanatoria are also defined as rehabilitative care, including speleotherapy and treatments with medicinal waters and mud (1997/20, 1999/13).

Rehabilitation services can be provided in an outpatient, inpatient, home care or daytime hospital setting by hospitals (using rehabilitation beds, in a daytime hospital unit, or in hospital outpatient centres), by daytime hospitals (in a daytime hospital or outpatient setting), by polyclinics (solely in an outpatient setting) and by home care providers in the patient's home (1999/1). Although intermediate care is not recognized as a separate service category, the daytime hospital is an intermediary type of facility that was first introduced in 1993 (1993/6) and further defined in 2003 (2003/15) to increase service provision outside the traditional inpatient care setting and thus prevent unnecessary hospitalization. A provider or department/unit of a provider can be considered a daytime hospital if it meets the minimum technical and material requirements of an inpatient care unit for at least 8 hours per day, 5 days a week. Importantly, the care provided by daytime hospitals is not the same as day care, which is described in section 5.4.3 (2003/15).

Any of these providers can be multi-specialty (for example, an acute hospital with a rehabilitation unit or department) or dedicated solely to the provision of rehabilitation services. In the latter category, three special subgroups should be distinguished.

First, there are so-called sanatoria, which provide inpatient and outpatient rehabilitation along with natural/alternative treatments for patients with conditions of the circulatory, respiratory, endocrine and locomotor systems, and who have a valid referral from an authorized specialist (1995/6). An annex to the relevant decree lists six sanatoria, four of which are state hospitals directly run by the State Secretariat for Healthcare, but omits one special-status sanatorium.

Second, Hungary has a large number of sites with thermal and medicinal waters, and range of medicinal spas provide balneotherapy and other rehabilitation services in an outpatient (and, more recently, in a daytime hospital) setting, mainly for patients with locomotor conditions. The National Chief Directorate of Health Resorts and Medicinal Spas registers the relevant natural treatments (including mineral waters, medicinal waters, medicinal mud and medicinal gas), health resorts (geographic areas in which the relevant natural treatments can be found) and the service providers that provide these treatments for rehabilitation and curative purposes (such as medicinal spas, sanatoria, medicinal grottos and spa hotels) (1999/13). Two main service categories are defined by a ministerial decree: (1) balneotherapy services (such as medicinal bath, medicinal mud-pack, medical massage, weight-bath, carbon-dioxide bath, under-water jet massage) and (2) medicinal swimming for children (2004/9). The decree regulates the minimum professional standards for each service type and the rules of utilization. Only services prescribed by an authorized specialist (that is, a rheumatologist, physiotherapist, orthopaedist, rehabilitation specialist or traumatologist) and for listed indications are subsidized through the HIF and require a provider who has a valid contract with the NHIFA (Article 3 and Annex 5, Article 12). The subsidy is limited to two eight-week courses of treatment per calendar year with fifteen treatment episodes per course (Articles 5 and 8). The extent of the SHI subsidy is also determined by a ministerial decree (2007/6).

Third, the most complex rehabilitation services are provided by the National Institute of Medical Rehabilitation, which serves the entire population. The Institute also carries out research and organizes professional education and training. It has 50 acute-care beds, 347 rehabilitation beds and 60 daytime hospital beds, and it allocates 773 hours per week for outpatient specialist services. There is an ongoing renewal project for buildings and medical infrastructure, which started in 2000 and should be completed in 2011.

In 2009, there were 9950 rehabilitation beds in Hungary in total, or 9.9 beds per 10 000 population (HCSO, 2010f). This was the result of a substantial capacity increase in 2007, as part of which entire acute inpatient care hospitals were transformed to chronic care/rehabilitation hospitals, leading to an increase in the latter category of some 3000 beds. This restructuring of service delivery aimed at supporting good-quality rehabilitation services. Nevertheless, the reform has been criticized, mostly because the necessary infrastructure and, more importantly, qualified human resources are still not available, and because complex rehabilitation is not well coordinated; according to a study by the Research Institute of the State Audit Office of Hungary, medical rehabilitation

is underfunded and short-staffed, and there are substantial regional disparities in access to services (Research Institute of the State Audit Office of Hungary, 2009).

In terms of financing and payment, because rehabilitation services are classified as chronic care they are paid for by patient-days (adjusted for the complexity of the case) (1999/1). Since March 2008, however, providers that do not meet the minimum standards – mainly related to human resources – have been paid for with lower weights for the same case (2007/12, 2009/5). Thus, in practice, rehabilitation services are paid according to the provider's staffing standards rather than the complexity of the case. This is an obvious financial incentive for providers to develop their rehabilitation staff, but also a disincentive to treat more complex cases, thus leading to risk selection. There are plans to introduce a DRG-type system on the basis of the International Classification of Functions, Disability and Health (referred to in Hungary as homogeneous rehabilitation groups).

5.8 Long-term care

Long-term care is provided both by the health and the social sectors. In principle, the location of service provision is determined based on the patient's health needs. In practice, however, the boundaries between the two sectors are quite unclear. Indeed, service categories can overlap and people can be assigned to the wrong setting, such as when long-term social care for the elderly is provided in acute wards due to the shortage of places in residential homes. Nevertheless, in line with the legal framework and the recommendations for the amendment of the System of Health Accounts classification (International Health Accounts Team, 2011), we describe the institutions of long-term health (or nursing) care and social care separately, while subsequently discussing the performance problems jointly.

5.8.1 Long-term nursing care

In the Hungarian health care system, long-term nursing care (LTNC) is one category of chronic care, together with general chronic care, rehabilitation, hospice and palliative care. There are different modes of provision (inpatient, daytime hospital, outpatient and home care), which generally correspond to the System of Health Accounts classification of long-term nursing care (“inpatient

LTNC”, “LTNC: day care” and “LTNC: home care”). It is important to note, however, that most LTNC services in Hungary are still provided on an inpatient basis.

Capacities in inpatient LTNC are difficult to measure using the official statistics because long-term care was not recognized as a separate category of chronic inpatient care in Hungary until 1997. Furthermore, until 2001, all pulmonology and psychiatry beds were considered chronic, and these specialties are still listed as separate categories within chronic care, whereas rehabilitation beds and beds in sanatoria were merged into a single category after 1990 (HCSO, 1998b, 2010f). Real changes in the number of chronic beds also took place, the most substantial of which was an increase of about 7500 beds in 2007. In 2009 the number of chronic hospital beds per 10 000 inhabitants was 27, 10% of which belonged to LTNC (HCSO, 2010f). In 1997 the corresponding numbers were 25 and 3.6% (HCSO, 1998b). In 2010 the average length of stay in chronic wards was 27.6 days and bed occupancy was 83.6%, while in long-term care wards they comprised 65.5 days and 86.3%, respectively. Bed occupancy was 76.4% and average length of stay was 45.6 days for LTNC (HCSO, 1998b). Both figures have shown a tendency to increase over the past 13 years.

The so-called daytime hospital is an emerging form of care that is mainly used in the long-term care of psychiatric patients. Home-based nursing care, on the other hand, is divided into two categories: (1) hospice home care and (2) specialist home care. Hospice care (both inpatient and home-based) is discussed in section 5.10. A decree defines the health care services that can be provided within the category of specialist home care (Annex 1), the qualifications required of the provider (Article 2) and the minimum infrastructure requirements, including those related to office equipment, vehicles, medical equipment and medical supplies (Annex 2). The providers of specialist home care have to contract with a regional branch of the NHIFA in order to supply services in a defined territory. Home care is paid from a separate sub-budget of the HIF on the basis of visits (adjusted for the complexity of the case and certain geographical factors). In 2008 a total of 366 providers were registered and 51.8 patients per 10 000 inhabitants were served. Pressure ulcers were the most frequent diagnosis, and special nursing and physiotherapy accounted for 94% of services provided in 2008 (NHIFA, 2009a).

5.8.2 Social care

Local governments are responsible for the provision of social care (1990/3), and Act III of 1993 on Social Services determines the types of care to be provided, the rules of eligibility and the rules of financing. In general, impoverished people and people with disabilities are eligible for social assistance. In the case of special institutional care for people with disabilities, certain groups are specified in the Act: elderly people, people with physical disabilities, people suffering from mental illness or drug addiction and homeless people. Care for vulnerable children is provided by the system of public guardianship (1997/2).

The scope of services includes cash and in-kind benefits. Cash benefits may be regular, such as old age allowances, or irregular (that is, occasional) in transitory crisis situations, such as funeral payments or home maintenance support (see Table 5.2).

Table 5.2

Cash and in-kind social benefits in 2007 (recipients per 10 000)

Local governments	
<i>Regular cash benefits</i>	
Regular social assistance	193.7
Old age allowance (recipients per 10 000 population over 60 years of age)	29.0
Regular child protection benefit (recipients per 10 000 population under 24 years of age)	1751.0
<i>Irregular (occasional) cash benefits</i>	
Temporary support	446.8
Home maintenance support (in cash)	266.6
Extraordinary child protection benefit (recipients per 10 000 population under 24 years of age)	797.0
Nursing allowance	51.8
<i>In-kind benefits</i>	
Funeral support and public funeral	59.9
Housing subsidies	9.8
Home maintenance support (in-kind)	92.8
Central government	
Transport allowance for the severely disabled	200.7
Public medicine services (user charge exemption scheme, <i>közgyógy</i>)	396.4
Disability support	108.6
PIF	
Disability benefit	30.8
War widowhood benefit (benefit for widows of war)	13.9
Health deterioration allowance (benefit to persons with reduced capacity to work, who are unemployed and not entitled to unemployment benefit, old age pension, disability pension)	3.0
Temporary allowance (benefit to persons with reduced capacity to work, who are unemployed and not entitled to unemployment benefit, old age pension, disability pension)	22.8
Regular social allowance (benefit to persons with reduced capacity to work, who are unemployed and not entitled to unemployment benefit, old age pension, disability pension)	184.8

Source: HCSO 2008.

Note: PIF: Pension Insurance Fund.

In addition to the listed cash benefits, the central government, the NPIFA and the NHIFA cover a wide range of benefits, entitlement to which is not related to the socioeconomic status of recipients. These include family benefits, such as pregnancy and confinement benefits, maternity benefits, child care benefits and allowance, and child raising support and family allowance; pensions, such as old age and disability pension; and income replacement in the event of illness, such as sick pay (HCSO, 2010f). The SHA classification considers households as providers of home care (International Health Accounts Team, 2011). The nursing allowance is a cash benefit bestowed by local governments to support care provided by laypeople, including relatives, to individuals with severe disabilities or chronically ill children under 18 years of age (1993/1).

In-kind benefits take two main forms: (1) in-kind benefits for impoverished people and (2) in-kind benefits for people with disabilities (services of personal social care). Benefits for impoverished people can take the form of either reimbursement of actual expenses or the provision of services in-kind. The two main health care related in-kind benefits are pharmaceutical co-payment exemptions and eligibility for health care services. In case of the former, the government covers the user charges for essential drugs and medical aids and prostheses. For the latter, impoverished people who otherwise would not have HIF coverage become eligible for health care. In both cases, the local government tests for eligibility and issues an identity card to the recipients certifying it to the provider. The government in power from 2006 to 2010 changed the rules of eligibility and utilization to decrease the abuse of the system (see section 5.6). The user charges exemption scheme (*közgyógy*) had 396 recipients per 10 000 inhabitants in 2007 (Table 5.2). The Public Foundation for the Homeless is a charity that provides health care for homeless people in both family doctor practices and mobile units. The Foundation also runs two residential institutions and two day-shelters (2004/3, 2004/8). There is another public foundation established by the government and the municipality of Budapest that is dedicated to serving the homeless in the capital (2003/14).

In-kind benefits for people with disabilities include primary social care provided at home and in the community (including social catering and domestic help) and special social care in residential institutions (including short- and long-term residential care and rehabilitation). Between 2002 and 2007, the classification of services changed and their scope broadened (Mester, 2010). Five new service types were introduced (alarm-system-based domestic assistance, community care for people with cognitive impairment or people with addictions, street social work for the homeless, and social support service

for people with disabilities) in the primary social care category, while daytime social care was shifted from the special social care category to primary social care.

According to the new classification, primary social care includes four community care services, daytime social care in institutions and five basic services: (1) village and homestead caretaker service ensures access to basic public services and meets the most important personal and community needs in villages with less than 600 inhabitants (village caretaker) or less than 400 with at least 70 people living in the outskirts (homestead caretaker); (2) social catering provides at least one hot meal per day for social service beneficiaries; (3) domestic help assists people in need in daily housekeeping and personal administration activities; (4) alarm-system-based domestic help, introduced in 2003, works as a stand-alone service or as a complementary service to domestic help; and (5) family assistance service helps to deal with crisis situations in families (particularly concerning social issues or mental illness). According to Act III of 1993 (1993/1), every settlement is obliged to provide social catering and domestic assistance, while family assistance is compulsory only in settlements with more than 2000 inhabitants. The target group of the alarm-system-based domestic help includes elderly people, people with severe disabilities or psychiatric patients living alone or in two-person households (Article 63).

In 2007 the number of persons utilizing the family assistance service was 455 per 10 000 inhabitants, and there were 692 village and 242 homestead caretaker services in operation. There were 101.4 recipients of social catering per 10 000 inhabitants, with 464.4 recipients per 10 000 in the population over 60 years of age. Only 75% of municipalities provided the service, with smaller villages typically being the exception (Mester, 2010). Domestic help was utilized by 45.8 recipients per 10 000 population, or 209.6 persons per 10 000 population aged over 60 years. Here, regional inequalities in access to care have been aggravated further by a decrease (of 1606 between 2002 and 2007) in the number of workers. Consequently, the number of care recipients increased from 5.5 per nurse to 7.3 per nurse (Mester, 2010).

Domestic assistance is of special relevance for specialist home care: it is meant to serve as the interface between social care and health care, since social nurses are expected to realize when their clients are in need of health care services and to notify home care services accordingly (1993/1, Article 63).

Community-based social services are a special form of primary social care for four target groups: psychiatric patients, people with drug addictions, people with disabilities (support services) and homeless persons (street social work). These services aim at providing care locally (in the community) for those who do not need to be admitted to residential institutions (see Table 5.3). Every municipality with more than 10 000 inhabitants has to provide community care, but street social work is compulsory only in municipalities with more than 50 000 inhabitants (Mester, 2010).

Table 5.3

Community-based services (recipients per 10 000), 2007

Community care for psychiatric patients	4.6
Community care for addictions	6.9
Support service	18.5
Street social work	10.8

Source: Mester, 2010.

Under daytime social care, local governments provide care, social or psychological support to the aforementioned population groups and to elderly people, but the recipient spends the night at their own home. The provision of this service is obligatory for municipalities with more than 3000 inhabitants. The most frequently utilized daytime social care service is the club for elderly people: 1221 clubs were visited regularly in 2007. This is equivalent to 177.2 recipients per 10 000 population aged over 60 years. Daytime social care for homeless persons is available in the form of daytime shelters or soup kitchens. In 2007 the average number of daily admissions was 7543 to the former (92 institutions) and 3923 to the latter (41 institutions). Daytime care was attended by 3986 people with disabilities, 1040 psychiatric patients and 1086 people with addictions (Mester, 2010).

Providers of institutional social care in residential homes can be categorized in four groups based on the function of the institution (1993/1, Articles 66 to 85). Long-term residential social institutions provide care for those who are unable to live on their own because of their age, health or social status (residential homes for elderly people, for people with physical or mental disabilities, and for impoverished people). Rehabilitation residential social institutions provide care for those who have the prospect of regaining self-sufficiency, at least partially. Transitory residential social institutions, with the exception of night-time shelters, provide residential care for a maximum of one year. A special form of institutional care takes place in community homes, which provide

accommodation for 8–14 people with physical or mental disabilities who are at least partially able to care for themselves, with the aim of reintegrating them into the community.

Just as for health care, the responsibility for provision does not imply that local governments have to deliver the services themselves and contracting out services is even more prevalent in the social sector than in the health care sector. In 2007, residential social care was provided by 999 institutions, 35.7% of which were NGOs. Total capacity was 88 525 beds (88.1 beds per 10 000 inhabitants), 59.7% of which were in homes for elderly people, 19% in homes for people with disabilities, 9.5% in homes for psychiatric patients, 2.6% in homes for addicts and 9.2% in homes for homeless persons. The number of residents was 85.0 per 10 000 population (Mester, 2010). The outsourcing of the delivery of primary social care services is not so widespread. In 2007, social catering was provided by NGOs to less than 5% of recipients (Mester, 2010).

There is a shortage of places in residential homes. In 2000 a total of 20 people per 10 000 population were on waiting lists, half of them for more than a year, the problem being most pressing in residential homes for elderly people (HCSO, 2001). Unfortunately, no statistics on waiting lists have been published since 2000, and although occupancy rates have slightly dropped in the past decade (Mester, 2010), various studies claim that the shortage of capacity has not been relieved (European Commission, 2009; State Audit Office, 2008b).

The absolute and relative shortage of places, the geographic disparities, insufficient coordination between health and social care, and contradictory financial incentives (high user charges in social care as opposed to low or no user charges in health care) have led to the abuse of acute inpatient care capacities by chronic and social care cases – otherwise known as the medicalization of social problems (European Commission, 2009). This is a fundamental performance issue, and addressing it is key to a successful health care reform. In addition, there is a lack of comprehensive quality assurance and accreditation mechanisms in social care and of proper coordination mechanisms between social care and health care (State Audit Office, 2008b).

5.9 Services for informal carers

Having recognized the value of informal carers in home-based care, the Hungarian social care system provides financial assistance for this category of caregivers. Relatives of patients requiring long-term care are eligible for a

nursing allowance, as has been discussed in section 5.8. The number of informal carers on nursing allowance was 51.8 per 10 000 inhabitants in 2007 (Table 5.2), but the real number of carers is probably higher because eligibility is strictly controlled. For instance, if an informal carer receives other social care benefits apart from sick pay, eligibility is lost. In addition, there are people who work in this sector informally, but the number of unregistered carers is unknown. The amount of the nursing allowance is determined on the basis of the current minimum of old-age pensions. In 2009 a typical nursing allowance consisted of approximately €100 per month, but a higher allowance of €130 could also be applied for in cases of patients with complex nursing needs (1993/1).

5.10 Palliative care

Palliative care is still in its infancy in Hungary. Although hospice care first appears in SHI financing regulations as early as 1994 (1996/2, Annex 6), and Act CLIV of 1997 on Health Care recognizes and defines hospice care as a separate service category (Article 99), inpatient hospice care as a form of chronic inpatient care was only included in the SHI financing in 1999 (1999/1, Annex 8), while hospice home care was incorporated as a separate payment category as late as 2004 (2004/2). Care for terminal patients as a service to be provided within specialist home care was incorporated into Decree No. 20/1996. (VII.26.) NM of the Minister of Welfare on Specialist Home Care in 1999 (1999/3), while relevant professional minimum standards were defined in 2003 (2003/15). Professional regulations separate from those for home care followed even later in 2009 (2009/4).

The Decree differentiates between three modes of care: (1) the palliative mobile team, (2) hospice home care and (3) hospice-palliative inpatient department. A hospice mobile team, for instance, should consist of at least a trained specialist, a skilled nurse, a psychologist or mental hygiene specialist and a coordinator (for example, a social worker), whereas a number of other specialists (including a physiotherapist, a dietician, a priest and the relevant medical specialists) must be available for consultation.

Hospice home care can be prescribed by an oncologist, other cancer specialists or the family doctor provided that a specialist diagnosis has already been made. Each episode of care is measured in care days. One course of hospice care lasts 50 days, which can be repeated twice per calendar year. The payment of hospice home care is different from specialist home care and is based on a per diem. The existing capacity is insufficient and, as in other areas

of chronic care, demands are systematically unmet. This is especially true for institutional hospice care, which, according to a report of the State Audit Office of Hungary, was not available in 75% of counties (State Audit Office, 2008b). Patients in need of hospice care often remain in chronic care wards because hospitals rarely establish a separate hospice ward (as they would then have to provide hospice home care services, too) (2003/14). The capacity of alternative providers, such as non-profit foundations, is also limited.

5.11 Mental health care

Mental health care is integrated into the main health and social care systems both organizationally and in terms of financing. In the area of chronic outpatient specialist care, psychiatric dispensaries provide services according to the territorial supply obligation, both at the surgery and at the patient's home. In 2008 there were 140 psychiatric, 35 youth and child psychiatric and 111 addictology dispensaries in Hungary. The patient turnover was 112.1, 10.2 and 9.4 per 1000 inhabitants, of which 41.0%, 44.3% and 65.2% were visits by patients already in care, respectively. The average number of consultations per patient in care per year was 7.7 for adults and 8.2 for children and adolescents (HCSO, 2010f).

Secondary inpatient care is divided into acute and chronic (long-term) care, but services are also provided on a daytime hospital basis. As part of the 2006–2007 service delivery restructuring reforms, approximately 1000 acute psychiatric beds were removed from the system, so the number of acute psychiatric beds decreased from 3.8 to 2.9 beds per 10 000 inhabitants. Chronic inpatient capacities, on the other hand, did not change substantially, but showed a slight increasing trend, amounting to 5.7 beds per 10 000 population in 2009 (HCSO, 2009b). Furthermore, the National Institute of Psychiatry and Neurology was closed down at the end of 2007. Certain parts of it were relocated to other inpatient care providers, and a new National Centre for Psychiatry was established within the organization of the National Centre for Healthcare Audit and Inspection.

Act IV of 1959 on the Civil Code recognizes three categories of legal capacity based on the scale of mental impairment: full capacity, limited capacity and incapacity (1959/1, Articles 14–16). Mental disability can be attributed to psychiatric conditions, intellectual disability or addiction. In the case of limited capacity or incapacity, a legal guardian appointed by the court, controls

decisions and acts on behalf of the patient in accordance with the patient's abilities. In 2008 a total of 50.4 people per 10 000 inhabitants in Hungary were reported to be under guardianship (HCSO, personal communication, 2010).

5.12 Dental care

With a few exceptions (removable dental prostheses for persons aged 18–60; technical dental costs for people under 18, students in a full-time course of studies and for people over 60; dentures for people under the age of 18, all of which require co-payments), most dental services are available free of charge within the single-payer health insurance system (1993/5, 1997/15, 1997/18, 2003/15). Dental care is divided into three services: (1) dental primary care, including, among other things, dental screening, school dental services and dental services for pregnant women, (2) dental specialist care and (3) dental out-of-hours services. Dental primary care is organized on a territorial basis similar to that for family doctor services, but unlike family doctors, patients are not allowed to choose their primary care dentist freely.

Dental care is reimbursed using a mixed payment system consisting of a fixed fee and a fee-for-service point system, the latter being the same as that used for all other outpatient specialist services (1997/19, 1999/1). The fixed component of the payment for dental primary care is a capitation payment adjusted for the age structure of the population served (calculated in terms of points and weights), and it is very similar to the capitation of family doctor services in so far as the fee paid per capitation point decreases above a certain number of capitation points. In the case of dental specialist services, there are fixed numbers of capitation points for 30 hours of surgery per week, and they decrease proportionately for fewer weekly hours of surgery. The capitation fee (HUF per point) is set in a governmental decree. Finally, in the case of dental out-of-hours services, the fixed fee (defined as a lump sum in HUF) depends on the number of inhabitants (fewer than 50 000; 50 000–100 000; over 100 000) and the number of duty hours per day (1999/1).

In Hungary, private provision is dominant in dental care. The development of private dental care capacities was facilitated by cross-border dental care and health tourism in general. The phenomenon started in the early 1980s, and was originally limited to the border regions with Austria. According to certain studies, Hungary is the target country for over 40% of all dental tourism in Europe, with about 63 000 patients visiting Hungary every year for dental treatment. Patients come mainly from the UK (30%), Ireland (20%), France

(15%) and Austria (15%). It is estimated that about 15% of all dentists and an additional 5000 skilled workers are involved in cross-border dental care in Hungary (Kámán, 2010).

5.13 Complementary and alternative medicine

Complementary and alternative medicine (CAM) is regulated by a government and a ministerial decree (1997/1). These apply to naturopathic methods and other forms of non-conventional medicine. According to the government decree, CAM is considered a health care activity that complements or, in special cases, substitutes for conventional medicine; it may be practised only by appropriately qualified professionals (Articles 1–3). The ministerial decree lists recognized CAM procedures in three main groups depending on the qualifications required for their practice. First, there are procedures that can be performed only by physicians, including manual therapy, neural therapy, traditional Chinese medicine and any other CAM techniques that are taught only in medical schools. Manual therapy, however, is an exception because physiotherapists are also authorized to use it (excluding manipulation of the spine). Second, procedures such as acupuncture or reflex-zone therapy can be performed by any skilled person with a professional qualification. Lastly, a simple certificate from a continuing education programme is sufficient for the use of less complex CAM procedures, including techniques utilizing bioenergy, phytotherapy or kinesiology (1997/1, Annex 1). The government decree regulates the therapeutic process; the registration and licensing of CAM practitioners; the choice of acceptable alternative medicines, therapeutic agents and equipment; the minimum standards of practice; and the professional qualification required to perform various CAM procedures.

Some procedures, such as acupuncture, are eligible for HIF financing, but the bulk of CAM services must be paid out-of-pocket (2002/18). The providers of CAM services are supervised by the municipal and capital district offices of the NPHMOS (1997/1).

5.14 Health care for specific populations

In Hungary the unfavourable health status of the Roma population is a significant problem, which is difficult to study, due to the lack of reliable socioeconomic, demographic and health data. According to the latest census in 2001, 190 000

people in Hungary declared themselves Roma, but experts estimate their number at around 500 000 or more (Hablicsek, 2009). Act LXXVII of 1993 on the Rights of National and Ethnic Minorities prohibits forcing anyone to reveal his/her ethnicity.

Large segments of the Roma population live under disadvantageous conditions, typically in underdeveloped regions of the country. This is reflected in their health status, which is worse than that of the non-Roma population, with life expectancy being ten years shorter (Babusik, 2004a). In 2004, a national representative survey of the adult Roma population (over the age of 19) found the frequency of certain diseases to be considerably higher than in the general population: ischaemic heart disease was 1.9 times, asthma 6.6 times, tuberculosis 12.9 times, anaemia with iron deficiency 14.7 times, and partial or complete blindness 15.5 times as prevalent (Babusik, 2004a). According to another report, infant mortality in 2008 was 21.4% in the Roma population of Borsod county, while the national average was only 5.6% (Szabó, Németh & Berkó, 2009). There were similarly bad figures for the Roma population for intrauterine mortality, the rate of premature delivery and the rate of low birth weight, and this trend increased over the past 10 years.

Access to health services by the Roma population is also problematic. Excluding Budapest, 18.6% live in villages without a resident family doctor, which implies a higher workload and less time spent per patient. Moreover, the range of services offered by family doctors as well as the quality of communication are usually worse in cases of Roma patients, although this was also the case for other socially disadvantaged groups. Discrimination against Roma was latent rather than manifest, and socioeconomic and structural factors played a more important role in the unequal access to primary care than prejudice. An interesting finding of the study is that small villages tend to be served by younger family doctors, who have better-equipped surgeries (Babusik, 2004b).

Initiatives to improve the health status and access to care of the Roma population have so far usually come from local governments and civil organizations (for example the Ghandi Secondary school), but there are some promising international projects to be piloted in Hungary (e.g. the Harlem Children's Zone), whose first phase of implementation, the selection of locations for the pilot phase, is already in progress.

6. Principal health reforms

6.1 Analysis of recent reforms

This chapter considers in detail the major reforms and policy interventions that have taken place since the previous HiT profile on Hungary was published in 2004. It sets these within their context and explains their impact on health and health service provision. The chapter considers the major reforms already implemented, as well as those that failed or were passed but never implemented, and provides an overview of future developments. For more details on older reforms and related policies, the chapter refers where appropriate to other sections of the present volume.

In the area of health system governance and organization, the chapter focuses on a third (and ultimately unsuccessful) attempt made to introduce managed competition to the health insurance system; the HISA; capacity regulation; the ownership and management of health care providers; coordination in health care; and intersectorality and public health. In the area of health system financing, the chapter describes important reforms made to revenue collection; the pharmaceutical market; provider payment methods; and user charges. Section 6.2 concludes the chapter by providing a brief outline of future developments.

6.1.1 Reforms of health system governance and organization

Third attempt to introduce managed competition to the health insurance system

Starting in 2006, one of the highest priorities of the government was to introduce managed competition to the SHI system by replacing the NHIFA/HIF with multiple health insurers that would be under partial private ownership. The stated aim of this change was to reduce inequities in the use of health care services, to improve efficiency and to ensure financial sustainability and

transparency (2008/7). This was the third and most elaborate attempt since the early 1990s to introduce a system of multiple, competing health insurers to Hungary. (For details on the two previous attempts, see section 2.2.)

A bill introducing managed competition to the SHI system was approved by the National Assembly in December 2007, but vetoed by the President shortly thereafter. In February 2008 the National Assembly overrode the presidential veto and passed the bill in the face of widespread public protest. At the same time, the main opposition parties initiated a referendum, which was held in March 2008, on user charges for physician visits and hospital stays and on tuition fees in state-funded higher education. By an overwhelming majority of more than 80%, voters approved a measure revoking both measures. In the meantime, the opposition parties had signalled their intention to hold a referendum on the legislation for managed competition in September 2008. Expecting that this would have the same outcome as the referendum held in March of that year, the National Assembly repealed the act in May 2008. This created what is most likely an unprecedented case in the history of the Hungarian lawmaking, with the same parliament approving a law twice and then repealing it within the space of six months. This situation caused the Alliance of Free Democrats to leave the governing coalition, leading to a break-up of the government and the formation of a minority government by the Hungarian Socialist Party.

If the managed competition model had been implemented, the NHIFA/HIF would have been replaced with 22 joint-stock companies. In each company, 49% of the stocks would have been sold to private investors and 51% would have remained in state ownership. The minority private stockholder, however, would have nominated the CEO and had deciding power to influence daily management. It would have been possible for a single investor to have a stake in more than one company, but only if the total number of individuals insured by these companies did not exceed 2 million. Insurers would have been expected to compete for enrolees through the quality of their services, and they were to form joint commissions at the national level to advise the government in purchasing decisions.

Administrative costs would have been limited to 3.5% of the revenue, which is approximately twice the percentage currently incurred by the NHIFA.

The HISA

With the stated aim of increasing accountability and transparency, a plan to establish the HISA was presented in June 2006 (2006/10). Doing so was considered by the government to be a precondition for introducing managed competition to the health insurance system (Government of the Republic of

Hungary, 2006). The HISA was to supervise private and public actors within the health care system, including new entrants to the health insurance market. In this capacity, it was also to oversee and evaluate the outcome of health services delivered by providers and to protect patient rights. No separate discussion paper was presented, and no formal health impact assessments were conducted, however, before the HISA was established and went into operation in January 2007.

After the repeal in 2008 of the bill that would have introduced managed competition to the health insurance system, the new authority did not play any supervisory role with regard to the NHIFA, but rather focused on monitoring waiting lists and the quality of services, as well as on examining patient complaints. In February 2009 the HISA published an activity report, which showed that only 1350 complaints had been submitted to the authority in 2009, which is very low compared to the total number of services provided within the health system. Most complaints were about care provided improperly and in a manner contrary to professional standards, insufficient patient information, and waiting lists. The HISA conducted some useful research to inform the public and policy-makers on quality issues and access to care (HISA, 2009).

Following the elections in April 2010, the new government eliminated the HISA (2010/10) with the stated aim of improving the efficiency of the health system. Some functions of the HISA were preserved by the government and distributed to other actors in the health system, such as the NHIFA and NPHMOS.

Capacity regulation

A stated goal of the governments in power from 2002 to 2010 was to make health care provision more equitable, increase the quality of care and improve the efficiency of health care delivery by adjusting the capacity of providers more precisely to the needs of patients (2006/12). In 2006 the government argued that (a) the structure of the health care delivery system (the ratio of acute, chronic and nursing care capacities) and its relationship with morbidity and mortality patterns were distorted and (b) the geographical distribution of the capacities was unequal, resulting in unfair disparities in access to care.

To address this issue, the government aimed to reshape the system so that treatments for emergencies and common diseases would become accessible in as many places as possible – preferably within the framework of outpatient care – while more serious and costly interventions would be limited to facilities where all necessary conditions were available. A new law to this effect was approved by the National Assembly in the second half of 2006 (2006/12) and

implemented starting in April 2007 (NISHR, 2007). This took place without the government having previously published a discussion paper or special policy paper for wider consideration, and several experts at the time criticized the law for its lack of transparent methodology (Ágoston et al., 2009).

In the wake of this legislation, the total number of acute hospital beds was reduced by 26% (to 44 215), some of which were transformed to increase chronic, rehabilitative and nursing care capacity by 35% (to 27 169) (Vas et al., 2009; NISHR, 2007). Five hospitals were closed down along with the acute-care departments of another twelve hospitals. Moreover, four hospitals were merged in a single state central hospital. The level of the acute care provided by the hospitals was split into categories, such as priority hospitals (39 in total) and territorial hospitals (77 in total) (NISHR, 2007). The priority hospitals, which consisted of a heterogeneous group including large university clinics, county hospitals and small municipal hospitals, accounted at the time for approximately 50% of all hospital beds in Hungary (Vitrai, Kiss & Kriston 2010). They were intended to work with the most advanced technology and with the best-trained physicians and to function as emergency centres providing urgent care around the clock every day of the year. In contrast, the territorial hospitals were intended to provide general acute care. In addition, 50 institutions were allowed to provide only rehabilitative and nursing care (NISHR, 2007), and the new regulation reshaped the catchment areas of all providers as well. The capacities of outpatient care were frozen at the level of 31 December 2006 (Ágoston et al., 2009).

Capacity regulation of the providers had already been reorganized twice since the mid-1990s (see section 2.2). The new regulation (2006/12) returned to the pattern of the capacity regulation legislated in 1996 in two important respects. First, the new system was introduced in both cases along with deep downsizing of the hospital beds. Second, implementing and managing capacity regulation was left to the stakeholders – that is, the county consensus committees after 1996 and the regional health councils after 2006. Furthermore, the decrease in the total number of beds seen in 2006 was 11%, which mirrored the reduction that had taken place in 1996 (Ágoston et al., 2009).

The regional health councils are convened by the NPHMOS and consist of representatives of the most important stakeholders, such as hospitals and the NHIFA. By establishing this mechanism, the government aimed to give more of a role to the stakeholders in monitoring unused capacity and to restructure this capacity through systematic negotiation. The councils are also entrusted with compiling regional health development plans. Unfortunately, the new system

does not have a clear process of health needs assessment, and the councils lack the proper policy capacities and authority (Tóth, 2008). Furthermore, no monitoring process has been put in place to evaluate how far the objectives of this reform have been achieved. Some observers have stated that the government's measures did not lead to a more equal distribution of capacities (Vas et al., 2009). Moreover, the impact of the reform on efficiency has not been analysed. Several projects to evaluate the impact of the reform on quality and on financial protection have been initiated, with the involvement of WHO experts, as part of the Biennial Collaborative Agreement through the WHO Country Office in Hungary. These studies are expected to be completed in the second half of 2011.

Regarding the impact of capacity regulation on the financial sustainability of the system, however, it seems clear that the health system has not been strengthened. Indeed, the system of prospective payment, which has served as the cornerstone of the Hungarian health financing system since 1993 (see subsection *Specialized ambulatory/inpatient care* in section 3.7), had almost collapsed by 2009, and the protest by hospitals against the financial restrictions of the government has intensified greatly. A new lobby organization, the Strategic Alliance for Hungarian Hospitals, was created to increase pressure on the government to improve health system financing. Moreover, Hungarian hospitals initiated a “green flag movement” in 2009 to inform patients of their financial situation and to put pressure on the government to ease the financial restrictions.

Ownership and management of health care providers

With the stated aim of increasing the efficiency of health care providers, the government announced in June 2006 that it would introduce measures to encourage the conversion of providers from public to other forms of ownership that would entail more private involvement (Government of the Republic of Hungary, 2006). The government also pledged that regulations affecting public providers would be modified so that their business operations would more closely resemble those in the more competitive business sector (Government of the Republic of Hungary, 2006). The link between the reform plans and general health objectives, however, was not clarified.

Previous attempts at creating transparent regulations governing the involvement of private providers had failed for a variety of reasons. The government in power from 1998 to 2002 chose to take a corporatist approach, preserving the public hospital system and allowing health care providers more discretion in their allocation of resources. The first law to this effect was crafted

in such a way that it encouraged the corporatization of public providers while restricting their privatization (2001/12). The government that came into power in 2002, however, suspended some of these restrictions (2002/16, 2002/17) and replaced the 2001 law with a new one that gave decision-makers more room to facilitate private investment in the health care system (2003/5, 2003/6). To support changes in the ownership of health care facilities, the government even offered subsidized loans to employee groups that intended to privatize public providers (2003/12) – a clear signal that the government preferred private investors to take a more active role in the health sector. The 2003 law was later annulled by the Constitutional Court, however, as the National Assembly had not devoted enough time to discussing the objections raised by the President of Hungary (2003/23).

Increasing privatization of many health services has actually been taking place since 1990, when dialysis services were privatized, following by diagnostic imaging (CT-MRI) services in 1994 and laboratory services in 1998. This was followed by a second wave of privatizations in the area of hospital background services, such as laundry, meals, energy and accounting. Subsequently, in 2004, a third wave of privatizations, involving the entire management of public providers, began in 2004 with the outsourcing of the management of a public hospital in the city of Kiskunhalas to Hospinvest, a company established in 2000. By the beginning of 2009, there were eight private companies running sixteen health care institutions (including hospitals and outpatient centres) in this manner (NISHR, 2009).

In the second half of 2008, the National Assembly approved a law regulating the legal status and financial management of public institutions, making it possible to corporatize hospitals (2008/8). According to a report published by the NISHR, 36 of the 126 state and local hospitals in Hungary had been transformed before the 2008 law was repealed by the government brought into power in April 2010 (2010/12) (NISHR, 2009).

In 2009, Hospinvest, which by that year was managing five local government hospitals and five outpatient care facilities, filed for bankruptcy and was forced to return the management rights of these facilities to the local governments. The company had played a leading role in the privatization of management in health care facilities owned by local governments and, as a result, its activities had led to intense public and media debate across the country. The European Bank for Reconstruction and Development, which had invested €4 million in 2007 into the company and owned 30% of its assets (NISHR, 2009), had already sold its share in March 2009, just half a year before the bankruptcy of the company

and despite its original plans for five to seven years of business cooperation. At the same time, more and more local governments with similar outsourcing contracts were reported to be lending significant amounts to their health care providers to maintain their operations.

The failure of private companies in running public providers has meant a serious failure of the business model whereby local governments retain ownership of a facility but outsource the provision of services or management to private individuals or companies – otherwise known as “functional privatization” in Hungary. In 2009, the State Audit Office published a study on the outsourcing of hospital services and management, which followed an earlier study on the privatization of secondary and tertiary care health services published in 2006. One of the conclusions of the 2006 report was that a lack of health policy guidance and regulation had resulted in the privatization process being governed by private companies rather than by public authorities (State Audit Office, 2006). The 2009 report confirmed this finding (State Audit Office, 2009b). The role of private capital in the provision and management of services in the Hungarian health care system remains an unsettled policy issue.

Coordination in health care

During the past decade, the most comprehensive measure in the area of health care coordination in Hungary was the CCS, which was launched as a pilot program in 1999 and was in operation until late 2008. The CCS was launched to address the shortcomings of health system monitoring and the various payment systems by employing new financial incentives. The content of the reform, however, was not developed in discussion papers or in a detailed policy proposal, and no specific regulation was prepared. Rather, the National Assembly approved the launch of the CCS by passing a brief amendment to Act XCI of 1998 on the Social Insurance Funds’ Budget of 1999, which was the same law that shifted the responsibility for collecting HIF contributions to the Tax Office.

In essence, the CCS offered health care providers the opportunity to take responsibility for the whole spectrum of care for a population group, initially up to 200 000 people (1998/26). The idea behind the pilot was to provide financial incentives to health care providers to coordinate their activities across levels of care for a population living in a geographically defined area, using the health care utilization data accumulated at the NHIFA.

Although the CCS showed some similarities with managed care in the US and general practitioner fundholding in the UK, it had the following innovative features:

- The care coordinator (that is, a group of family doctors, a polyclinic or a hospital) had no financing/budget-holding responsibilities. Retained at the central level, the financing and payment functions continued to be carried out by the NHIFA.
- The budget-holding function was virtualized. Although care coordinators were assigned a budget on the basis of an adjusted capitation formula, the budget amount was not transferred to the care coordinator's bank account, but rather served only a basis for comparison: if the actual spending on the patients of the population to be cared for was lower than the virtual budget, only the difference (that is, the savings) was transferred to the care coordinator, which could subsequently use the money to remunerate doctors (or other health care providers within the model), or to improve working conditions, etc.
- Family doctors and not individual inhabitants chose whether to join the CCS, minimizing the possibility of risk selection.
- Patients retained the right to choose providers freely and could utilize health care at providers outside the system, but all the payments made to these providers were deducted from the care coordinator's virtual budget. In short, the financial responsibility for all episodes of care of a patient in the population to be cared for lay with the care coordinator. This limited incentives to maximize savings by undertreating patients.
- Incentives to undertreat patients were also limited by the fact that providers within the model still had to generate enough revenue by treating patients to survive month by month till the end of the year, when the income from the savings could be realized.
- The NHIFA provided access for the care coordinators to the health care utilization data of patients in their respective populations to be cared for. This database provided the unique opportunity to analyse practice patterns, protocol compliance, patient pathways at the level of individuals, and to evaluate the impact of interventions implemented by the care coordinator retrospectively.
- The pilot did not change how the system operates. If anything went wrong, the care coordination function could be withdrawn, without any risk of people remaining without adequate care.

By design, the CCS assumed the cooperation of local health care providers, that is, the establishment of a functional network of primary care doctors, outpatient specialist clinics and hospitals. When family doctor groups served

as a care coordinator, the population receiving coordinated care automatically consisted of the people who were registered with the family doctors within the group. When other providers, such as polyclinics or hospitals, served as a care coordinator, they first had to contract with local family doctors to bring their registered patients into the model. Naturally, all three types of care coordinators had to contract with other health care providers in their region in order to realize maximum efficiency improvements. These contracts were based on the sharing of these savings among providers within the model. Importantly, provider networks were formed only within the health care system, as social care was not part of the initiative.

The first wave of the CCS project was launched in July 1999 with nine care coordinator organizations. The largest organization, the Misszió non-profit-making corporation (a polyclinic) based in the city of Veresegyház, covered a population of 240 000 in 2003. The part of the total population of Hungary that could be drawn into the pilot was expanded gradually. By 2005 the project covered more than 20% of the Hungarian population, or some 2.2 million inhabitants, and the system was regulated in detail (2005/12).

After plans were introduced in 2006 to privatize parts of the SHI system and entrust competing private health insurance companies with the care coordination function, the CCS was assigned low priority. Although the privatization plan was ultimately unsuccessful (see subsection *A third attempt to introduce managed competition to the SHI system* in section 6.1.1), the CCS remained a low priority and was eventually eliminated in December 2008 (2008/9). Although ample data were available considering that the CCS had been in operation for 10 years, this decision was not based on the results of a scientific evaluation. Moreover, there was no evidence of worsening health outcomes, of problems with access to care, or of inefficiencies or any malfunctions in general. On the contrary, published assessments of the CCS show that many care coordinators employed a range of case and disease management techniques, none of which were enforced, prescribed or suggested any way by the Ministry of Health¹ or the NHIFA. Rather, the application of these techniques appears to have been motivated by the financial incentives inherent in the system – that is, the ability to take the savings resulting from improved coordination in care and use these to remunerate providers.

¹ As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

Intersectorality and public health

In 2001, a 10-year public health action programme was launched with the aim of increasing the life expectancy of men and women to 70 and 78 years, respectively (2001/9). Coordinated by a project unit within the NPHMOS, the programme was continued and later expanded by the government after 2002. Known as the Johan Béla National Programme for the Decade of Health, it was accepted by the National Assembly in April 2003. Still in effect today, the programme has ambitious targets in four main areas – social environment, lifestyles, avoidable mortality and public health institutions – and focuses on cardiovascular disease, cancer (e.g. national screening programmes in breast, cervical and colorectal cancer), mental health, locomotor diseases, HIV/AIDS and risk factors such as smoking, alcohol, drugs, unhealthy diet and lack of exercise (2003/1). National screening programmes for breast (2002), cervical (2003) and colorectal cancer (still a pilot programme) were introduced within its framework (2003/8). Compared to previous plans, the novelty of the new programme was that it focused on the wider environment and determinants beyond the health sector.

After the National Assembly stressed the importance of intersectoral, multilevel national collaboration, with a particular focus on non-communicable disease, in its resolution on the NPHP (2003/1), the Ministry of Health² set up an Intersectoral Public Health Committee, which was led by the State Secretary of the Ministry in 2003 and 2004, and subsequently by a Government Commissioner (Vokó, 2009). The necessity to incorporate the priorities of the NPHP into policy-making in all sectors was reinforced by the National Assembly once again in 2004 (2004/11).

6.1.2. Reforms of health system financing

The lack of a stable and predictable flow of resources is arguably the most serious shortcoming of the Hungarian health system. The funding of the health system is strongly influenced by policy goals unrelated to health, such as labour and broader economic policy objectives. Moreover, the large deficit of the HIF, especially since 2004, has been a major driver of health system reforms, most of which have focused on cost-containment and on broadening the revenue base of the system.

² As of 2010 called the State Secretariat for Healthcare within the Ministry of National Resources.

Revenue collection

Various government programmes between 2002 and 2010 have focused on establishing a registration and monitoring mechanism to check whether patients had actually paid the necessary HIF contributions and were thus entitled to obtain health care services (Government of the Republic of Hungary, 2006). The system that was ultimately introduced in 2006 is located on site with the providers, who have thus assumed the monitoring function. Importantly, even if they have not paid their HIF contributions, patients cannot be denied necessary care; instead, the patients and the Tax Office are notified about the case for further proceedings (for more details see subsection *Breadth of coverage* in section 3.3.1). Despite problems related to delayed communication between the NHIFA and Tax Office, several reports published by the NHIFA and the State Audit Office show that the share of the population with an unclear registration status has declined to 3% (State Audit Office, 2008a).

In 2005 a new type of hybrid tax/contribution called a “simplified contribution payment” was launched. It applies to individuals and small entrepreneurs working in media or in the arts and earning below a certain income ceiling (2005/6). Instead of paying regular HIF contributions or income tax, the employees and, when applicable, employers in these occupational groups pay a preferential contribution rate (see subsection *General government budget* in section 3.3.2). The stated aim of the measure was to support free debates of public issues in the media and arts, and to promote freedom of artistic activity. The HIF collects 1.8 billion HUF (around €6.5 million) from this source annually, which amounts to about 0.1% of its total expenditure. This measure well characterizes the fragmentation of revenue collection in a system in which the government applies policy measures that have little to do with overall health system goals.

Since 2006, deep cuts in the HIF contribution rate paid by employers have led to a shift towards funding through general taxation, as has a redefinition of the central government contribution to the HIF using a new formula to account for non-contributing social groups (2007/11) (see section 3.3). Whereas in the late 1990s employer contributions accounted for 73.6% of HIF revenue (versus 11.3% for employee contributions), they accounted for only an estimated 16.1% (versus 29.6%) in 2010. Furthermore, the lump-sum component of the hypothecated health care tax was eliminated in 2010. At the same time, the total transfer from the central government budget, including deficit financing, is estimated to be almost five times higher in 2010 than it was in 1997. In short, general taxation has become as important as wage-related contributions as a source of revenue in the Hungarian health care system (see section 3.2).

One of the stated goals of successive governments has been to foster the creation of jobs by deeply reducing the contribution rate of employers. This goal has been pursued since the mid-1990s, but data from the employment database of the HCSO show that the employment ratio for the population between the ages of 15 and 64 years increased only slightly, from 53.6% in 1998 to 56.0% in 2000 and to 56.7% in 2008 (HCSO, 2010c). Although the economic situation in Hungary has been complex in this regard, these data indicate, at the very least, that lowering the employer contribution rate is likely not the panacea it has so frequently been portrayed to be. As this is a particularly expensive policy tool, it would be helpful to elucidate its impact on employment with more evidence.

Pharmaceuticals

In its programme presented in 2006, the government indicated that its chief goal would be to contain expenditure on pharmaceuticals (Government of the Republic of Hungary, 2006). Several new measures were introduced to this effect in 2007, such as inciting competition in the generic market by fine-tuning the reference pricing system (2006/20); using NHIFA-certified IT tools to support and monitor the cost-effectiveness of physician prescribing; imposing a 12% tax on pharmaceutical companies, a 2.5% tax on wholesalers and a solidarity tax on pharmacies based on the reimbursed value of pharmaceuticals; and introducing an annual tax of 5 million HUF (around €19 700) to be paid by pharmaceutical companies for each marketing agent they employ (2006/8). Moreover, as had been done by previous governments, the level of reimbursement for pharmaceuticals paid by the HIF was reduced significantly, that is, user charges were increased (2006/20). Altogether these led to a sharp decrease in public expenditure on pharmaceuticals in real terms.

Also, before 2004 there was no systematic and elaborated process for deciding which services should be included in or excluded from the statutory benefits package and the final decisions were made in a non-transparent way. With accession to the EU in May 2004, the adoption of the Council Directive 89/105/EEC, laying down harmonized provisions to ensure the transparency of measures adopted by national authorities to regulate the pricing and reimbursement of medicinal products, was used to establish the process (2006/8) of HTA. The new appraisal process aimed to strengthen the active purchasing of the NHIFA with proper evaluation of the application of the pharmaceutical companies (see more detail in 2.7.2 and in 3.3.2). This was done successfully, and since then, the usage of HTA was extended for other medical technologies and equipment in 2010 (2010/3).

Provider payment methods

As a part of cost-containment efforts, and in addition to the existing DRG-type system in place in inpatient care and the fee-for-service payment methods used in outpatient care, a limit on the volume of billable services was introduced in 2004. Known in Hungarian as a “performance volume limit” (*teljesítmény volumen korlát*) – “performance” here meaning “output” rather than “outcome” – this artificial limit was calculated as 98% of a hospital’s or outpatient department’s total output in 2003. Until June 2006, a degressive scale was applied for services delivered beyond the limit (see subsection *Specialized ambulatory/inpatient care* in section 3.7.1). After July 2006, the baseline volume was reduced to 95% of the 2003 output total, and the degressive scale was eliminated completely. This meant that when a hospital or outpatient centre provided health care services beyond the ceiling, they did not receive additional reimbursement. Because this led small hospitals to refer their “over the limit” patients to bigger hospitals, this put the large university clinics (university teaching hospitals) at a disadvantage.

This strict limit led to a difficult financial situation for hospitals and forced hospital management to introduce measures, such as increasing the length of waiting lists, to reduce expenditure and the volume of services provided. In April 2009, the government decided to eliminate the aforementioned limit, albeit only for inpatient services and for specialist outpatient services. For these two groups of providers, the previous payment mechanism was replaced with one that combined a predetermined national base rate and a floating fee based on the volume of services provided (see *Specialized ambulatory/inpatient care* in section 3.7.1). This change was likely the main reason that provider payment system almost collapsed in mid-2009. A plan to introduce a predetermined global budget was scrapped after weeks of discussions with representatives of the providers. Instead, the previous system, with its strict limit on the volume of billable services, was reintroduced in October 2009.

Private expenditure on health

Although the government programme presented in 2006 did not mention user charges for the health care services by name, it did declare the intent of the government to determine which services would be excluded from HIF coverage and made available for a fee (Government of the Republic of Hungary, 2006). In the summer of 2006, the government presented, as an alternative option for debate, the introduction of user charges on a wider scale as a way to reduce the magnitude of informal payments in the health system. This alternative was published in a discussion paper along with many other reform options (Ministry of Health, 2006).

Until 2007 the main rationale for using and increasing the level of OOP payments was not so much to increase allocative efficiency in the provision of health care as it was to raise additional revenue for the HIF. In February 2007, the allocative efficiency argument came to fore with the introduction of a flat user charge per outpatient visit and a per diem payment for inpatient care (2006/9). Revenue from these OOP payments amounted to HUF 13.3 billion (around €52.5 million) in 2007, which was the equivalent of about 0.7% of total health expenditure that year (see also section 3.4).

These new measures quickly became a hot button issue, proving to be extremely unpopular even among the government's traditional supporters. The situation was capitalized on by the opposition parties, which organized a national referendum both on this topic and that of tuition fees in state-funded higher education. The outcome of the referendum, which led to the repeal of both measures, is described in more detail in section 6.1.1.

6.2 Future developments

The government in power since April 2010 published its programme entitled *The programme of national cooperation* in May 2010. The programme describes a range of planned policy interventions, including:

- linking capacity planning with health needs assessment to reduce geographical and human resource inequities;
- ceasing the privatization of hospitals;
- decreasing pharmaceutical co-payments and expenditure, facilitated in part through long-term agreements between the government and the pharmaceutical companies;
- increasing overall public spending on health care as a share of GDP;
- refining incentives to increase generic competition;
- restoring the personal ownership of pharmacies;
- maintaining a single health insurance scheme;
- establishing a clearer career path model for health professionals;
- improving the quality assurance system by strengthening the mandate of the NPHMOS in this area. (Government of the Republic of Hungary, 2010).

In October 2010, the Ministry of National Resources published a discussion plan to assist in the preparation of a government decree containing a detailed strategy for the health care system. This plan consists of a list of actions and general objectives for the health care system, albeit without establishing direct links between the two. The plan includes policy interventions such as:

- setting up a public care coordination system;
- allowing privatization only in the case of outpatient providers and family doctors;
- improving quality assurance by establishing an accreditation system for the providers;
- easing the restrictive system of volume limits used in the payment of providers;
- reducing hospital debt;
- developing eHealth comprehensively;
- implementing technical improvements in payment methods;
- refining emergency care. (Ministry of National Resources, 2010).

In sum, the current government seems to be returning to the health policy pattern of the governments in power between 1990 and 1994 and between 1998 and 2002, focusing on ensuring strong public influence in the governance and in the organization of the health care, while the payment methods are to be improved through incremental technical upscaling of innovations. However, it is not clear from the current policy papers how the government wants to address the serious problems of resource collection, which is the main cause of the long-lasting crisis of the Hungarian health care system.

7. Assessment of the health system

7.1 Stated objectives of the health system

In Hungary, the objectives of the health system are either set explicitly in the various laws, regulations and policy documents, or implicitly by the actions taken by the government. In the latter case, the objectives are not written down or declared openly, but can be inferred from actual policy measures. In general, there seems to be an unspoken consensus among the main political parties regarding the most important, core objectives of the health system, at least on a political statement level. In contrast, there has been much debate, even within political parties, on how these objectives should be interpreted and consequently put into practice and little political commitment for their operationalization. Naturally, the priority attached to the objectives has also changed with election cycles, and minority positions also appear in policy debates from time to time, occasionally occupying the political action space as a result of the power relationships in coalition governments.

Various laws and regulations, as well as rulings of the Constitutional Court have dealt with these issues. As far as the codified policy objectives are concerned, the starting point has always been the constitution of the Republic of Hungary¹. The constitution defines health as a right of Hungarian citizens. Article 70/D of the constitution declares that:

- 1) People living within the territory of the Republic of Hungary have the right to the highest possible level of physical and mental health *and that*:
- 2) The Republic of Hungary implements this right through arrangements for labour safety, with health institutions and medical care, through ensuring the possibility for regular physical training, and through the protection of the man-made and natural environment.

¹ A new constitution was approved by the National Assembly in April 2011. It is to come into effect on 1 January 2012.

Throughout various legislative periods, government reform initiatives have often been challenged by opposition parties on the basis of these provisions. For instance, any measures aiming at curtailing the benefits package could have been challenged at the Constitutional Court on the basis that they violated the “right to the highest possible level of physical and mental health”. In Ruling No. 56/1995, the Constitutional Court stated that the right to health had to be interpreted within the confines of the performance of the economy, but also that the benefits package could not be curtailed infinitely without violating a number of constitutional rights and principles. The ruling also called for the government to introduce new laws on social insurance, which were eventually enacted in 1997. Since then, these pieces of legislation have been the most important documents providing the legal basis for the objectives of the Hungarian health care system.

The main health policy objectives defined in Act CLIV of 1997 on Health and related later regulation are briefly discussed below. More detail on the specifications of the legal acts is provided in the annexed list of laws and regulations.

Protection and promotion of patient rights

Act CLIV of 1997 on Health interprets the constitutional right to health by defining the content of the right to health services. It differentiates between health services all citizens are entitled to without restriction (entitlement based on citizenship) and those provided based on SHI status or private contracts. According to the Act, the right to health services is unconditional only for emergency life-saving services, services that prevent serious or permanent health damage, and services that reduce pain and suffering. The essence of all rights stated in the Act is that patients’ freedom to make decisions about their health care must not be restricted unless it interferes with others’ rights, and that health care providers are obliged to facilitate this process. Several pathways are in place for patients and their relatives to voice their complaints concerning the care provided. Cases can be taken to court or settled per arbitration (1997/20, 2000/9) and all providers must have an internal system, which handles patient complaints. Act CLIV also established the institution of the patient rights representative (see also sections 2.9.3 and 7.3.1). Other more or less local complaint pathways range from the hospital supervisory council and ethical committee on the provider level to the State Secretariat for Healthcare and the ombudsmen on the national level (see also section 2.9.4). Act CXVI of 2006 assigned the investigation of complaints submitted directly by the users

of health services to the HISA, which thus played an important role in patient protection until it was abolished in August 2010. Its functions were distributed between the State Secretariat for Healthcare, the NPHMOS and the NHIFA.

Equal access for equal need

Equity is also a defining objective in Act CLIV of 1997, with roots in the preceding, Semashko-style health care system – where access to care was not to depend on one's ability to pay – and has remained unaltered throughout successive government reforms. Act LXXXIII of 1997 on the Services of Statutory Health Insurance and related lower-level regulations further clarify the practical implementation of the equity objective (see also annexed list of laws and regulations in the Annex (section 9.1). as well as sections 3.3.1 and 3.4). Within the legal framework of the statutory health insurance system, each patient is supposed to receive the same standard of care as far as clinical quality is concerned (see also section 3.3.1). Legal coverage, however, does not say much about effective coverage, that is, actual access to services of the publicly funded benefit package. The introduction of the DRG system (HDGs) in 1993 made visible the uneven development of specialties and the geographical disparities in access to care. The implementation of the new payment system rectified some distortions of resource allocation, as did the two waves of downsizing of the excess capacity in acute inpatient care (see also section 4.1.2). The introduction of the CCS in 1998 made the significance of the problem of unmet need more obvious (see also section 7.5.2). Another obstacle to achieving this objective is the long-standing, deep-rooted practice of informal payments, which endorse inequity in more ways than one (see sections 7.2.1, 7.2.2 and 3.4.3). Since autumn 2008, access to care has been further compromised by the consequences of the global financing crisis and the serious budget cuts in health care, coupled with a rapidly accelerating health workforce migration (see also section 7.3.2).

Evidence-based provision of services

Act CLIV of 1997 on Health declares that health care should be provided according to evidence-based guidelines, protocols or, in the absence of these, published and widely accepted professional requirements (1997/20). Moreover, Act LXXXIII of 1997 on the Services of Compulsory Health Insurance explicitly excludes from the benefit package health services whose effectiveness has not been established on the basis of evidence. As a general rule, the insured are entitled to services according to guidelines and protocols issued by the State Secretariat for Healthcare. However, the Act does allow medical doctors to

deviate from their provisions in order to ensure the best medical outcome for individual patients. Several measures have been implemented endorsing quality control and improvement in Hungary (see section 7.4.2).

Efficient provision of services

Several measures have been taken over time to improve service provision and increase the efficiency of the system. Although the overall public expenditure on health seems to have been contained successfully, this does not necessarily mean that resource allocation has been efficient within the health sector (see section 7.5.1). Improving technical (production) efficiency has been strived for over almost two decades: introducing HDGs in 1993 was seen as a means to increase productivity and efficiency and promote cost-consciousness among hospital management. Several mechanisms to prevent the abuse of the system and ensure quality of care for patients are also in place and technical efficiency seems to have increased over the past few years (see section 7.5.2).

Cost-containment

Even though it cannot be classified as an objective of the health system per se, one of the most important policy goals over the past 20 years has been the containment of health expenditures. The actions of successive governments and resulting health care budget cuts leave no doubt that these have been under tight central control: between 1990 and 2000, health expenditures dropped by nearly 30% in real terms (see also section 3.1). Given that the government is obliged to cover the deficit of the HIF, rising health expenditures have increasingly been seen as a potential threat to fiscal balance (see section 3.3.2). While the overall cost-containment policy was successfully implemented, no explicit priorities were set for the use of resources within this reduced budget. Further, not enough attention has been paid to the potential negative impact of these measures on population health status and the quality, accessibility and long-term sustainability of health care.

7.2 Financial protection and equity in financing

7.2.1 Financial protection

The magnitude of private expenditure on health in Hungary – most of which is attributable to OOP spending – is still unclear, not least because of divergent estimates on the extent of informal payments (see section 3.4.3 as well as section 3.1). OECD data indicate that after an increase from about 11% in 1991 to a peak of 31% in 2001, private expenditure as a share of total expenditure on

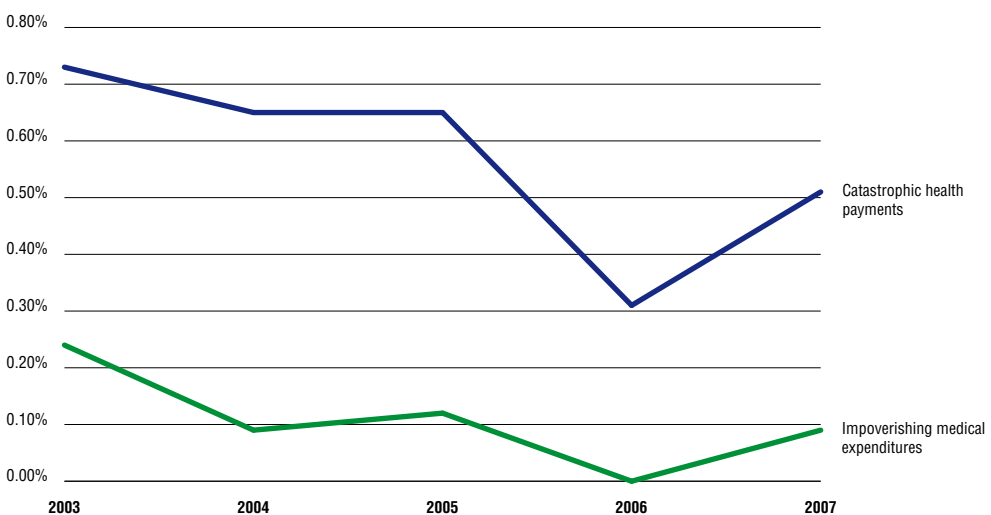
health has hovered between 27% and 30%. The figure for 2008 was 29%, which puts Hungary in second place within the EU – just below the Slovak Republic (30%), slightly above Poland (28%), and considerably higher than the Czech Republic (18%) (OECD, 2010). A breakdown of OOP spending in Hungary can be found in section 3.4.

Despite these numbers, according to a recent WHO study on financial protection, less than 1% of Hungarian households experienced catastrophic² (0.31–0.73%) or impoverishing (0.003–0.24%) health expenditure between 2003 and 2007, and the poverty gap was small. This means that some 11 000–28 000 households in Hungary experienced catastrophic expenditure, and 3400–9000 households experienced impoverishing health expenditure during this period, with a poverty gap of HUF 1–2 billion (€3.95–7.9 million) (Gaál, 2009).

Looking at these indicators over time shows that between 2003 and 2006, there was a decrease in the percentage of catastrophic and impoverishing health expenditure, followed by a notable increase in 2007 (Fig. 7.1). This increase coincides temporally with the introduction of several health policy measures, including user fees in ambulatory and inpatient care (see section 3.4) and an increase in and restructuring of cost-sharing for pharmaceuticals (2006/8).

Fig. 7.1

Percentage of households in Hungary experiencing catastrophic or impoverishing health expenditure, 2003–2007



Source: Gaál, 2009.

² In this study, household expenditure on health was considered catastrophic when it exceeded 40% of the household's disposable income.

An important disadvantage of indicators such as catastrophic and impoverishing health expenditure is that they cannot capture the whole impact OOP spending has on the poor. For example, low-income households might not experience catastrophic health expenditure during a particular study period because they delay or forgo health care precisely due to the deterrent effect of high OOP payments.

Even though user charges introduced in February 2007 (and eliminated in April 2008) involved the seemingly negligible amount of HUF 300 (or about €1.20) per outpatient visit and per hospital day, their deterrent effect on the poor was indeed unexpectedly large. According to a survey carried out in April 2007, 15% of respondents said that had not visited a physician because of the co-payments. Among people who had completed only their primary education, this figure was as high as 25%, whereas it was 10% among those with a higher degree of educational attainment. Similar differences were observed among different income groups (GfK Hungaria, 2007).

These user charges were also expected to tackle the issue of informal payments (see section 3.4). However, according to another survey, 30% of participating physicians reported that the introduction of co-payments diminished informal payments by an average of 14%, whereas 47% did not notice any change and 1% observed an increase. Only 6.6% of patients said that they had not made any informal payments, or paid less since the introduction of user charges (Szinapszis Kft, 2007). A different study estimated a decrease of 25% in informal payments overall (Medián, 2008). Finally, expenditure on informal payments and the newly introduced co-payments combined increased by over 20% in nominal terms in 2007. This suggests that the overall burden on patients increased, compromising financial protection, equity in financing and access to care.

7.2.2 Equity in financing

When evaluating equity in financing in the Hungarian health care system, it is essential to distinguish between theory and practice. By design, the sources of health care financing in Hungary are predominantly public and thus theoretically closer to the middle of the regressivity–progressivity spectrum. Although no longer subject to a ceiling, HIF contributions remain mildly regressive because (a) they are levied only on gross wages (and not on capital income) and (b) there is a minimum contribution base. The hypothecated health care tax, however, is more difficult to place on the regressivity–progressivity spectrum. Whereas the lump-sum component, in place until January 2010, was clearly regressive,

In practice, it is essential to take into account the ability and willingness of members of society to pay taxes and contributions. Avoidance and evasion have been a persistent problem in Hungary, especially in the health care system. Combined, unpaid health and pension insurance contributions peaked at 4.3% of GDP in 1994, but still amounted to almost 1% of GDP in 2008, out of which 40% was HIF-related payment arrears and claims (NHIFA, 2008, 2009b). In the past, the high rate of social insurance contributions in Hungary likely contributed to late payments, non-payment and under-reporting of income. Arguing that high contribution rates also have an adverse impact on (formal) employment and the competitiveness of the Hungarian economy, successive governments have attempted to address the problem by cross-checking patients' insurance status (see section 3.3.1), lowering contribution rates, widening the contribution base and introducing other forms of revenue that are less prone to evasion (see section 3.3.2). According to government estimates, the first measure identified 150 000 free-riders, increasing revenues from this source by almost 70% between 2007 and 2008 (i.e. an additional HUF 1.75 billion or €6.9 million). The reduction of the employer contribution rate, on the other hand, decreased HIF revenues without successfully boosting employment (see section 3.3.2) (NHIFA 2009b).

Changes have also been implemented to shift some of the burden from the public to the private purse, whether through increased OOP payments (see also section 3.1) or by encouraging voluntary complementary health insurance. Initially, the voluntary health insurance scheme introduced in 1993 was non-profit, with community rating and no risk-adjustment prior to participation (1993/10). The risk-sharing component was decreased to 40% of the insurance premium in 1996 and was eventually eliminated in 2003, whereupon the entire scheme was transformed to a system of MSAs, which is a more regressive form of private financing (see also section 3.5.1).

The overall impact of related reforms over the past 20 years is difficult to assess, as the success of different measures varies greatly. A study published in 2002 used the Kakwani index,³ a summary indicator of equity in financing widely used in international literature, and estimated the total financing burden of the Hungarian health care system as mildly regressive (-0.0211), with overall public sources being mildly progressive (0.0260) and private sources regressive (-0.2745) (Szende et al., 2002). Unfortunately, there is no recent evidence on this issue, except for private expenditure, which was found to be slightly less regressive in 2007 (-0.2726) than in 1999 (Csaba, 2007).

³ The Kakwani index combines population income distribution with concentration of the burden of various health financing revenue sources. It does not take into account the potential level of tax and contribution evasion.

7.3 User experience and equity of access to health care

7.3.1 User experience

Patient empowerment and participation in the treatment process and in the governance of the health care system is comprehensively regulated by Act CLIV of 1997 on Health (see section 2.9). As mentioned in section 7.1, there are several mechanisms in place for the implementation and protection of patient rights as well as for the expression of dissatisfaction with services. How well these ensure the responsiveness of the system has been addressed by several European and international studies.

A study comparing the responsiveness of health care systems to users' non-medical expectations of health services in Slovakia, the Czech Republic, Slovenia, Croatia and Hungary found that 0.7% of all respondents felt that their health care needs were not met when seeking health care, with Hungary ranking last among the five countries. Hungary scored about average in terms of medicine availability, but ranked last regarding discrimination, treatment inadequacy and involvement in health-related decision-making. Only 15% of Hungarian respondents gave a rating of "good" or "very good" as opposed to 44% in Croatia and 29% overall. Furthermore, only 33.7% were satisfied or very satisfied with how the health care system was run (here Slovakia was the only one with a lower rating). Beside the overall evaluation of the health system, respondents rated their experiences in eight domains (seven in outpatient care) of responsiveness on a five-item scale. The average composite level of health system responsiveness in the study was 68% and Hungary's score of 71% was second only to that of the Czech Republic (Vitrai, 2007). The results are presented in detail in Table 7.2.

An interesting overall finding was the discrepancy between the general health care system ratings and those based on actual experience of utilization: patients anticipated worse performance than they eventually received. This suggests a general distrust (loss of social capital), which also plays a definite role in the persistence of informal payments (Gaál et al., 2006) (see also section 3.4.3).

Table 7.2

Comparison of responsiveness (%) in inpatient and outpatient care in Hungary and selected countries, 2002

Domain	Croatia	Czech Republic	Hungary	Slovakia	Slovenia	Average across countries
<i>Inpatient care (overall)</i>	50.9	76.3	68.3	68.7	68.9	66.9
prompt attention	42.5	73.8	45.0	70.7	61.0	57.8
dignity	64.3	82.2	79.2	79.7	79.3	77.2
communication	55.6	72.6	74.8	79.7	70.9	71.8
autonomy	31.6	56.7	62.8	56.4	57.1	53.9
confidentiality	54.0	77.6	69.9	74.0	74.6	70.0
choice of provider	54.3	78.7	64.2	60.6	60.4	63.5
quality of basic amenities	43.8	79.5	57.2	58.9	66.2	60.1
social support	61.0	87.4	92.8	70.9	80.8	79.6
<i>Outpatient care (overall)</i>	62.6	79.1	74.0	66.0	71.5	69.7
prompt attention	45.1	66.4	33.2	46.8	49.6	47.8
dignity	76.5	90.6	89.5	82.7	82.8	84.2
communication	77.1	85.3	86.7	76.0	77.2	79.9
autonomy	47.9	65.4	75.2	49.6	64.1	58.1
confidentiality	70.5	80.9	83.2	74.3	75.1	75.9
choice of provider	63.9	85.0	83.2	74.3	75.1	75.9
quality of basic amenities	57.4	80.1	69.1	54.9	65.7	63.5

Source: Vitrai, 2007.

A *Eurobarometer* survey addressing perceptions on patient safety and quality of care in 2009 seems to confirm the dissatisfaction of Hungarian citizens with the health system in general. According to the survey, 22% of Hungarian respondents perceived the quality of care as very bad and an additional 50% as bad. As a result, Hungary ranked 26th among the 27 Member States of the EU, surpassing only Greece. Accordingly, 67% of Hungarian respondents considered quality of care in Hungary worse than in other EU Member States, while only 2% believed it to be better (European Opinion Research Group, 2010).

According to a report on 10 years of patient rights representative activity, the number of patient complaints increased from 6750 in 2000 to 11 297 in 2009 (Foundation for the Rights of Patients, 2010). In 2009, patient rights representatives covered 144 inpatient care providers and 28 polyclinics with regular office hours. Of patient rights complaints, 42% were related to hospital care, 25.2% to outpatient specialist care and 15.8% to primary care (a notable increase from 11.0% in 2008). As in previous years, violation of the right to health care was the most common complaint with 37%. According to the annual report of the Parliamentary Commissioner for Civil Rights, overall 9.6% of

all complaints were related to health care, pension and labour issues, while the constitutional right to health was violated in 3.5% of all cases investigated in 2009. Most problems were related to access to care and the respect of patient rights, which stemmed mainly from the financing restrictions and structural changes of recent health care reforms (Office of the Parliamentary Commissioner, 2010: 15–17).

The confidentiality of personal medical information is protected by a separate law and a parliamentary commissioner is dedicated to this task. The main principle underlying the protection of personal medical data is that identifying personal information can only be used by designated organizations and persons for purposes stipulated in related regulation. Any use of personal data beyond these is permitted only with written consent of the individuals concerned (1997/3).

7.3.2 Equity of access to health care

In principle, the Hungarian health care system provides universal and comprehensive coverage with the same benefits for the entire population. In practice, however, large variations exist in service delivery, both geographically and by specialization. This phenomenon is partially due to the legacy of the communist era, with which governments of the past 20 years have struggled, and which has been evolving since. Currently, unequal access spans several types of services, such as emergency care, family doctors in rural areas, certain interventions with waiting lists, etc. (compare section 7.5.2) and can be influenced by several health determinants (e.g. for socioeconomic status see section 7.2.1). It is neither extensively researched nor particularly well documented.

A recent survey comparing the health of people living in Roma settlements to that of the general population in Hungary found that minority status may play an important role in access to health services. Compared to the general population, Roma were less likely to use health services, especially those offered by specialists and dentists. No differences were found, however, in the share of individuals with one hospital stay during the previous year. Despite the presence of a universal breast cancer screening programme in Hungary, only 25% of Roma women between the ages of 45 and 64 years who took part in the survey indicated that they had undergone mammography within the previous two years. The corresponding figure in the general population was 70%. Finally, the survey indicated that the use of health services by Roma

individuals was similar to that seen in the lowest income quartile of the general population (Kósa et al., 2007) (see also sections 5.14 and 7.4.3 for equity of health outcomes).

Structural reforms to reorganize care capacities and payment reforms to decrease inequities in access to care and to tackle informal payments to achieve a more efficient and more equitable service delivery system remain on the policy agenda and are among the most difficult challenges that policy-makers face today.

7.4 Health outcomes, health service outcomes and quality of care

7.4.1 Population health

When looking at population health trends, it is usually difficult to discern the extent to which health care and, in consequence, the health care system, contributes to change. In Hungary, however, the clear change of regime in 1989 brought about the introduction of a new health system, which has been evolving ever since. This change was coupled, at least chronologically, with a change in population health status: life expectancy decreased for men and plateaued for women until the mid-1990s, a phenomenon unique in central Europe at the time (see section 1.4). Since the mid-1990s, however, Hungary has seen a strong and steady increase in life expectancy at birth among men and women alike (see Table 1.3). Half of this increase has been attributed to a decrease in cardiovascular mortality over the same period. Other mortality indicators, however, have continued to increase and Hungary still trails behind the EU and regional averages regarding life expectancy (see section 1.4).

The main causes of death in Hungary are diseases of the circulatory system, malignant neoplasms, diseases of the digestive system (including liver disease) and external causes (including suicide). Communicable diseases play a subordinate role, with the incidence and mortality rates for most childhood infectious diseases continuing to be lower than the EU12 average (WHO Regional Office for Europe, 2011) (for trends over time see Table 1.4). Lifestyle factors – especially the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – play an important role in shaping the overall health of the population.

One of the concepts for assessing health system performance is that of avoidable mortality.⁴ A recent study shows that Hungary's avoidable mortality rate ranked very high among OECD countries in 2005, both overall and disaggregated by gender. Even though this was not the case for all individual causes of disease (Hungary had a relatively low rate of avoidable mortality for infectious diseases), the rate for non-transmittable diseases was among the highest. Between 1997 and 2005 there was a relatively low decline in overall avoidable mortality rates and, in conjunction with the fact that the rate itself remained high, the conclusion could be drawn that more progress could be achieved within the health system (Gay et al., 2011).

At present, the only compulsory screening programmes in Hungary are those for infants and children, including screening for congenital disorders and examinations of the sensory organs and blood pressure on an annual basis (1997/17). Even though screening programmes for both breast and cervical cancer have been in place since 2002 and 2003, respectively, participation remains low and there is no recent assessment of the programmes' impact.

The EU-SILC survey regularly assesses the self-reported health status of the population in the EU. In 2008, 19.2% of respondents in Hungary reported that their health status was "bad" or "very bad", compared to 9.5% in the EU27 as a whole. Conversely, the share of respondents reporting that their health status was "good" or "very good" was 55.2% in Hungary versus 68% in the EU27 (see also section 1.4) (European Commission, 2011).

7.4.2 Health service outcomes and quality of care

Despite the fact that Hungary has a relatively low life expectancy at birth and a considerably high avoidable mortality rate (see section 7.4.1), there are quality measures that paint a more positive picture. For example, the vaccination system is well organized and serves the public health needs of the population. Among children, measles immunization coverage was 99.8%, in 2009, which is an outstanding result among all OECD countries and also in the WHO European Region. Coverage for immunization against diphtheria, pertussis and tetanus is equally high (WHO Regional Office for Europe, 2011).

Several measures have been implemented endorsing quality control and improvement, such as the formulation of registration and licensing regulations; the definition of minimum standards for the provision of various health services; the establishment of internal and external quality-control systems for health

⁴ The term "avoidable mortality" is used throughout this review to designate deaths caused by conditions considered treatable or preventable by health care services. This concept has been variably described as "avoidable", "amenable", "treatable" or "preventable" mortality. For a terminological discussion see, for example, Nolte and McKee (2004) and Gay et al. (2011).

care providers; the introduction of HTA for the inclusion of new technologies in the benefit package; the update of clinical guidelines and protocols; the establishment of the professional supervisory system of the NPHMOS by means of the National Centre for Healthcare Audit and Inspection in 2005; the quality indicator initiative of the NHIFA and the introduction of the system of indicators of the HISA. However, there are still substantial variations in clinical practice and outcome indicators (Belicza, 2004), and little has been published on the direct impact of various measures on service provision. The refurbishment of existing polyclinics under the Regional Operative Programmes, and the building of new polyclinics under the Social Infrastructure Operative Programmes of the New Hungary Development Programme, financed by EU structural funds (2006/6). In the former, day care was optional, while in the latter it was a compulsory component. Both the introduction of the new payment system in 1993 and the incentivization of day care (see section 5.4.1) also aimed at improved care and fewer unnecessary hospitalizations. In addition, the CCS revealed some interesting areas of potential progress before it was eliminated in 2008 (see section 7.5 for more information).

A survey carried out at 102 Hungarian hospitals in 2005 found that even though all participating hospitals reported the utilization of quality management systems, patient safety activities were not as widely implemented (even if committed to in theory). The study concludes that separate, additional policies are called for in order to improve patient safety in Hungary (Makai et al., 2009). Regarding quality control, the government in power since April 2010 published a programme entitled *The programme of national cooperation* (see section 6.2), which also aims at improving the quality assurance system by strengthening the mandate of the NPHMOS.

7.4.3 Equity of outcomes

According to a recent study analysing geographical disparities in health status based on individual mortality data at the micro-regional level, all-cause mortality differed by 215% between the worst and best micro-regions: 56% was attributable to the age and gender composition of the population, 8% to the level of education and economic activity of individual inhabitants and 8% by the social and economic status of the micro-region.⁵ The remaining difference disappeared when micro-regions were grouped based on level of disadvantage and development as well as the proportion of Roma population (Kaposvari & Vitrai, 2008) (see also section 7.3.2 and 5.14).

⁵ The significance of these factors may be different if the analysis is made on a societal and not on a micro-regional level.

Large segments of the Roma population in Hungary live under disadvantageous conditions, typically in underdeveloped regions of the country. This is reflected in their health status, which is worse than that of the non-Roma population, with life expectancy being 10 years shorter. The frequency of certain diseases is also considerably higher among the adult Roma population (over the age of 19) than in the general population (Babusik, 2004a). Vokó et al. (2009) found, however, that socioeconomic status is a strong determinant of health of people living in Roma settlements in Hungary and thus ethnicity per se may not be the only explanation.

7.5 Health system efficiency

Payment reforms are one of the health care reform success stories in Hungary. First, the output-based payment methods substantially improved the technical (production) efficiency of the system and potentially paved the way for a direct increase in allocative efficiency by enabling the allocation of more financial resources to previously underfunded high-need regions. Second, the reforms were implemented over a long period of time, extending over election cycles, that is, there was a political (albeit unspoken) consensus making the reforms feasible. Third, as a by-product, the information system built around these payment reforms has made the system more transparent and accountable (e.g. quality indicators could be constructed from the reported performance data and compared across providers). Finally, Hungary was one of the first countries in Europe to introduce a DRG-based system for the payment of acute inpatient care, which is now the dominant payment technique all over Europe. As will be discussed in the following section, however, allocative efficiency in the health care system is still problematic, and these problems cannot be addressed by adjusting the payment system alone.

7.5.1 Allocative efficiency

As far as resource allocation among the various sectors of the economy is concerned, current overall public spending on health care in Hungary is low, both in comparison with neighbouring countries at a similar level of economic development and with historical spending. According to a study carried out by the Hungarian National Bank in 2007, net public expenditure on health as a share of GDP was 2.1 percentage points less than the average of the other three Visegrád countries (P. Kiss & Szemere, 2009), while Hungary was spending

more on general public services, economic activities and especially social protection. In other areas, such as education and defence, public spending was close to the averages of Slovakia, Czech Republic and Poland.

This study made considerable adjustments to absolute expenditure numbers in order to render them as comparable as possible. Therefore figures may differ from other data sources used in this review (such as the OECD Health Data) where such adjustments are not implemented.

Moreover, HIF expenditure on curative and preventive services was almost 25% (225 billion HUF, or 0.9% of GDP) less in real terms in 2009 than in 1990, although this comparison does not account for technological developments in the past 20 years (authors' calculations based on HCSO, 2010f). Accordingly, OECD data shows a substantial drop in public expenditure on health, which fell from 7.1% of GDP in 1994 to 5.2% in 2009, moving in the opposite direction to the trend in many other European countries (see section 3.1).

All of this suggests that the policies of successive governments to contain public expenditure on health have been implemented effectively. However, cost-containment in itself does not ensure efficient resource allocation within the health sector. It is difficult to assess inefficiency resulting from the misallocation of resources among various levels of care and service areas from aggregate spending data, but the structure of HIF expenditure could be used as a crude proxy. The allocation of financial resources has not changed significantly since 1994: there was a small drop in the share of inpatient care and a slight increase in the share of outpatient specialist care around the 2007 structural reforms, but these changes have remained within a range of five percentage points, without showing any clear or sustained trend that might be interpreted as a sign of the purposeful reallocation of resources among levels of care (see also section 3.1 and Table 3.2).

In contrast, spending in the pharmaceutical sub-budget of the HIF has shown a general upward trend since 1993. It has peaked twice, in 1998 and 2006, spurring government efforts to contain pharmaceutical expenditure. The strict cost-containment measures introduced in 2007 have yielded concrete and measurable results in decreasing the overspending of the pharmaceutical sub-budget of the HIF, although this was mainly achieved by increasing patient cost-sharing (2006/8) (see also section 3.3.3).

7.5.2 Technical (production) efficiency

During the communist era, hospitals received line-item budgets based on historical spending, which has long been associated with inefficiency and low-quality services. In Hungary, however, the influence of politics on the budget negotiation process also led to large geographical disparities and an uneven development of the various specialties. Introducing DRGs (HDGs) for hospital payment was seen as a way to address these problems by providing incentives to increase productivity and efficiency, promote cost-consciousness among hospital management and somewhat reduce regional differences in service provision (see subsection *Specialized ambulatory/inpatient care* in section 3.7.1). Initially, however, the extent of geographical disparities already in place was mirrored in the HDG production cost (Table 7.3).

Table 7.3

HDG base rate (per standard case), 1993

	HUF	Deviation from average (mean = 100%)	Difference between min-max & E-W
Medical universities average*	30 900	100.0%	
minimum	26 320	85.2%	
maximum	52 680	170.5%	200.2%
County hospitals average	29 210	100.0%	
minimum	20 860	71.4%	
maximum	38 990	133.5%	186.9%
County hospitals – East Hungary average	26 450	90.6%	
County hospitals – West Hungary average	29 980	102.6%	113.3%
Municipal hospitals average	25 200	100.0%	
minimum	17 000	67.5%	
maximum	40 380	160.2%	237.5%
Municipal hospitals – East Hungary average	23 820	94.5%	
Municipal hospitals – West Hungary average	25 980	103.1%	109.1%

Source: Gyogyinfok data, personal communication.

To analyse the impact of the HDG payment system on technical efficiency, it is helpful to look at a range of performance indicators from 1990 to 2008 (Table 7.4). However, the two most readily available indicators of technical efficiency – bed occupancy rate and average length of stay – are not very useful in this case.⁶

⁶ Bed occupancy rate depends on the number of beds, which alone is only loosely correlated with actual costs of care. The same is true for average length of stay: the association between the number of hospital days and cost of care is not linear, with the bulk of the costs being concentrated in the first couple of days of inpatient care (Carey, 2000).

Production efficiency requires the comparison of the total cost of inputs (expressed in terms of money) with the quantity and quality of outputs produced by the hospital using these inputs, and the efficiency measure is the cost per unit of output produced. For the inputs, a better overview is provided by HIF expenditure on acute inpatient care (Fig. 7.2) than by patient-days. HIF expenditure on acute inpatient care decreased by 16% in real terms between 1994 and 1997, stagnated between 1998 and 2001, and then began to rise again in 2002 and 2003 as a result of increased public spending (e.g. the 50% pay rise of health workers; see also section 3.7.2). This was followed by another period of stagnation and then a drop in 2007. In 2008, HIF spending on acute inpatient care was virtually the same as in 1994.

As for the outputs, the number of hospital discharges is one option for assessment. Between 1994 and 2005, all hospital discharges increased by 20%; the 11% drop in 2007 is attributable to the introduction of the strict limit placed on the volume of billable services (Fig. 7.3).

Table 7.4
Selected performance indicators, 1989–2008 (selected years)

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Population ('000)	10 421	10 375	10 373	10 374	10 365	10 350	10 337	10 321	10 301	10 280	10 253	10 222	10 200	10 175	10 142	10 117	10 098	10 077	10 066	10 045
Number of approved hospital beds per 1 000 population*	10.03	10.09	9.96	9.74	9.99	9.77	9.01	9.01	8.16	8.19	8.24	8.24	7.94	7.95	7.90	7.91	7.94	7.96	7.20	7.11
Number of acute hospital beds per 1 000 population*	7.06	7.12	7.06	6.92	-	7.10	6.27	6.24	5.68	5.73	5.64	5.64	6.05	6.03	5.98	5.97	5.97	5.94	4.45	4.42
Number of chronic hospital beds per 1 000 population*	2.97	2.97	2.90	2.82	-	2.67	2.74	2.77	2.49	2.46	2.60	2.61	1.89	1.92	1.92	1.94	1.97	2.02	2.75	2.69
Number of hospital beds in operation per 1 000 population*	9.76	9.83	9.71	9.50	9.69	9.44	8.96	8.87	8.10	8.15	8.19	8.16	7.89	7.90	7.77	7.87	7.88	7.92	7.14	7.07
Number of discharged patients ('000)	2 277	2 258	2 279	2 272	2 280	2 335	2 387	2 467	2 482	2 530	2 556	2 610	2 655	2 708	2 749	2 777	2 800	2 716	2 423	2 508
Number of hospital cases per 1 000 inhabitants	219	218	220	220	221	227	233	242	244	250	253	256	261	267	271	275	278	270	241	250
Average length of stay acute care (days)	9.9	9.9	9.7	9.5	9.5	9.0	8.6	8.0	7.6	7.3	7.0	6.7	7.0	6.9	6.7	6.5	6.3	6.1	5.6	5.5
Average length of stay chronic care (days)	32.4	32.2	31.9	30.1	-	27.1	26.9	26	24	23.4	22.3	22.2	31.3	30.5	31.4	31.5	31.8	32.2	27	27.4
Bed occupancy acute care (%)	75.9	74.9	74.0	73.6	67.6	71.6	71.9	74.4	77.8	75.8	73.5	72.5	76.9	77.8	77.2	76.6	75.7	70.3	69.2	75.3
Bed occupancy chronic care (%)	86.7	84.6	84.8	83.2	-	80.9	80.6	81.3	86.2	86.2	84.8	85.0	87.3	86.3	86.5	87.2	87	85.9	75.5	80.9
Sum of HDG cost weights / points ('000)	-	-	-	-	-	2 078	2 279	2 449	2 271	2 478	2 271	2 408	2 264	2 582	2 702	2 594	2 691	2 609	2 285	2 406
CMI (case-mix-index)	-	-	-	-	-	1 027	1 070	1 110	1 085	1 153	1 060	1 096	1 013	1 077	1 135	1 084	1 107	1 109	1 137	1 173
NHIFA expenditures on acute hospital care including special payment category (billion HUF)	-	-	-	-	-	86.08	100.38	119.83	140.82	165.26	189.54	198.91	223.17	265.08	337.80	345.53	369.90	376.58	355.10	378.61
Of which paid by HDGs (billion HUF)	-	-	-	-	-	83.47	96.88	116.07	135.27	159.46	182.48	191.11	214.86	254.71	327.21	332.62	354.72	360.97	336.11	354.87
Of which special payment category (billion HUF)	-	-	-	-	-	2.61	3.50	3.76	5.55	5.80	7.06	7.80	8.30	10.37	10.59	12.92	15.18	15.61	18.99	23.75
Health Care Price Index (% of previous year)	117.0	128.9	135.0	123.0	122.5	118.8	128.2	123.6	118.2	114.3	110.0	109.8	109.2	105.3	104.7	106.8	103.6	103.9	108.0	106.1
NHIFA expenditures on acute hospital care (billion HUF constant 1994 prices)**	-	-	-	-	-	86.08	75.57	73.25	72.22	74.49	77.49	73.91	76.10	85.67	105.12	100.05	102.99	100.87	86.97	86.54
Hospital mortality (%)	3.4	3.4	3.3	3.5	-	3.4	3.3	3.2	3.1	3.1	3.1	2.9	2.8	2.8	2.8	2.9	2.8	2.8	2.8	3.2
SDR appendicitis (0–64 years per 10 000 inhabitants)	2.4	2.4	2.4	2.7	3.4	1.4	1.8	1.3	1.6	1.5	2.0	0.6	1.4	1.0	1.4	1.3	1.5	1.4	1.2	1.1
SDR hernia (0–64 years per 10 000 inhabitants)	12.5	12.0	10.5	9.5	10.8	10.1	9.0	8.7	7.7	7.4	8.9	6.9	6.1	6.8	9.2	6.8	7.5	7.7	8.6	7.9
Number of non-diagnostic referrals to outpatient specialist care by family physicians per 1 000 population	-	133.4	-	-	-	-	196.9	-	-	263.2	279.1	301.7	307.5	325.5	342.3	363.8	382.8	443.6	529.7	570.9
Number of referrals to hospital inpatient care by family physicians per 1 000 population	-	20.8	-	-	-	26.0	25.8	26.8	30.0	34.5	33.7	34.7	34.9	36.2	38.1	40.9	41.3	43.4	41.7	43.0
NHIFA payment per HDG cost weight (point) at constant 1994 prices (HUF)	-	-	-	-	-	41 424	33 159	29 911	31 802	30 059	34 122	30 694	33 613	33 829	38 906	38 571	38 272	38 659	38 059	35 972
NHIFA payment per HDG cost weight (point) as % of 1994	-	-	-	-	-	100.0	80.0	72.2	76.8	72.6	82.4	74.1	81.1	81.7	93.9	93.1	92.4	93.3	91.9	86.8

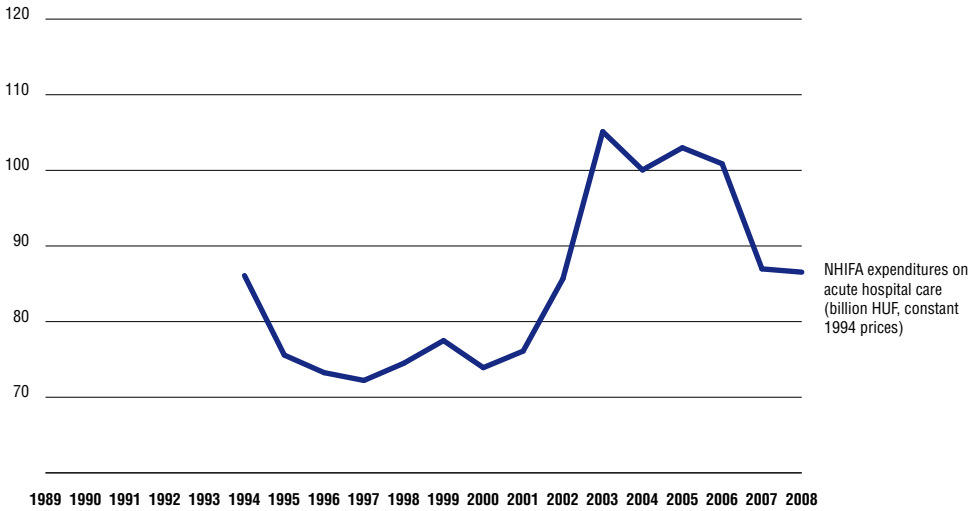
Source: HCSD, 2009b; Information Centre for Health Care, 2010; WHO Regional Office for Europe, 2010.

*Excluding beds of the Ministry of Justice, till 1993 without the beds of the Ministry of Internal Affairs and Ministry of Defence;

**Health care price deflator.

Fig. 7.2

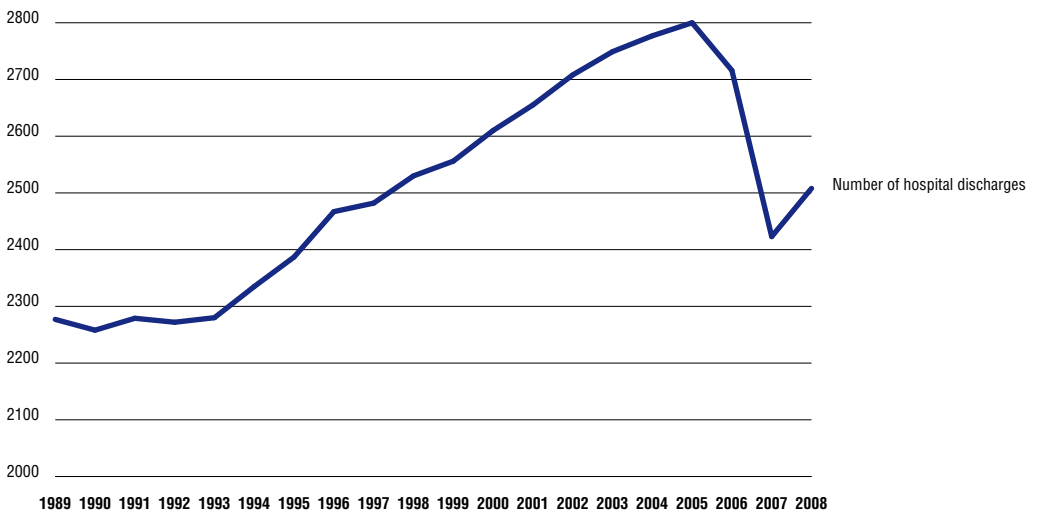
NHIFA expenditure on acute hospital care (billion HUF, constant 1994 prices)



Source: HCSO, 2009b.

Fig. 7.3

Number of hospital discharges, 1989–2008



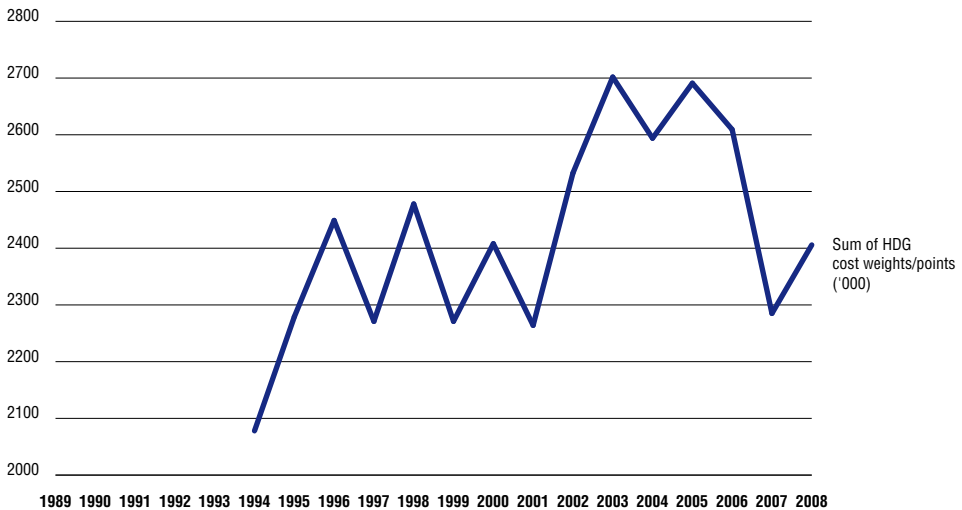
Source: HCSO, 2009b.

Since the introduction of HDGs, however, a better measure of outputs in acute inpatient care is the total number of HDG points produced by hospitals (Fig. 7.4). In the HDG system, hospital cases are weighted according to complexity and costs – bypass surgery, for instance, is assigned more points than an appendectomy – and these points (not just the number of cases) are added up. In short, the HDG system considers not just the number, but the complexity of hospital cases; this is referred to as the case-mix.

Comparing cost (that is, the HIF budget for acute inpatient care at constant prices) and output, acute inpatient care produced more output in terms of HDG points from the same budget in 2008 than in 1994 (Fig. 7.5). This also suggests that, by reducing the cost per unit of output, efficiency in acute hospitals increased by more than 15% during the period in question.

Fig. 7.4

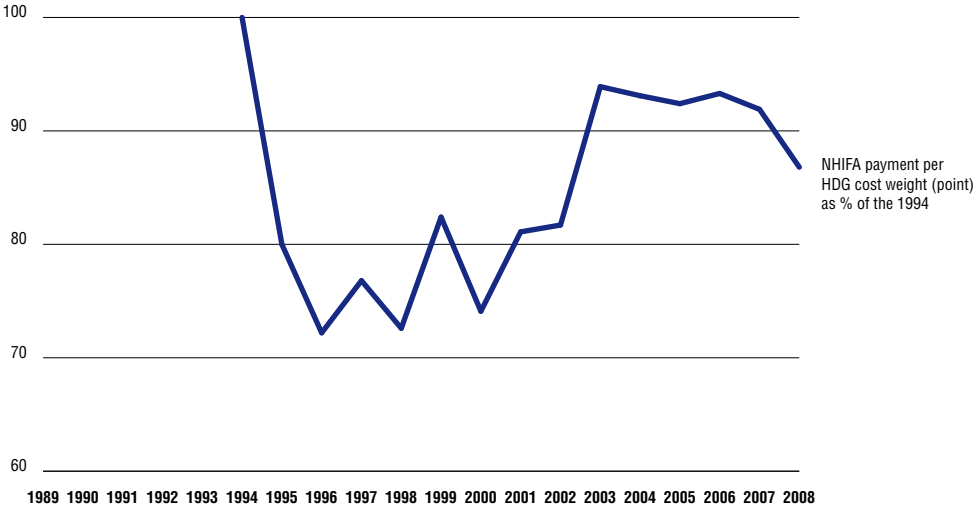
Sum of HDGs cost weights/points (thousands)



Source: Information Centre for Health Care, 2010.

Fig. 7.5

NHIFA payment per HDG cost weight (point) as a percentage of the 1994 figure (1994 = 100%), 1994–2008

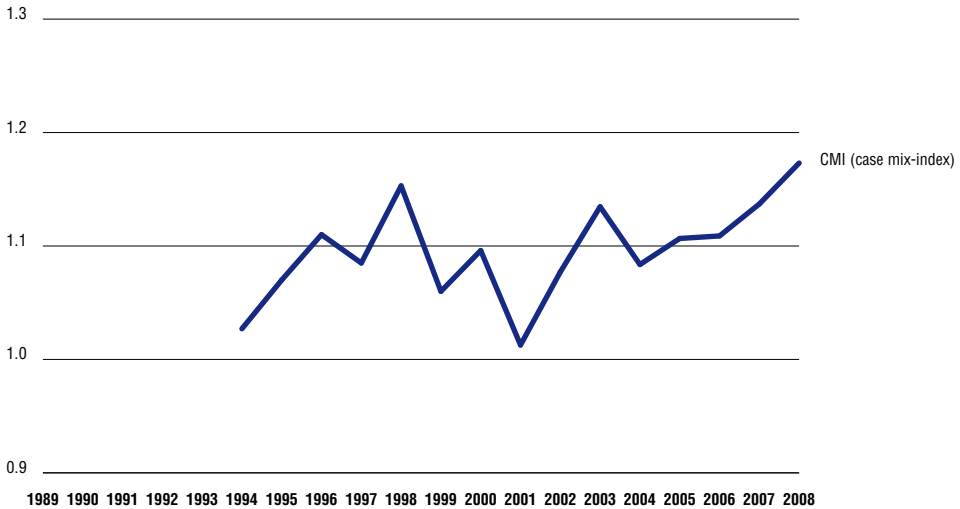


Source: Information Centre for Health Care, 2010.

It is important to note that this increase in output would have been even more substantial if the cost weights of all HDGs had not been regularly cut back to offset the steady increase in the average case severity, the so-called case-mix index (CMI) (Fig. 7.6). This process is called “re-standardization” and assumes that part of the increase in the total number of points produced in a particular year is the result of an upcoding of cases in the provider’s report to the NHIFA and not of a real increase in case severity. It is well known that the HDG system incentivizes hospitals to assign actual cases the highest possible severity in order to create more revenue (DRG-creep), thus increasing the CMI (Hsia et al., 1992; Rosenberg & Browne, 2001). There is some evidence of DRG-creep in the Hungarian health care system, as the increases in the CMI have not been accompanied by an increase in hospital mortality (Table 7.4). Any interpretation of efficiency indicators must take into account that a rise in output may represent manipulated reporting rather than a real increase on the one hand or better coding practices on the other.

Fig. 7.6

CMI in Hungary, 1994–2008



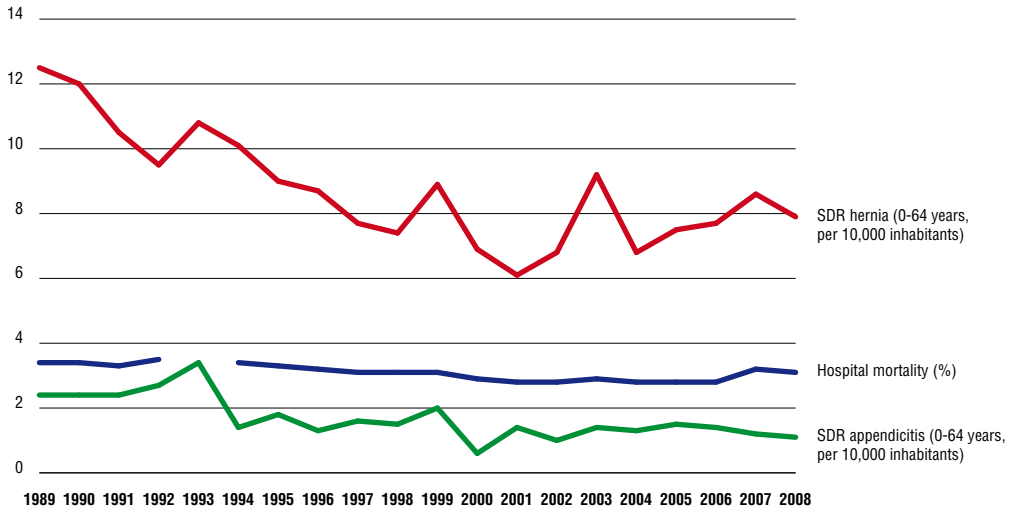
Source: Information Centre for Health Care, 2010.

Making a robust statement about the technical (production) efficiency of the Hungarian acute inpatient care sector requires that several other points be taken into account. First, HIF payments are not the only source of expenditure associated with acute inpatient care. There are also capital costs, which are covered separately by the owners of health care facilities. In addition, patients often pay physicians (and, to a lesser extent, other health care workers) informally. Another portion of financing is covered by suppliers providing extra-long payment deadlines, and there are also some minor external sources of funding, such as donations by charities. The share of these additional financing sources is, however, much smaller than that of the HIF, and they have followed trends over time that are, by and large, in line with those followed by HIF expenditure on acute inpatient care.

Second, an increase in output and a reduction of cost produces efficiency gains only if the quality of care does not suffer in the process. Trends for certain indicators of hospital mortality, avoidable causes of death (Fig. 7.7) or infant and maternal mortality have not been unfavourable and, in some cases, have improved (Table 1.10). At the very least, this suggests that the quality of acute inpatient care has not been affected dramatically. It is worth noting that there are some built-in mechanisms in the HDG system to prevent providers from cutting costs at the expense of the quality of care, such as the lower threshold of length of stay for each HDG.

Fig. 7.7

Crude indicators of quality in acute inpatient care in Hungary, 1989–2008



Source: HCSO, 2009b; WHO Regional Office for Europe, 2011.

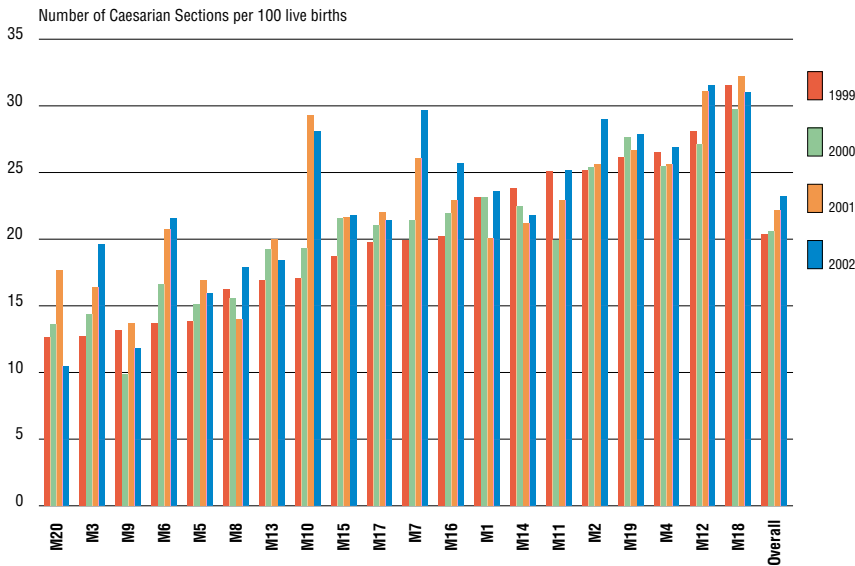
Based on the above, technical and production efficiency have most probably improved in the Hungarian health care system, at least within particular levels of care, as a result of the systematic introduction of new payment methods. Nonetheless, an increase in efficiency at one level of care, such as in the acute inpatient care sector, does not say anything about the efficiency of the health care system as a whole.

Between 1993 and 2005, the number of hospital admissions per 1000 population in Hungary showed a steady increase of more than 25%. This certainly cannot be explained by changes in the health status of the population alone. Indeed, the incentives of the new payment methods do not encourage treatment at the lowest possible level of care. On the contrary, whereas the line-item budgets did not link the size of the budget to performance, the current system induces overtreatment, DRG-creep and point inflation. Hospitals had no financial incentive to treat people as outpatients rather than inpatients and there were no effective incentives or control mechanisms in place that would prevent unnecessary hospitalization until the beginning of 2004, when a new measure (the system of volume regulation with depression) was applied to contain output inflation (2003/25). This effort was intensified in 2007 (see 2006/5). Originally, it was also presumed that family doctors would become gatekeepers to higher (more expensive) levels of care, but neither the financial incentives nor the regulatory framework support this function (see section 5.3).

Other types of inefficiency that were not addressed during the health care reforms of the late 1980s and the 1990s in Hungary include the use of ineffective or obsolete⁷ technologies, inappropriate care, provision of unnecessary services (e.g. parallel service provision), and the medicalization of social problems (“social admissions”). It is not uncommon for patients to wander around the system before being correctly diagnosed and treated, and there are clear problems with the interface between acute, chronic and social care, with long-term social care for the elderly being provided in acute wards due to the shortage of places in residential homes (see also section 5.8). Geographical practice and outcome variations are considerable and cannot be attributed to population characteristics alone (see Figs 7.8–7.11).

Fig. 7.8

Variation in rates of Caesarean section in county hospitals, 1999–2002

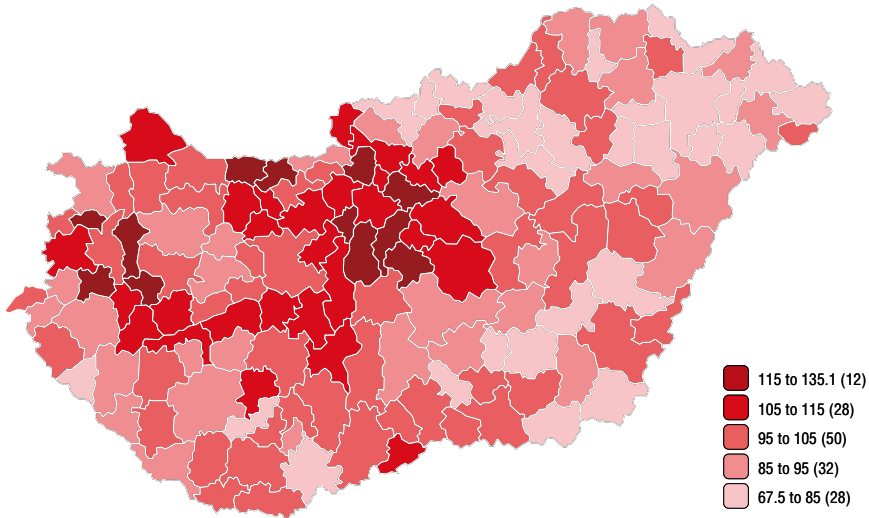


Source: Belicza, 2004.

⁷ Health technologies for which there is a more effective alternative at equal or lower cost or an equally effective alternative at lower cost.

Fig. 7.9

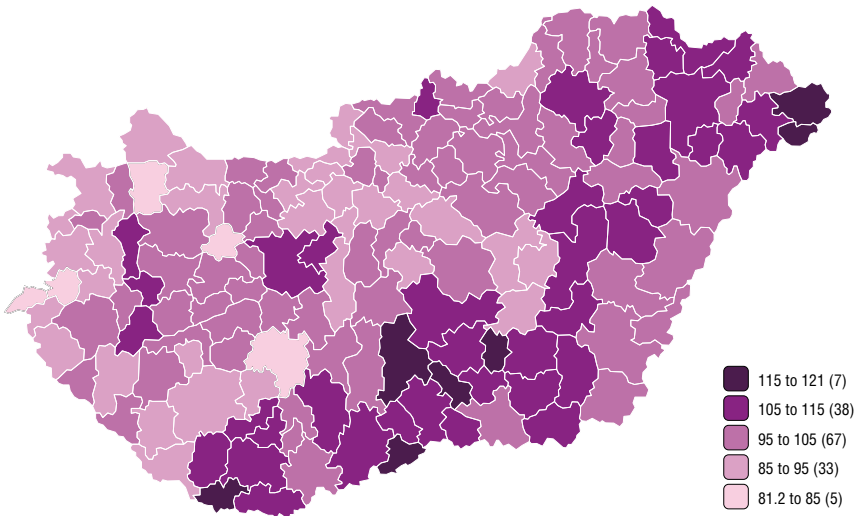
Variation in use of prescription drugs for diabetes (age and sex standardized), 2002–2003



Source: Belicza, 2004.

Fig. 7.10

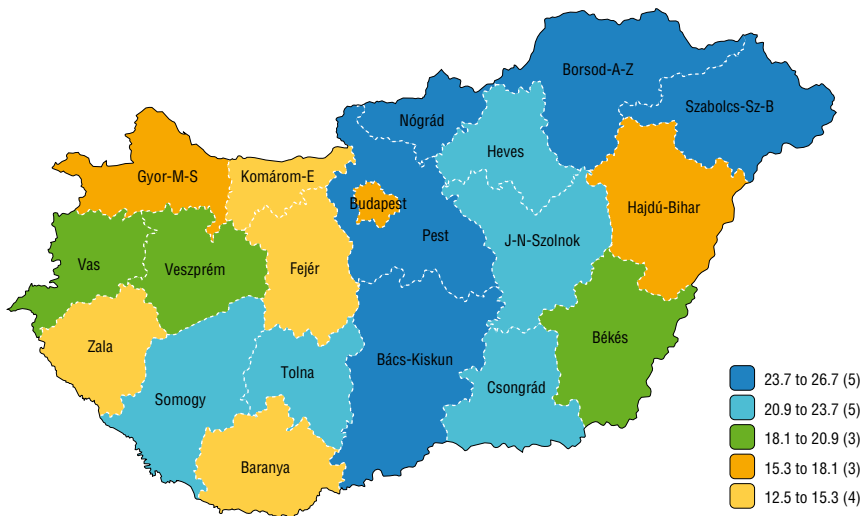
Variation in use of antibiotics (age and sex standardized), 2002–2003



Source: Belicza, 2004.

Fig. 7.11

Variation in 30-day mortality (%) in patients with acute myocardial infarction according to county of the hospital of first admission, 2008



Source: Belicza, 2008.

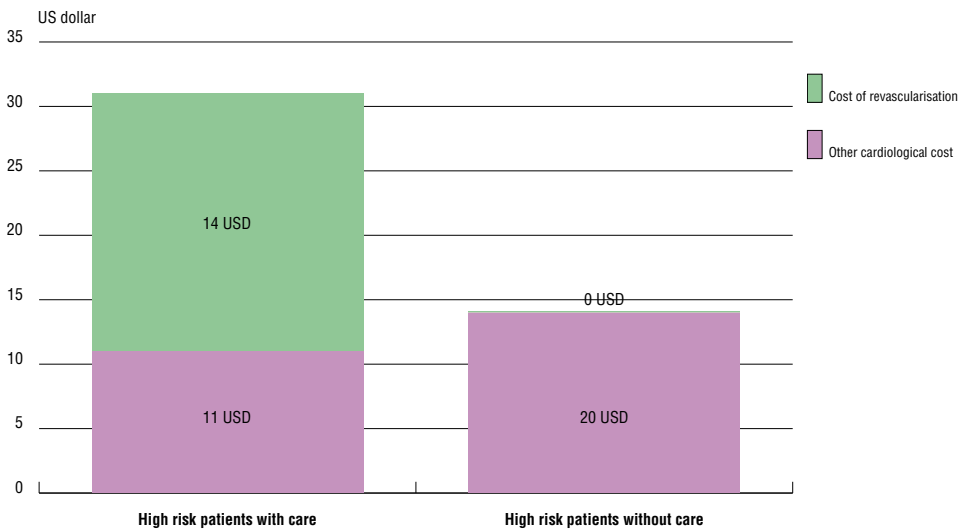
During the late 1990s and the 2000s, there were a few attempts to address these problems comprehensively by entrusting one actor with the coordination of care. The earliest of these initiatives was the CCS, which was launched as a pilot programme in 1999 and eventually eliminated in 2008 (2008/9). The CCS assigned the care coordination function to health care providers on the basis of financial incentives and covered more than 20% of the population of the country (about 2.2 million inhabitants) in 2005. The project was criticized mainly for lack of transparency as well as inequitable distribution (State Audit Office, 2008a) (see also subsection *Coordination in health care* in section 6.1.1).

One of the most important issues identified by the CCS is the manifestation of previously unmet need due to the improvement of care activities by the care coordinators. Relevant findings suggest that the early identification and proper care of patients with chronic diseases does not generate savings in the short term (Fig. 7.12). Although the cost of care for cardiovascular patients identified by screening programmes was lower on average, the total cost was higher, because these patients accessed high-cost interventions (such as Percutaneous Coronary Intervention [PCI]) on time. Undiagnosed and not properly cared for patients, on the other hand, did not, either because they succumbed to their condition or because they were past the critical time period indicated for the intervention. This finding also suggests that the sustainability

of models based on the financial incentives of potential efficiency savings is heavily dependent on the balance between potential savings resulting from the elimination of unnecessary services and the increased cost of addressing previously unmet need.

Fig. 7.12

Average cost of cardiovascular care of high-risk patients with and without proper care



Source: Misszió Központ Kht, personal communication, 2003.

On the system level, however, care coordination makes more sense, since it selectively tackles inefficiencies by addressing both the provision of unnecessary services and the absence of necessary ones. In contrast, non-selective interventions such as user charges, decrease cost by reducing both superfluous and necessary provision, at least in the short term, by deterring patients from utilizing health care. This is undesirable from the point of view of both efficiency and equity.

7.6 Transparency and accountability

Transparency and accountability in the Hungarian health care system are unevenly developed for different areas of service provision and for different actors. A comprehensive system for monitoring performance has not been established, although the main reason for this is not a lack of routinely collected

data, but rather of a comprehensive conceptual and legal framework for dealing with the various obstacles entailed in merging routine databases that are maintained by different actors in the health sector. This is largely attributable to a lack of political commitment to health policy objectives other than fiscal sustainability and a prolonged narrow focus on short-term cost-containment.

Thus, the most sophisticated transparency and accountability framework in the Hungarian health system today is that related to costs. Publicly funded providers are obliged to observe predefined budgets at various levels of the health system and to follow the rules of the different health care financing mechanisms. Sanctions range from fines and the withdrawal of funds or operational licences to civil and criminal penalties (including financial compensation and banning from public affairs), and have become increasingly strict.

The framework for setting targets and for monitoring and evaluating equity and quality in the system is less well developed. Attempts to ensure transparency and accountability have been based on the secondary analysis of existing routine databases, mainly the health care utilization database of the NHIFA. Currently, responsibility for ensuring equity is not clearly defined and is limited to waiting lists, such as those for transplantation, which have been established at the national level or at the level of providers, in accordance with the legal framework defined by the legislation on health and health insurance in 1997 (see section 7.1 and the annexed list of laws and regulations in section 9.1). At present, quality of care in Hungary is controlled mostly indirectly, by means of minimum standards for facilities, equipment and human resources required from providers of primary, outpatient specialist and inpatient care. The NPHMOS is responsible for registering and licensing providers, including individual physicians and hospitals. Hospitals that are legally obliged to supply services in a given geographical area as part of the territorial supply obligation are required to maintain a quality-control system and to establish a supervisory council.

Although a range of initiatives have been developed to measure and track the quality of care using quality indicators, these have not yet been implemented systematically. Some health care providers have established their own internal and external quality-control mechanisms based on models developed by the International Organization for Standardization and the European Foundation for Quality Management (see also section 7.4.2). A professional supervisory system maintained by the National Centre for Healthcare Audit and Inspection was created in 2005 based on the principles and practice of clinical audit.

8. Conclusions

Since the mid-1990s, Hungary has seen substantial increases in life expectancy among both men and women. Nevertheless, many health outcomes – including mortality from cancer, cardiovascular disease, liver disease and suicide – remain poor, placing Hungary among the countries in Europe with the worst health status. Mortality is especially high among middle-aged men and is primarily attributable to lifestyle factors such as smoking, alcohol consumption and an unhealthy diet. Prevention and health promotion are underfunded, their organization underdeveloped and the activities of the NPHP have been substantially curtailed in recent years. Intersectoral activities are poorly coordinated and growing inequities are not addressed properly.

However, indicators of avoidable mortality, such as infant and maternal mortality, as well as mortality from appendicitis and hernia, paint a more positive picture, as does Hungary's excellent immunization record with virtually 100% coverage against childhood diseases.

Hungary has a functioning single-payer health insurance system with virtually universal coverage. It has achieved a successful transition from an over-centralized, integrated Semashko-style health care system to a purchaser-provider split model with new payment methods that have created incentives for increased technical efficiency. For instance, Hungary introduced a DRG-based payment system for hospitals as early as 1993 and has accumulated a wealth of experience operating it. There is a unique patient identification system that provides information on pharmaceuticals consumption and use of specialist inpatient and outpatient services at the level of individual patients. This is a rich, integrated data set whose potential has yet to be fully realized in academic research and health policy decision-making.

Stewardship of the single-payer health insurance system in Hungary has become increasingly blurred. The initial self-regulation arrangement was quickly eliminated and the governance structure of the HIF has gone through a series of changes that have increased direct central control, reduced stakeholder participation and exposed the system to political pressures, thus leading to less transparent and more unpredictable funding arrangements. Although large-scale and strategic reform initiatives addressing the stewardship function of the system have failed in most cases, there have been several useful technical improvements, especially in the area of health financing. Examples include the successful introduction of HTAs and the creation of incentives to increase generic competition.

Health care reforms have also been unable to address increasing problems related to allocative efficiency, even though technical efficiency has improved over time. Informal payments have survived 20 years of health sector reform, and there is a human resource crisis emerging due to the ageing of health care professionals, staff shortages and increasing migration, especially among physicians.

Ensuring appropriate incentives to increase efficiency in patient pathways has been addressed by successive governments. The CCS (introduced as a pilot programme in 1999) had many innovative features and provided a country-specific response to the problem of allocative efficiency, but was eliminated in 2008 without a full scientific evaluation.

In the years since 2004, cost-containment has remained the dominant health policy objective. Public expenditure on health has declined substantially, falling to 5.1% of GDP in 2009. This has had a direct impact on the growing human resource crisis. Moreover, during the periods of cost-containment, efficiency gains resulting from cost-containment measures have been extracted to help reduce state debt rather than being reinvested in the health sector. A key problem is the continuing lack of an overarching, evidence-based strategy for mobilizing resources for health. Without this, the health system remains vulnerable to broader economic policy objectives. A diversification of revenue sources for health seems to be developing, along with a recent strategic policy on taxation, but it remains to be seen whether the mix of insurance contributions and budget transfers from general taxation will provide a stable funding arrangement.

Two further challenges the government faces in achieving a more efficient and more equitable service delivery system is to reorganize existing capacities based on health needs assessment and to tackle informal payments. There is some evidence that the introduction of user fees reduced the magnitude of

informal payments, though not substantially. There is also evidence, however, that user fees compromised financial protection, equity in financing and especially access to care. At the same time, several existing initiatives would provide substantial improvements if built upon and further implemented. New information systems have made the health care system more transparent and accountable. Good governance, however, would require more evidence-based and transparent policy-making, performance-monitoring and accountability at the health policy level. Although attempts have been made to measure the quality of care using various quality indicators, these have yet to be implemented in a systematic fashion.

Finally, Hungary is a target country in cross-border health care, mainly for dental care but also for rehabilitative services, such as medical spa treatment. Thus, the health industry is seen by the government as a potential strategic area for economic development and growth.

9. Annex

9.1 Laws and regulations in chronological order

In this section laws and regulations are grouped according to years. For each year, entries are listed with Arabic numbers in ascending chronological order based on the date of promulgation. The official number of each law and regulation is given in its title (roman numerals for Acts and Arabic numbers for Decrees and Resolutions). The date of promulgation is also included in each title, so indicated for Acts and in a parenthesis which includes the month in roman and the day in arabic numerals for Decrees and Resolutions. When more than one regulation need to be considered together and are grouped in one entry, this is ordered based on the earliest promulgation date. In most cases, some content is highlighted in bullet points, but these are by no means exhaustive.

Laws and regulations are published in the *Hungarian Gazette* (“*Magyar Közlöny*”), which is available only in Hungarian. All effective laws and regulations are also available in electronic format in Hungarian (CD database published monthly by KJK–Kerszöv, Budapest). Certain health related laws and regulations are available in English on the web-site of the Ministry of National Resources.

1949

1. Act XX of 1949 on the Constitution of the People’s Republic of Hungary (adopted 20/08/1949)
 - establishes the communist dictatorship in Hungary.

1950

1. Council of Ministers Decree No. 139/1950. (V. 14.) on health care provision for the workers
 - determines that the provision of health care services is state responsibility (Article 1)
 - nationalizes the providers of the Health and Sickness Insurance Institutions (Article 3, Section 3).

1952

1. Decree No. 95/1952. (X. 13.) MT of the Ministerial Council on the District and Public Health Physician Services
 - establishes the district physician services, unifying primary care.

1959

1. Act IV on the Civil Code (promulgated: 11/08/1959).

1972

1. Act II of 1972 on Health (promulgated: 29/04/1972) (also called the old law on health care)
 - establishes access to health services as a right linked to citizenship (Article 25, Section 1)
 - allows for the possibility to set co-payments for certain health services (Article 25, Section 2) – came into effect in 1975
 - defines the National Health Service (Article 85, Section 1 and 4).
2. Decree No. 11/1972. (VI. 30.) EüM of the Minister of Health on the Code of Order of Health Workers
 - describes the process of registration and regulation of health workers
 - disallows full time private practice (Article 39, section 2, point b).

1975

1. Act II of 1975 on Social Insurance and its executive order No. 17/1975. (VI. 14.) MT of the Ministerial Council
 - is the old social insurance law, which the new social insurance structures and institutions have been built on
 - determines that overspending should be covered by the central government budget (Article 5).

1982

1. Decree No. 9/1982. (VII. 21.) EüM of the Minister of Health on the National Institute of Pharmacy (see also the Deed of Foundation in the *Welfare Gazette* 1998/11)
 - determines that the National Institute of Pharmacy runs the registration and licensing system of pharmaceuticals.

1987

1. Order No. 3/1987. (Eü.K. 3.) EüM of the Minister of Health on the Information Centre for Health Care of the Ministry of Health (see also Order No. 3/1991. (NK. 23.) NM of Minister of Welfare and Deed of Foundation in the *Welfare Gazette* 1995/13)
 - establishes the Information Centre for Health Care (ICHC), which piloted and runs the performance based provider payment methods of FFS points and Hungarian DRGs in specialist outpatient and inpatient care.

1988

1. Decree No. 10/1988. (VIII. 16.) SZEM of the Minister of Social Affairs and Health on the treatment of the Hungarian patient in other countries
2. Decree No. 85/1988 (XII.15) SzEM of the Minister of Social Affairs and Health on the Social Insurance Subsidies for Pharmaceuticals
 - sets reimbursement categories of pharmaceuticals at 80, 90, or 100% (Article 2, section 1)
3. Decree No. 22/1988. (XII. 26.) SzEM of the Minister of Social Affairs and Health on the Social Insurance Subsidies for Pharmaceuticals
 - determines the extent of subsidies provided for registered medicines
4. Act XXI of 1988 on the Social Insurance Fund (promulgated: 31/12/1988)
 - separates the Social Insurance Fund from the central government budget.

1989

1. Decree No. 4/1989. (II. 17.) SzEM of the Minister of Social Affairs and Health on the co-payment of certain health services (Article 1)
 - introduces co-payments for the vaccine against tick-borne encephalitis
 - determines that diagnostic services be paid upon request of the insurer
2. Decree No. 6/1989. (III. 22.) SZEM of the Minister of Social Affairs and Health on Professional Colleges (see also Decree No. 16/1995. (IV. 13.) NM **and** Decree No. 53/1996. (XII. 27.) NM **and** Decree No. 52/1999. (IX. 12.) EüM on the Medical Professional Colleges)
 - determines the advisory bodies of the minister of health in the relevant specialities and professional areas
3. Order No. 5/1989. (SZEK 9.) SZEM of the Minister of Social Affairs and Health on the Health Care Scientific Council (see also Decree No. 10/1997. (V. 23.) NM **and** Decree No. 17/2001. (IV. 28.) EüM)
 - determines the advisory body of the minister of health on health sciences and policy
4. Act XXXI of 1989 on the Amendment of Act XX of 1949 on the Constitution of the Republic of Hungary (promulgated: 23/10/1989) (see also Act XL 1990 and Act LXIII of 1990)
 - establishes an independent democratic constitutional state and its core institutions: the president, the National Assembly, the Constitutional Court (Article 32/A, section 3), the ombudsmen (Article 32/B, section 1), and the central and local governments, whose discretion is guaranteed over local Affairs (Article 44/A)
 - declares that Hungary has a market economy (Article 9)
 - establishes the right to private property (Article 14), and to peaceful assembly and association (Article 62, 63)
 - reinforces health as a fundamental right, including: a right to healthy environment (Article 18), a right to physical and mental health (Article 70/D, section 1), a right to income maintenance (Article 70/E)

- implements the right to health through the provision of labour safety, health care within social security (Comments 2 and 4 of Article 70/D), regular physical activity, environmental protection (Article 70/D, section 2) with the overall responsibility of the central government (Article 35, section 1, point g)
5. Decree No. 113/1989. (XI. 15.) MT of the Ministerial Council on Social and Health Enterprises **and** Decree No. 30/1989. (XI. 15.) SZEM of the Minister of Social Affairs & Health on the Practice of Medicine, Clinical Psychology and Other Health and Social Services
 - allows for fully private providers to be established in the area of health and social services
 6. Act XLVIII of 1989 on the Social Insurance Fund's Budget of 1990 (promulgated: 27/12/1989)
 - establishes the “fund exchange”: health services are financed from the Social Insurance Fund.

1990

1. Government Decree No. 49/1990. (IV. 12.) Korm. on the Scope of Duties and Authority of the Minister of Welfare
2. Decree No. 14/1990. (IV. 17.) SZEM of the Minister of Social Affairs & Health on the National Institute of Hospital and Medical Engineering (see also the Deed of Foundation of the Institute for Medical and Hospital Engineering in *Health Gazette* 2000/7)
 - describes the registration and licensing process for medical devices
3. ActLXV of 1990 on Local Government (promulgated: 14/08/1990) (see also Act XX of 1991 on the Scope of Duties and Division of Authority between Local Governments and their Organs, the Central Government Representatives and Certain Centrally Controlled Organs)
 - transfers ownership of most public health care facilities to local governments (Article 107, section 1, point c)
 - makes local governments responsible for supplying primary and secondary care to the local population (territorial supply obligation) on the basis of the principal division of tasks (Article 8, section 4 and Article 70, point b) and the principle of subsidiarity (Article 69, section 2–6)
 - sets the scope of territorial supply obligation and the catchment area of service providers as the status quo, which can only be modified by an agreement between local governments concerned (Act XX of 1991, Article 132; for primary care Article 129, section 1 and Article 133, point l)
4. Act LXXXVII of 1990 on Price Setting (promulgated 05/12/1990).

1991

1. Act XI of 1991 on the National Public Health and Medical Officer Service (promulgated: 09/04/1991) **and** Decree No. 7/1991. (IV. 26.) NM of the Minister of Welfare on the Organisation and Operation of the National Public Health and Medical Officer Service
 - establishes the Service as a state agency on the basis of the former public hygiene stations, but tasks are defined according to the concept of modern public health, and include the professional supervision of health care
 - defines the structure and organs of the NPHMOS

2. Decree No. 9/1991. (IV. 17.) NM of the Minister of Welfare on the Amendment of Decree No. 11/1972. (VI. 30.) EüM of the Minister of Health
 - stipulates that doctors with foreign diplomas have to pass an exam before they can be registered
3. Resolution No. 60/1991. (X. 29.) OGY of the National Assembly on Social Insurance
 - proclaims that the National Assembly sets out the main directions of the pension and health insurance system
4. Decree No. 18/1991. (XI. 5.) NM of the Minister of Welfare on the Prescription and Dispensing of Pharmaceuticals
 - determines which pharmaceuticals can be obtained with or without prescription
5. Act LXXXIV of 1991 on the Self-Governance of Social Insurance (promulgated: 28/12/1991)
 - determines the structure of self-governance of social insurance
6. Decree No. 26/1991. (XII. 28.) NM of the Minister of Welfare on the National Institute of Family Medicine (see also Deed of Foundation of the National Institute for Primary Care in *Welfare Gazette* 1998/2).

1992

1. Act IX of 1992 on the Amendment and Complement of Act II of 1975 on Social Insurance (promulgated: 09/03/1992)
 - determines entitlement to and defines services covered by the statutory health insurance scheme (Article 4, 5 (15, 16/A))
 - divides the social insurance contribution into health insurance and pension insurance contributions (Article 19 (103))
 - sets the ceiling for employee contributions (Article 21 (103/B))
2. Act X of 1992 on the Social Insurance Fund's Budget of 1992 and the Amendment of Act XXI of 1988 on the Social Insurance Fund (promulgated: 09/03/1992)
 - divides the Social Insurance Fund into health insurance and pension funds
3. Government Decree No. 55/1992. (III. 21.) Korm. on the Amendment of Decree No. 16/1972. (IV. 29.) MT on the Executive Order of Act II of 1972 on Health and Decree No. 6/1992. (III. 31.) NM of the Minister of Welfare on the Family Physician and Paediatric Primary Care Services
 - separates the former district doctor system from hospitals and renames it "family physician service"
 - establishes free choice of family physician and family paediatrician
 - regulates professional standards, including family doctor specialization to be obtained
4. Government Decree No. 79/1992. (IV. 12.) Korm. on the Social Insurance Financing of Health Services in 1992
 - Introduces contracting and capitation payment in family physician's services
5. Act XXXIII of 1992 on the Legal Status of Public Employees (promulgated: 02/06/1992)
 - regulates employment in the public sector and determines the compulsory minimum salaries of public employees according to a pay scale
6. Act XXXVIII of 1992 on Public Finance (promulgated: 18/06/1992)

- mandates the government to make suggestions to the National Assembly if it estimates that expenditure will exceed revenues in the HIF budget, resulting in significant deficit (Article 86, section 9)
 - determines that the HIF deficit should be approved by the National Assembly within the final budget review based on the central government budget (Article 86, Section 1)
7. Government Decree No. 107/1992. (VI. 26.) Korm. on Health Services which Can Be Utilized with Co-payments Only and on the Method of Payment
 8. Act LXXXIV of 1992 on the Social Insurance Fund and Its Budget for the year 1993 (promulgated: 30/12/1992)
 - introduces new financing methods for outpatient specialist care and hospital care as of July 1993
 - stipulates that hospitals have individual base fees (the monetary value of 1 DRG point) until 1 October 1995
 - determines that the HIF covers only the recurrent costs of health services (Article 17, section (1))
 9. Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (promulgated: 31/12/1992)
 - provides for the assistance of local governments for financing capital costs of their facilities including hospitals, medical equipment, etc.

1993

1. Act III of 1993 on Social Services (promulgated: 27/01/1993)
 - determines cash and in-kind social provisions
 - defines the obligation of local governments to provide services for local residents
 - determines the eligibility for and administration of the co-payment exemption system in health care
2. Government Decree No. 28/1993. (II. 27.) Korm. on the Certificate for Co-payment Exemption
3. Act XII of 1993 on the Election Rules of Social Insurance Representatives (promulgated: 12/03/1993) and its executive orders of Decree No. 5/1993. (III. 26.) BM and 6/1993. (III. 26.) BM of the Minister of the Interior
 - regulates the elections of trade union representatives of the social insurance self governments on 23 May 1993
4. Decree No. 8/1993. (III. 31.) NM of the Minister of Welfare on the Professional Supervision of Health Care Institutions
 - determines the system of professional supervision of health services, within the National Public Health and Medical Officer Service
5. Decree No. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services
 - provides a detailed list of outpatient specialist interventions, DRGs of acute inpatient care and their point values
 - regulates the financing of dental care (Article 9 and Annex 12)
6. Government Decree No. 52/1993. (IV. 2.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services

- describes the payment systems of various services in detail
 - introduces the concept of 'daytime institutional care' (Article 25, sections (1) and (4))
7. Government Decree No. 91/1993. (VI. 9.) Korm. on the Establishment of the National Pension Insurance Administration and the National Health Insurance Fund Administration and their Administrative Organs and Other Measures in Connection with this
 - divides the Social Insurance Fund Administration is divided into the National Health Insurance Fund Administration and the National Pension Insurance Administration as of July 1993
 - determines the organizational structure of the National Health Insurance Fund Administration (NHIFA)
 8. Act LXXX of 1993 on Higher Education (promulgated: 03/08/1993)
 - places medical universities under the supervision of the Ministry of Education
 9. Act XCII of 1993 on the Amendment of Certain Provision of the Civil Code (promulgated: 30/10/1993)
 - provides the legal framework for the establishment of non-profit corporations in the areas of public benefit activities, including health care
 10. Act XCVI of 1993 on Voluntary Mutual Insurance Funds (promulgated: 06/12/1993)
 - provides the legal framework for the establishment of voluntary non-profit insurance in the area of health, pension and self-support.

1994

1. Decree No. 6/1994 (IV.1.) NM of the Minister of Welfare on the Amendment of Decree No. 9/1993 (IV.2.) NM
 - includes a first list of day care services (Article 1 to be inserted as Article 9/A and Annex 5 to be inserted as Annex 9 into the Original Decree.)
2. Act XXVIII of 1994 on the Hungarian Medical Chamber (promulgated: 05/04/1994)
 - makes membership compulsory for all practising physicians
 - gives the Medical Chamber the right to establish ethical norms and procedures, to negotiate the general rules and content of contracts between the NHIFA and physicians and to participate in health policy formulation
3. Decree No. 16/1994. (IV. 26.) KHVM of the Minister of Transport, Communication and Water Management on the Scope of Insurance by the Railway Health Insurance and the Rules of Referral to the Institutions of the Railway Health Service
 - integrates the railway health service into the main system of funding and delivery
 - gives priority to railway workers and their dependants with regard to utilization
4. Resolution No. 1030/1994. (IV. 29.) Korm. on the Principles of Long Term Health Promotion Policy
 - sets health policy goals and targets of the government
5. Act LI of 1994 on the Hungarian Chamber of Pharmacists (promulgated: 07/05/1994)
 - makes membership compulsory for all practising pharmacists, based on the same principles as in the case of the Hungarian Medical Chamber (see Act XXVIII of 1994)
6. Act LIV of 1994 on the Establishment and Rules of Operation of Pharmacies (promulgated: 07/05/1994)

7. Government Decree No. 1107/1994. (XI. 23.) on the action plan on health care
 - Develops a quality assurance system (Article 1, section C).

1995

1. Decree No. 2/1995. (II. 8.) NM of the Minister of Welfare on Pharmaceuticals which can be Prescribed with Social Insurance Subsidies and on the Extent of Subsidies Provided for Prices Accepted as the Basis of Subsidy
 - determines the consumer price of pharmaceuticals as the basis of social insurance subsidies
 - determines the extent of subsidies provided for purchasing of registered medicines
2. Decree No. 3/1995. (II. 8.) NM of the Minister of Welfare on the Prescription and Dispensing of Pharmaceuticals
 - determines which pharmaceuticals can be obtained with or without prescription
3. Decree No. 5/1995. (II. 8.) NM of the Minister of Welfare on the District Mother and Child Health Nurse Service
4. Decree No. 16/1995. (IV. 13.) on Professional Colleges
 - defines the quality-related tasks of the Colleges
5. Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization (promulgated: 05/06/1995) **and** its executive orders of Government Decree No. 69/1995. (VI. 17.) Korm, Government Decree No. 70/1995. (VI. 17.) Korm. **and** Government Decree No. 71/1995. (VI. 17.) Korm.
 - introduces economic stabilization measures (the so-called “Bokros package”)
 - curtails health insurance benefits (excludes most dental services and certain cases of sanatorium treatment and removes subsidies on spa treatment)
 - introduces co-payments for patient transfer
 - defines the scope of territorial supply obligation as capacities contracted by the NHIFA
6. Decree No. 20/1995. (VI.17.) NM of the Minister of Welfare on the Treatment Sanatoria for Medical Rehabilitation
 - defines treatment in sanatoria as part of medical rehabilitation (Articles 2, 7)
 - lists health service providers, who provide sanatorium treatment (Annex 1)
7. Act LIII of 1995 on the General Environmental Protection Rules (promulgated: 22 June 1995)
 - determines that an environment impact assessment (EIA) has to be performed before commencing activities with environmental impact (Article 68, Section 1)
 - further determines for which activities environmental assessment is obligatory or optional (Article 68, Section 2)
 - stipulates that EIA outcomes need to be reported in an environmental assessment study (Article 69, Section 1)
8. Government Decree No. 89/1995. (VII. 14.) Korm. on Occupational Health Services
 - makes employers responsible for the provision (financing) of occupational health services
9. Act LXXIII of 1995 on the Social Insurance Fund Budget of 1995 and Payment Methods for In-kind Benefits (promulgated: 14/07/1995)

- introduces budget cuts
 - leaves the principles of the payment system unaltered
 - modifies hospital payment by weighing performance according to the level of care and speciality
 - determines that the Minister of Welfare define capacities to be contracted by the NHIFA (Article 10, section 2)
10. Government Decree No. 103/1995. (VIII. 25.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - describes of the payment system of various services in detail
 11. Decree No. 26 /1995 (IX. 3.) NM of the Minister of Welfare on School Health Services
 12. Act XCVI of 1995 on insurance institutions and insurance activities (promulgated: 24/11/1995)
 13. Ruling No. 77/1995. (XII. 21.) AB of the Constitutional Court
 - finds the process of defining health care capacities under territorial supply obligation unconstitutional
 14. Act CXVII of 1995 on Personal Income Tax (promulgated: 22/12/1995)
 - introduces tax rebates for the purchase of voluntary, not-for-profit health insurance (Article 35, section 2; Article 44/A, Section 1/b).

1996

1. Act XIV of 1996 on the 1996 Budget of the Social Insurance Funds (promulgated: 29/03/1996) and Government Decree No. 61/1996. (IV. 26.) Korm.
 - reintroduces dental services into the social insurance benefit package with some co-payments
2. Act XL of 1996 on the Implementation of the Social Insurance Funds' Budget of 1994 (promulgated: 22/05/1996)
 - defines hospice care as a separate service category (Annex 6)
3. Act XLVII of 1996 on the Amendment of Act LXXXIV of 1991 on the Self Governance of Social Insurance (promulgated: 07/06/1996)
 - curtails the rights of the Self Government of Health Insurance concerning budgetary decisions
4. Act LXIII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms (promulgated: 23/07/1996)
 - determines health care capacity per county in terms of hospital beds and consultation hours which local governments are obliged to supply and the NHIFA to contract for (territorial supply obligation)
5. Government Decree No. 113/1996. (VII. 23.) Korm. on Licences for Supplying Health Care Services
 - updates the health care provider licensing system
6. Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on Minimum Standards of Certain Institutions Providing Health Services
 - regulates minimum standards for specialist service providers in terms of buildings, equipment, personnel requirements
7. Decree No. 20/1996. (VII. 26.) NM of the Minister of Welfare on Home Care

- determines the requirements for providing home care
8. Act LXXXVII of 1996 on the Amendment of Act II of 1975 on Social Insurance (promulgated: 16/11/1996)
 - widens the social insurance contribution base
 - decreases the employer health insurance contribution rate by 3% points (Article 10)
 - halts central government transfers for non-contributing groups in their previous form (Article 21 modifies Article 119 of Act II of 1975)
 9. Act LXXXVIII of 1996 on the Hypothecated health care tax (promulgated: 16/11/1996) **and** its executive order Government Decree No. 202/1996. (XII. 23.) Korm.
 - introduces an earmarked lump sum tax for health services in order to collect funds to cover expenditure for social groups entitled to health services (Article 1)
 10. Government Decree No. 173/1996. (XI.29.) Korm. on the National Statistical Data Collection Program for 1997 and on the Amendment of Government Decree No. 170/1993. (XII.3.) Korm. on the Executive Order of Act XLVI of 1993 on Statistics Annex, items No. 1630 and 1631
 11. Act CXXI of 1996 on the Amendment of Act XXXVIII of 1992 and Related Laws (promulgated: 21/12/1996)
 - curtails the rights of the self governments of social insurance (Article 55 and 56)
 12. Act CXXV of 1996 on the Social Insurance Funds' Budget of 1997 (promulgated: 25/12/1996)
 - modifies the performance principle in the payment system and introduces a new fixed (guaranteed) element
 - abolishes cross-subsidization between social insurance funds (Article 30, section 2 repeals Article 3, section 5 of Act LXXXIV of 1992)
 13. Act CXXVI of 1996 on the Use of a Specified Amount of Personal Income Tax for Public Purposes in Accordance with the Taxpayer's Instruction (promulgated: 26/12/1996)
 - stipulates that taxpayers can offer 1% of their personal income tax to non-profit organizations, including those in the area of health services
 14. Government Decree No. 238/1996. (XII. 26.) Korm. on the Amendment of Decree No. 103/1995. (VIII. 25.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - unifies the base fee for all hospitals in the country in acute inpatient care over a 12-month period as of 1 March 1998 (3) (24(6))
 - introduces a fixed element to the payment of providers (Article 10, section (3) (20(8)))
 15. Decree No. 55/1996. (XII. 27.) NM of the Minister of Welfare on the National Emergency Ambulance Service (see also the Deed of Foundation in the *Welfare Gazette* 1997/11).

1997

1. Government Decree No. 40/1997 (III.5.) Korm. on the Naturopathic Practice {Practice of Alternative Medicine} **and** Decree No. 11/1997. (V. 28.) NM of the Minister of Welfare on Certain Aspects of the Practice of Naturopathy {Alternative Medicine}
 - regulates complementary and alternative medicine
2. Act XXXI of 1997 on the Protection of Children and the Public Administration of Guardianship (promulgated: 08/05/1997)

3. Act XLVII of 1997 on Management and Protection of Health Care and Related Personal Data (promulgated: 05/06/1997)
 - protects confidentiality of personal information in health services
4. Decree No. 12/1997. (VI. 5.) NM of the Minister of Welfare on the Amendment of Decree No. 19/1996. (VII. 26.) NM on the Minimum Standards of Certain Institutions Providing Health Services
 - extends the deadline by which providers have to meet minimum standards
5. Act XLVIII of 1997 on the Amendment of Various Acts in Connection with the Self Governance of Social Insurance (promulgated: 11/06/1997)
 - determines that self-governments not be elected and decreases the number of representatives
6. Decree No. 17/1997. (VI. 30.) NM of the Minister of Welfare on the Prescription of Balneotherapy in the Frame of Medical Rehabilitation, on the Professional Requirements of Providing Balneotherapy which is Subsidized by Social Insurance, and on the Administration of these Social Insurance Subsidies
7. Act LVIII of 1997 on Commercial Advertising (promulgated: 04/07/1997)
 - limits advertising on health damaging products such as tobacco
8. Act LXXX of 1997 on those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services (promulgated: 25/07/1997) **and** its executive order of Government Decree No. 195/1997. (XI. 5.) Korm.
 - provides the rules for social insurance including compulsory participation (Article 2, section 1), entitlement for services and contribution rates
 - obligates the government to cover any deficit incurred by the HIF (Article 3, section 2)
 - stipulates that participation is compulsory for every citizen, including small farmers (Article 39, section 2), who can choose to pay a higher contribution to be eligible for cash benefits (Article 34, section 3)
 - determines that the government transfer the revenue from the hypothecated health care tax to the HIF to compensate for non-contributing groups, such as pensioners, women on maternity leave, conscripts and the poor (Article 39, section 1 and Article 16, section 1, points b-o)
 - further determines that contribution rates are to be determined annually by the National Assembly (Article 19, contribution ceiling – Article 24)
 - sets the minimum level of the contribution base (Article 20, Section 2) and a ceiling for employee contributions (Article 24, Section 2), calculated as twice the brutto monthly wages (5520 NCU per calendar day in 2000)
 - declares that medical services have to be paid for out-of-pocket by persons neither insured nor entitled to medical services and when the free movement of persons regulation (1408//1/EC) does not apply, (Articles 19 and 39)
 - mandates the government to prepare recommendations for the National Assembly to ensure fiscal stability (Article 60)
 - distinguishes between *insured persons*, such as employed persons, members of cooperatives, apprentices in industrial training, artisans, self-employed persons, independent farmers, performing artists, lawyers, and recipients of unemployment benefits and *entitled persons*, such as pensioners, beneficiaries of unemployment benefits, beneficiaries of social assistance benefits and allowances, beneficiaries of pensions provided by churches, full-time students who are Hungarian citizens residing

- in Hungary, and all dependent family members and children. Hungarian citizens in otherwise exempted activities (including dependents) who have no alternative coverage must contribute for medical benefits. (Article 5, 6, 10,11,12,13 and 39 with section 2–4
9. Act LXXXIII of 1997 on the Services of Compulsory Health Insurance (promulgated: 25/07/1997) **and** its executive order of Government Decree No. 217/1997. (XII. 1.) Korm.
 - determines the in-kind and cash benefits of the social health insurance, and the rules of their utilization
 - declares the responsibility of the state to provide services, regardless of the revenues of the HIF (Article 4)
 - regulates entitlement to services for foreigners (Article 8)
 - determines the right to free choice of family doctors and change of providers and medical professionals (Articles 11, 18, 19, GD 3, GD 11)
 - defines services, which are excluded from statutory health insurance coverage (Article 18, section 4–6; high cost, high-tech interventions – Article 18, section 5, point g), which can be utilized with co-payment (Article 23), and whose price is subsidized (Article 21)
 - defines the rules of utilization and the referral system (Article 18, section 1–3; Executive order, Article 2)
 - regulates the concept, type and supervision of waiting lists, when these are to be set up and what deviation rules are (Article 20)
 - regulates provision and reimbursement issues for treatment abroad (Articles 27 and 28)
 - defines the rules of contracting (Article 30–33, and Executive order Article 13–25) and the control of implementation of the contracts (Article 36–38)
 - determines methods of payment in general, and that the HIF covers recurrent costs of services only (Article 34–35)
 - further regulates dental care (Article 10, section (1), points bb) and dc), Article 12, Article 23, points a) and c), Article 24, section (3)
 10. Decree No. 26/1997. (IX. 3.) NM of Minister of Welfare on School Health Services
 - regulates the operation of school health services in Hungary in detail
 11. Decree No. 32/1997. (X. 28.) NM of the Minister of Welfare on the Registration and Licensing of Health Care Providers
 - regulates the administration of registration and licensing in detail
 12. Act CXXIX of 1997 on the Amendment of Act CXXVI of 1996 on the Use of a Specified Amount of Personal Income Tax for Public Purposes in Accordance with the Taxpayer's Instruction (promulgated: 10/12/1997)
 - allows for taxpayers to offer 1% of their personal income tax to registered churches
 13. Act CXXXI of 1997 on the Amendment of Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (promulgated 10/12/1997)
 - introduces a new, decentralized component of the earmarked and target subsidy system, the target-type decentralized grants, which are allocated by the county regional development councils (Article 2)
 14. Decree No. 46/1997. (XII. 17.) NM of the Minister of Welfare on Health Services, which are not Covered by Social Health Insurance
 - lists services that are excluded from HIF financing but covered by the central government budget (Annex 1)

- lists services which are excluded from public finance
15. Decree No. 48/1997. (XII. 17.) NM of the Minister of Welfare on Dental Services which Can Be Utilized in the Frame of the Statutory Health Insurance
 16. Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare on Infertility Treatments which Can Be Utilized in the Frame of the Statutory Health Insurance
 17. Decree No. 51/1997 (XII. 18.) NM of the Minister of Welfare on Preventive and Early Diagnostic Services that Can be Utilized in the Frame of Social Health Insurance System and on the Certification of Participation in Screening Programmes
 - lists compulsory (Article 3, section (2), point a), Annex, Part I) and discretionary screening programmes (Annex, Part II)
 18. Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees for Certain Health Services which Can Be Utilized with Co-payments Only
 - determines the amount of co-payment for certain services, e.g for dental care (Article 2 and Annex 1), and the full fee for services which are not covered by the statutory (social) health insurance (medical examination for driving and shotgun licences, blood alcohol test, detoxification, forensic health status determination)
 19. Act CLIII of 1997 on the Social Insurance Fund Budget of 1998 (promulgated: 23/12/1997)
 - determines the main methods of provider payment (e.g. dental care in Article 25, section (2))
 - stipulates that the HIF cover only the recurrent costs of health services (the so-called curative-preventive services) (Article 6, section (2))
 20. Act CLIV of 1997 on Health (promulgated: 23/12/1997)
 - sets up the general framework for health care including patient rights, the organization of the health care system, major actors and responsibilities for health care (Article 143).
 - declares that every patient has a right to life-saving or preserving health care interventions (Article 6) and to proper, continually accessible and equitable health services according to health status, which are set in a properly defined legal framework (Article 7)
 - regulates the obligations (Article 26) and rights of patients, including the right to health care provision (Article 6–9), to human dignity (Article 10), to maintaining personal contacts (Article 11), to interrupt medical interventions and to leave the medical institution (Article 12); to information (Articles 5 (3) and 13), including refusal of information (14), to autonomy (Articles 5 (3) and 15–19), to prior consent (Article 15/3 and 15/4), to refuse provision of services (Article 20–21), to be privy to and in possession of medical documentation (Article 24), to privacy (25)
 - establishes the institutions of patient right representatives (Article 30–33), arbitration (Article 34), hospital supervisory councils (Article 156, section 1–5) and hospital ethical committees (Article 156, section 1–2, 6–7) as well as the procedure of investigating patient complaints (Article 29) and addressing medical negligence (Article 140/A)
 - establishes the National Health Council (Article 148, 149)
 - introduces the National Health Promotion Programme, to be approved by the National Assembly (Article 146)
 - determines the services which have to be financed from the central government budget (Article 142, section 2, high cost, high tech interventions – point d)

- establishes the Health Care Professional Training and Continuing Education Council (Articles 116 and 117)
- describes the quality assurance system for health care (119–124)
- confirms national institutes to assist the Minister of Health (Article 150)
- defines maintenance obligation (Article 155, section 2)
- endorses utilisation according to the principle of “appropriate level of specialisation” (or “progressivity” principle) (Article 75, section 3 and Article 76)
- further endorses the efficient use of resources (Article 75, section 4)
- defines hospice care as a separate service category (Article 99)
- regulates registration of medical professionals, including the recognition of foreign diplomas based on EU standards for mutual recognition.

1998

1. Government Decree No. 13/1998. (I. 30.) Korm
 - introduces the uniform national base fee in March 1998, with the provision that it can be recalculated if output exceeds budget reserves
2. Decree No. 6/1998. (III. 11.) NM of the Minister of Welfare on the Regulation of Updating Professional Classification Systems and Financing Parameters Used in Health Care
 - establishes the Committee of Updating Financing Parameters and details procedures for the modification of existing classification systems including HDGs
3. Act XXV of 1998 on the Pharmaceuticals for Human Use (promulgated: 01/04/1998) and Government Decree No. 37/2000. (III. 23.) Korm. on the Personnel and Material Requirements of Production of Pharmaceuticals for Human Use **and** Decree No. 60/1999. (XII. 1.) EüM of the Minister of Health on the Wholesale of Pharmaceuticals **and** Decree No. 12/2001. (IV. 12.) EüM of the Minister of Health on the Registration and Licensing of Pharmaceuticals for Human Use
 - comprehensively regulate the pharmaceutical industry in accordance with the practice of the European Union
4. Government Decree No. 72/1998. (IV. 10.) Korm. on the Financing of Higher Education on the Basis of Training and Maintenance Capitation
 - stipulates that higher education be financed by capitation according to the number of students
5. Ruling No. 16/1998. (V. 8.) AB of the Constitutional Court
 - deems the restructuring of self-governments of social insurance unconstitutional
6. Decree No. 18/1998. (VI. 3.) NM of Minister of Welfare on the Prevention and Control of Infectious Diseases and Epidemics
 - regulates the operation of surveillance systems for communicable diseases in Hungary, the immunization against communicable diseases and the procedures of infectious disease control
 - introduces compulsory screenings with epidemiological purpose (Article 17–24)
7. Decree No. 19/1998. (VI. 3.) NM of the Minister of Welfare on Patient Transfer
8. Decree No. 20/1998. (VI. 3.) NM of the Minister of Welfare on Emergency Ambulance Services

9. Decree No. 21/1998. (VI. 3.) NM of the Minister of Welfare on Minimum Standards of Certain Institutions Providing Health Services
 - further extends the deadline by which providers have to meet the defined minimum personnel and material requirements
10. Decree No. 25/1998. (VI. 17.) NM of the Minister of Welfare on Artificial Sterilization
11. Decree No. 26/1998. (VI. 17.) NM of the Minister of Welfare on the National Blood Supply Service (see also the Deed of Foundation in *Welfare Gazette* 1998/12)
 - reorganizes of the blood supply units of hospitals into one national organization
12. Decree No. 27/1998. (VI. 17.) NM of the Minister of Welfare on the Registration and Licensing of Paramedical Workers
 - establishes a registration system for paramedical workers
13. Decree No. 30/1998. (VI. 24.) NM of the Minister of Welfare on the Rules of Special Procedures for Human Reproduction and on the Detailed Rules of Use and Freeze-Storage of Reproductive Cells and Embryos
14. Act XXXVI of 1998 on the Enumeration of the Ministries of the Republic of Hungary (promulgated: 1/7/2002)
 - divides the Ministry of Welfare into the Ministry of Health and the Ministry of Social and Family Affairs
15. Act XXXIX of 1998 on the State Supervision of Social Insurance Funds and their Administration (promulgated: 15/07/1998)
 - abolishes self-governance of social insurance funds and reinstates government supervision
16. Government Decree No. 131/1998. (VII. 23.) Korm on the Scope of Duties and Authority Concerning the Control of Social Insurance Administration
 - relocates the control of social insurance administration to the Prime Minister's Office
17. Government Decree No. 137/1998. (VIII. 18.) Korm. on the Prime Minister's Office
 - strengthens the role of the Prime Minister's Office in policy making and coordination
18. Government Decree No. 154/1998. (IX. 30.) Korm. on the Scope of Duties and Authority of the Minister of Health
19. Act LXVI of 1998 on the Hypothecated Health Care Tax (promulgated: 14/11/1998)
 - complements the original lump sum hypothecated tax with a proportional component
20. Act LXVII of 1998 on Amendment of Act LXXX of 1997 (promulgated: 14/11/1998)
 - decreases employer social insurance contribution substantially (6% points) as of January 1st 1999 and increases the hypothecated health care tax by more than 70%
21. Decree No. 10/1998. (XII. 11.) EüM of the Minister of Health on the Organization and Operation of the Health Care Professional Training and Continuing Education Council
 - establishes a new body for the coordination and supervision of professional training in health care
22. Decree No. 14/1998 (XII. 11.) EüM of the Minister of Health on Hospital Ethical Committees
 - establishes hospital ethical committees, to be set up in the first half of 1999
23. Decree No. 18/1998 (XII. 11.) EüM of the Minister of Health on the Implementation of Provisions of Act CLIV of 1997 concerning Tissue and Organ Transplantation and Storage, and Certain Pathohistological Investigations

24. Decree No. 22/1998. (XII. 27.) EüM of the Minister of Health on Health Services that can be Provided on the Basis of Waiting Lists
 - establishes waiting lists and waiting list committees, to be set up in the first half of 1999
25. Decree No. 23/1998. (XII. 27.) EüM of the Minister of Health on the Hospital Supervisory Councils
 - establishes hospital supervisory councils, to be set up in the first half of 1999
 - determines that councils are to be set up for hospitals with territorial supply obligation, and should represent the interests of the local population cared for by the hospital
26. Act XCI of 1998 on the Social Insurance Funds' Budget of 1999 (promulgated: 29/12/1998)
 - strengthens control of the pharmaceutical budget (Article 4, section 1, point d)
 - empowers the Minister of Health to reallocate between sub-budgets of preventive and curative services of the HIF (Article 5, section 3)
 - launches the care coordination pilot with a maximum population of 200 000 (Article 16)
 - abolishes the partial fixed element in the payment for specialist services (Article 19)
 - stipulates that primary and secondary dental be paid for by capitation and FFS points, respectively
 - relocates the collection of social insurance contributions to the Tax Office (Article 24–31)
27. Government Decree No. 217/1998. (XII. 30.) on the functioning of the National Budget
 - determines the process of transferring collected contributions from the Tax Office to the account of the HIF (Article 1–4)
 - obligates the Tax Office to report to the HIF on the outcome of collection (Article 5, 8–9)
28. Government Decree No. 229/1998. (XII. 30.) Korm. on the Scope of Duties, Organization and Operation of the National Health Council
 - establishes the National Health Council for assisting the Government in health policy.

1999

1. Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - regulates payment methods for all services in detail (Article 31, section 1 – chronic outpatient care; Article 32 – CT, MRI; Article 33 – patient transportation; Article 43 – expensive medical devices and prostheses; Article 44 – not widespread, high cost interventions, Annex 8 – chronic inpatient care includes hospice care, Articles 22–23 – dental care)
 - determines that the national base fee for inpatient services is fixed in advance for a year as of 1 April 1999 (Article 38, section 3)
 - regulates the care coordination pilot programme in detail (Article 50)
 - sets the details of obligatory provider reports to the NHIFA, including pathways and data structure (Article 4, Section 2 and appendices)

2. Act XLII of 1999 on the Protection of Non-Smokers and Certain Rules of the Consumption and Distribution of Tobacco Products (promulgated: 23/04/1999)
 - protects non-smokers by restricting locations where smoking is allowed and where tobacco products can be sold
3. Government Decree No. 75/1999. (V. 21.) Korm. on the Transitional Rules of Operation, and the Scope of Duties and Authority of the Central Administration of Social Insurance
4. Decree No. 15/1999. (VI.9.) EüM of the Minister of Health on the Amendment of Decree No. 20/1996. (VII.26.) NM of the Minister of Welfare on Specialist Home Care
 - defines hospice home care as a separate category of specialist home care
5. Government Decree No. 99/1999. (VI. 21.) Korm on the Amendment of Certain Regulations Concerning the Control of Social Insurance Administration
 - relocates the control of social insurance administration to the Ministry of Finance as of 21 June 1999
6. Decree No. 30/1999. (VII. 16.) EüM of the Minister of Health on the Registration and Licensing of Medical Doctors, Dentists, Pharmacists and Clinical Psychologists and on the Licensing of Non-Registered Persons
 - determines that basic registration is to be operated by the Ministry of Health and licensing by the relevant professional chambers
7. Government Decree No. 134/1999. (VIII. 31.) Korm on the Reimbursement of Social Insurance Subsidies of Pharmaceuticals, Medical Aids and Protheses, and Balneotherapy Prescribed in the Frame of Outpatient Specialist Care
 - regulates the process of contracting between the county branches of the NHIFA and suppliers of pharmaceutical products, medical aids and protheses and balneotherapy
8. Decree No. 47/1999. (X. 6.) EüM of the Minister of Health on Medical Devices
 - regulates the introduction of medical devices into commerce, according to the practice of the EU
9. Government Decree No. 154/1999. (X.22.) Korm. on the National Statistical Data Collection Program for 2000 Annex 1, items No. 1630 and 1631
10. Act XCII of 1999 on the Amendment of Act XXI of 1996 on Regional and Rural Development (promulgated: 30/10/1999)
 - strengthens the institution of regional development councils
11. Decree No. 52/1999. (XI. 12.) EüM of the Minister of Health on Medical Professional Colleges
12. Act CIX of 1999 on the Social Insurance Funds' Budget of 2000 (promulgated: 18/12/1999)
 - allows providers to use HIF financing for capital costs (Article 6, section (2))
13. Decree No. 74/1999. (XII.25.) EüM of the Minister of Health on Natural Therapeutic Factors
 - defines natural therapeutic factors, including mineral waters, medicinal waters, medicinal mud and medicinal gas (Articles 13–21), health resorts (geographical areas, where the natural therapeutic factors can be found) (Articles 2–9), as well as the service providers, which use these natural therapeutic factors for rehabilitation and curative purposes (Articles 10–12)
 - mandates the NPHMOS to operate a registration and licensing system and maintains a registration database (Articles 2, 10, 13, 22–23)

14. Decree No. 77/1999. (XII. 29.) EüM of the Minister of Health on Patient Right Representatives and the Rules of Procedures.

2000

1. Act II of 2000 on Independent Medical Practice (promulgated: 11/02/2000)
 - grants practising family doctors a right to practice which can be sold and bought
2. Government Decree No. 18/2000. (II. 25.) Korm on the Procurement and Withdrawal of a Family Doctor's Right to Practice, and the Terms and Conditions of Loans for Procurement of the Tangible and Intangible Assets and Right to Practice Required for Family Doctor's Practice
 - regulates buying and selling the right to practice in detail
 - provides subsidized loans to family doctors for buying medical equipment and surgery
3. Decree No. 4/2000. (II. 25.) EüM of the Minister of Health on the Family Doctor, Paediatric and Dental Primary Care Services
 - defines the professional content and rules of the provision of primary care
4. Announcement of the Ministry of Health on the Establishment of the Authority for Medical Devices of Ministry of Health (see the Deed of Foundation in *Health Gazette* 2000/7)
 - transfers the registration and licensing of medical devices to a newly established organization of the Ministry of Health as of 1 April 2000
5. Government Decree No. 48/2000. (IV. 13.) Korm. on Medical Aids and Prostheses which can be Prescribed with Social Insurance Subsidy and the Amount of Subsidy **and** Decree No. 12/2000. (IV. 13.) EüM of the Minister of Health on the Prescription, Distribution, Repair and Renting of Medical Aids and Prostheses which can be Prescribed with Social Insurance Subsidy
 - regulates the usage and financing of medical aids and prostheses
6. Government Decree No. 112/2000. (VI. 29.) Korm on the Scope of Duties and Authority of the Social Insurance Price and Subsidy Committee
 - establishes an advisory committee in price subsidy matters
7. Resolution No. 2150/2000. (VI. 30.) Korm. of the Government on Measures to Reduce Overspending in the Pharmaceutical Sub-budget of the HIF
 - includes price negotiations, the elaboration of a new system of pharmaceutical subsidies and decreases price margins
8. Act CXIII of 2000 on the Amendment of Various Laws on Taxes, Contributions and Other Government Revenues (promulgated: 14/11/2000)
 - abolishes the ceiling on the health insurance contribution of employees as of 1 January 2001, (Article 153, section 1)
9. Act CXVI of 2000 on Arbitration in Health Care (promulgated: 22/11/2000) **and** Joint Decree No. 4/2001. (II. 20.) EüM-IM of the Minister of Health and the Minister of Justice on Certain Aspects of Arbitration in Health Care
 - establish the institution and procedures of arbitration to resolve disputes between patients and health care providers outside of court
10. Government Decree No. 227/2000. (XII. 19.) Korm on the Amendment of Certain Regulations Concerning the Control of Social Insurance Administration

- relocates the control of the health insurance administration back to the Ministry of Health as of 1 January 2001
11. Resolution No. 2329/2000. (XII. 21.) Korm. of the Government on the Agreement with the Pharmaceutical Companies and Wholesalers to Contain the Pharmaceutical Sub-budget of HIF
- guarantees price increases below the level of inflation for three years.

2001

1. Decree No. 7/2001. (III. 2.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of Minister of Welfare
 - introduces version 4.3. of Homogeneous Diseases Groups (HDGs)
2. Decree No. 19/2001. (V. 23.) EüM of the Minister of Health on the Commercial Price Margins of Pharmaceutical Products (see also Decree No. 22/1992. (VIII. 19.) NM of the Minister of Welfare)
 - decreases the wholesale and retail price margins for expensive pharmaceuticals
3. Resolution No. 1052/2001. (V. 30.) Korm. of the Government on Measures to Reduce the Overspending of the Pharmaceutical Sub-budget of HIF
 - determines the objective to rationalize prescribing
 - endorses the inclusion in the positive list of the NHIFA (at 100% or 90% reimbursement) of substances that are more cost-effective than current therapies (Section 2)
4. Decree No. 22/2001. (VI. 1.) EüM of the Minister of Health on the Sales Promotion and Representation of Pharmaceuticals for Human Use
 - regulates sales promotion and representation, including medical representatives
5. Act XXXIV of 2001 on the Territorial Supply Obligation of Specialist Health Services, further more on the Amendment of Various Laws in Connection with Health Care (promulgated: 12/06/2001) **and** Government Decree No. 77/2001. (V. 9.) Korm. on the Amendment of Government Decree No. 217/1997. (XII. 1.) Korm.
 - abolishes capacity norms and stipulates that the inclusion of new capacities is to be approved by the Minister of Health, while allowing local governments more flexibility to restructure and reduce capacities
6. Government Decree No. 109/2001. (VI. 21.) Korm. on Pharmaceuticals which can be Prescribed with Social Insurance Subsidies and on the Extent of Subsidies
 - extends fixed amount subsidies
7. Decree No. 24/2001. (VI. 29.) EüM on the Amendment of Certain Decrees in Connection with the Reorganization of Certain National Institutes and Announcement of the Minister of Health on the Establishment of the National Health Promotion Centre (see the Deed of Foundation in: *Health Gazette* 2001/13; see also *Welfare Gazette* 1997/16 and *Health Gazette* 2000/5 on the National Institute of Prevention, and *Health Gazette* 1999/5 on the Health Promotion Research Institute)
 - merges the Health Promotion Research Institute and the National Institute of Health Promotion into a new institute, which is integrated into the National Office of the NPHMOS as of October 2001
8. Act LXII of 2001 on Hungarians living in Neighbouring Countries (promulgated: 7/7/2001)

- provides benefits to Hungarian ethnic minorities in neighbouring countries
 - stipulates that those who work in Hungary must participate in the statutory health insurance scheme and are entitled to health services (Article 7)
 - further stipulates that those who do not work in Hungary but utilize health services in the country can apply for reimbursement of actual expenses (Article 7)
9. Resolution No. 1066/2001. (VII. 10.) Korm. of the Government on the Principles of the Healthy Nation Public Health Programme, 2001–2010.
 - presents a public health action programme aiming to increase life expectancy of men and women to 70 and 78 years respectively
 10. Act LXX of 2001 on the Amendment of Various Acts Concerning Health Care, Supply of Pharmaceuticals, and Social Care for the Purpose of Legal Harmonization, and of Act LXXXIII of 1997 on the Services of Compulsory Health Insurance, and of Various Acts Concerning Social Insurance Contribution and Hypothecated Health Care Tax (promulgated: 25/10/2001) **and** Decree No. 34/2001. (X. 17.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of Minister of Welfare
 - abolishes dental co-payments on tooth preserving treatments as of 1 November 2001
 - increases the compulsory minimum ownership share of pharmacists in pharmacies to 50% (to be reached by 31 December 2006), and excludes pharmaceutical manufacturers and wholesalers from the ownership of pharmacies (Article 12)
 11. Act LXXXIII of 2001 on the Amendment of Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (promulgated on 4/12/2001)
 12. Act CVII of 2001 on Provision of Publicly Funded Health Care Services and on the Forms of Practising Medicine (promulgated: 24/12/2001)
 - widens the range of organizational options open to institutional and individual providers of health services, including the possibility of corporatization of hospitals (Article 12, section (3)) and self-employment of medical doctors and pharmacists (“free-lance” medical doctors and pharmacists).

2002

1. Government Decree No. 50/2002. (III. 26.) Korm. on the Technical Conditions of Modifying Specialist Health Care Capacities and on the Regulations of its Procedure and of Contracting New Providers
2. Decree No. 11/2002. (III. 26.) EüM of the Minister of Health on the Implementation of Certain Provisions of Act XXXIV of 2001 on the Territorial Supply Obligation of Specialist Health Services, further more on the Amendment of Various Laws in Connection with Health Care
3. Decree No. 12/2002. (III. 28.) EüM of the Minister of Health on the Rules about the Professional Development Plan of Public Health Care Institutions
4. Decree No. 13/2002. (III. 28.) EüM of the Minister of Health on the Qualification Requirements of the Director and Deputy Directors of Public Health Care Institutions as well as on the Detailed Regulations of Application for These Posts
 - requires that top managers of public health care institutions have a masters degree in management (Article 1, section (1), point b))
5. Decree No. 14/2002. (III. 28.) EüM of the Minister of Health on the Terms of Contracting Out Publicly Funded Health Care Services

6. Decree No. 15/2002. (III. 28.) EüM of the Minister of Health on the Operation and Professional Governing Body of Public Health Care Institutions
7. Government Decree No. 58/2002. (III. 29.) Korm. on the Detailed Regulations of Contracting Out Service Provision and Production and of Tendering Procedures
8. Government Decree No. 69/2002. (IV. 12.) Korm. on the General Conditions of Practising Medicine, on the Practice Licences and on the Health Services, which can be Provided as a Private Entrepreneur
9. Government Decree No. 70/2002. (IV. 12.) Korm. on the Detailed Regulations of the Contract on Practising Medicine
10. Government Decree No. 116/2002. (V. 15.) Korm. on the Detailed Regulations of the Establishment, Operation and Closing Down of University Centre of Clinical Departments, as well as of the Cooperation between the University and the University Centre of Clinical Departments
11. Act XI of 2002 on the Enumeration of the Ministries of the Republic of Hungary (promulgated: 22/5/2002)
 - merges the Ministry of Health and the Ministry of Social and Family Affairs into the Ministry of Health, Social and Family Affairs
12. Ministry of Health Guideline for the Economic Evaluation of Health Care Interventions (*Health Gazette* 2002/11; issued on 23/5/2002)
13. Government Decree No. 142/2002. (VI. 28.) Korm. on the Scope of Duties and Authority of the Minister of Health, Social and Family Affairs
14. Government Decree No. 148/2002. (VII. 1.) Korm. on the Prime Minister's Office
15. Resolution No. 38/2002. (VII. 4.) OGY of the National Assembly on preserving the long-term continuity of health policy
 - creates an independent system for the representation of patient rights and citizens participating in social welfare programmes (Section D)
16. Act XXIII of 2002 on the Amendment of Act CXXXIII of 2000 on the 2001 and 2002 Budget of the Republic of Hungary (promulgated: 19/7/2002)
 - Increases the salary of health workers (and other public employees) by an average of 50% as of 1 October 2002
 - suspends those clauses of Act CVII of 2001, which restricted the contracting out of publicly funded health services
17. Government Decree No. 163/2002. (VII. 26.) Korm. on the Amendment of Certain Government Decrees on the Implementation of the Provisions of Act CVII of 2001 on the Provision of Publicly Funded Health Care Services and on the Forms of Practising Medicine
 - suspends the implementation of government decrees No. 116/2002, 69/2002 and 58/2002 until 1 March 2003 in accordance with Act XXIII of 2002
18. Decree No. 10/2002. (XI. 7.) ESzCsM of the Minister of Health, Social and Family Affairs on the Amendment of Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services
 - modifies the list of outpatient specialist services
 - includes acupuncture in the list of services (Code 85400 and 85401 in Annex 2 of Decree 9/1993. (IV. 2.) NM)

19. Government Decree No. 227/2002. (XI.27.) Korm. on the National Statistical Data Collection Program for 2003 and on the Amendment of Government Decree No. 154/1999. (X.22.) Korm. Annex 2, items No. 1630/00 and 1631/00
20. Decree No. 16/2002. (XII. 12.) ESzCsM of the Minister of Health, Social and Family Affairs on the Professional Standards and Requirements for One Day Surgery and Course-Like Health Services
 - Defines one-day surgery (Article 2, section (1))
 - Regulates the organizational, infrastructural and human resource requirements of day care (Article 2, section (2), Article 3)
21. Decree No. 295/2002. (XII. 27.) on the Amendment of the Government Decree No. 217/1997
 - Allows individual price-volume agreements with manufacturers (Article 11).

2003

1. Resolution No. 46/2003. (IV. 16.) OGY of the National Assembly on the Johan Béla National Programme for the Decade of Health
 - introduces a ten-year national public health programme
 - launches national screening programmes on breast and cervical cancer as well as colorectal cancer (2005)
2. Resolution No. 2084/2003. (IV. 24.) Korm. of the Government on the Announcement of a Tender on the Inclusion of Extra Specialist Capacities into Social Health Insurance Financing
 - endorses the shift of more inpatient cases to day care
3. Decree No. 34/2003. (VI. 7.) ESzCsM on the Health Care Scientific Council
4. Call for proposals of the Ministry of Health, Social and Family Affairs for the Establishment of Regional Health Councils and for the Elaboration of Regional Health Care Development Plans (*Health Gazette* 2003/22, 10/6/2003)
 - provides financial assistance to set up Regional Health Councils and Regional Health Care Development Plans on a voluntary basis within the framework of the statistical-planning regions of Hungary
5. Act XLIII of 2003 on Health Care Providers and on the Organization of Publicly Funded Health Care Services (promulgated: 30/6/2003)
 - relaxes the regulation on the privatization of hospitals and polyclinics
6. Act XLIV of 2003 on the Repeal of Act CVII of 2001 on Provision of Publicly Funded Health Care Services and on the Forms of Practicing Medicine (promulgated: 30/6/2003)
 - repeals the previous act on corporatization and privatization in conjunction with the passing of Act XLIII of 2003
7. Decree No. 96/2003. (VII. 15.) on the general conditions for providing health care services and on provider licensing
8. Decree No. 40/2003. (VII. 16.) ESzCsM of the Minister of Health, Social and Family Affairs on the Amendment of Various Ministerial Decrees in Connection with Age-related Screening Programmes
 - introduces a new category of screening programmes, the so-called “Targeted Public Health Screening Programmes”, including cervical (in the age group 25 to 65) and breast cancer screening (in the age group 45 to 65), (Article 1 and 3)

- launches national cancer screening programmes
9. Announcement of the Minister of Health, Social and Family Affairs on the Deed of Foundation of the National Institute of Child Health (*Health Gazette* 2003/17, published on 21/7/2003)
 10. Announcement of the Minister of Health, Social and Family Affairs on the Amendment of the Deed of Foundation of the National Health Promotion Centre (*Health Gazette* 2003/17, published on 21/7/2003)
 - transfers the National Health Promotion Centre from the National Public Health and Medical Officer Services to the Ministry of Health, Social and Family Affairs, renames it to National Health Promotion Institute and relocates the professional supervision and coordination of youth health care to the newly established National Institute of Child Health
 11. Decree No. 43/2003 (VII. 29.) ESZCSM of Minister of Health, Social, and Family Affairs on the operation and management of health care providers
 12. Government Decree No. 1085/2003. (VIII. 19.) Korm. on the Upcoming Tasks of Modernization of the Health Care System
 - presents the objectives of health care reform measures
 - determines the main directions of health care reform, including regionalization (2.1), reinforcement of the purchasing function of the National Health Insurance Fund Administration (2.2), encouragement of privatization of outpatient specialist services (2.3), introduction of insurance for long term care and medical savings accounts (2.4), evaluation and further development of the care coordination pilot (2.5, 2.6), further development of information systems in the health sector (2.7)
 13. Resolution No. 2234/2003. (X.1.) Korm. of the Government on the Establishment of the Foundation for the Rights of Patients, Socially Indigents and Children
 14. Government Resolution No. CXXXVI of 2004. (X. 18.) Korm. on the Establishment of the Cooperation for People without a Flat and the Homeless People in Budapest and on the Amendment of the Deed of Foundation of the Emmi Pikler International Public Foundation
 15. Decree No. 60/2003. (X. 20.) ESzCsM of the Minister of Health, Social and Family Affairs on the Minimum Standards of Providing Health Care Services
 - defines the minimum standards for various types of services
 - further defines “daytime hospital” (Article 4, section (2), and Article 5, section (1), point d))
 - further defines the professional minimum standards of hospice care under Code 7306 (Annex 2)
 - regulates liability insurance (Article 2)
 16. Decree No. 61/2003. (X. 27.) ESzCsM the Minister of Health, Social and Family Affairs on Health Care Services that can be Provided exclusively on the Basis of Waiting Lists
 17. Government Decree No. 184/2003. (XI. 5.) Korm. on the Health Care Investment Loan Programme and on the conditions of Bank Guarantees
 - provides subsidized loans for the privatization of health care facilities
 18. Act LXXXIII of 2003 on the Chamber of Paramedical Workers (promulgated: 6/11/2003)
 - establishes professional self-regulation for non-medical qualified health personnel

19. Act LXXXIV of 2003 on the Various Aspects of Practicing Medicine (promulgated: 11/11/2003)
 - regulates the various employment options for health workers
20. Resolution No. 1115/2003. (XI. 26.) Korm. of the Government on the Scope of Duties and Authority of the Governmental Commissioner Responsible for the Implementation and Coordination of Health Sector Reform
21. Decree No. 68/2003. (XII. 13.) ESzCsM of the Minister of Health, Social and Family Affairs on the Corrective Coefficient to be Applied for the Reimbursement of Social Insurance Subsidies of Pharmaceuticals for Human Use and of Nutritional Products for October 2003
 - determines that pharmaceutical companies have to pay subsidies for any quantity of drugs that exceeds the volume agreed on with the National Health Insurance Fund Administration
22. Act LX of 2003 on Insurance Companies and Insurance (promulgated: 15/12/2003)
23. Ruling No. 63/2003. (XII. 15.) AB of the Constitutional Court
 - finds Act XLIII of 2003 unconstitutional for procedural reasons
24. Act CXVI of 2003 on the 2004 Budget of the Republic of Hungary and on the Three-year Principles of the State Budget (promulgated: 22/12/2003)
 - expands the Care Coordination Pilot up to 2 million inhabitants (Article 77)
25. Government Decree No. 264/2003. (XII. 24.) Korm. on the Amendment of Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - introduces payment limits in specialist care for performance above the 2003 level (Article 12 modifies Article 27).

2004

1. Decree No. 1/2004 (I. 5.) ESzCsM of the Minister of Health, Social and Family Affairs on the Regulation of the Operation of Patients', Socially Indigents' and Children's Right Representatives
 - defines the tasks of the Public Foundation of Patient, Child and Social care rights representative (Article 2), conditions for employment and obligation of representatives (Articles 1,3,4,5,7)
2. Governmental Decree No. 112/2004. (IV.12.) Korm. On the Amendment of Governmental Decree No. 43/1999. (III. 3.) Korm.
 - incorporates hospice home care as a separate payment category
3. Government Resolution No. 1035/2004. (IV. 19.) Korm. on the Reorganization of the Foundation for the Homeless into Public Foundation for the Homeless and on the abolishment of certain foundations without legal successor
4. Decree No. 32/2004 (IV. 26.) ESzCsM of the Minister of Health, Social and Family Affairs on the Criteria of the Inclusion of Registered Medicines and Special Nutritional Formulae into Social Health Insurance Financing and on the Modification of the Inclusion Decision or the Extent of the Subsidy
 - sets new inclusion and exclusion rules according to the Transparency Directive (Article 24, section (3))

- establishes new criteria to be used as a basis for decision-making regarding, for example, cost-containment and cost-effectiveness in the classification of pharmaceuticals reimbursed by the HIF
 - defines possible reimbursement categories for pharmaceuticals (Article 4)
 - regulates internal reference pricing (Articles 6–10) and step pricing (Article 19)
 - sets the list of countries to be used for external price referencing (Annex 6/a)
 - endorses the establishment of a Technology Appraisal Committee and the involvement of ESKI in the process of HTA on behalf of the NHIFA (Article 19)
5. Decree No 44/2004 (IV.28.) ESzCsM of the Minister of Health, Social and Family Affairs on the Prescription and Dispensing of Pharmaceuticals for Human Use
 - determines the rules for the prescription of medicines
 6. Decree No. 49/2004. (IV. 29.) ESzCsM on the Regional Mother-and-Child Health Nurse Service
 - reorganizes the MCH Service by transferring the responsibility for the age group 6–16 from the regional service to the school health service (Article 3, point d) and f), Article 8, section (2))
 7. Resolution No. 2207/2004. (VIII. 27.) Korm. of the Government on the Actual Tasks in Connection with the Infrastructure Development Programme of Higher Education Institutions under the Supervision of the Ministry of Education
 8. Deed of Foundation of the Public Foundation for the Homeless (*Official Bulletin* – the Annex of the *Hungarian Gazette*, issue No. 134/2004, 14/09/2004)
 9. Decree No. 5/2004. (XI.19.) EüM of the Minister of Health on the Therapeutic Services that can be Utilized with Social Health Insurance Subsidy for the Purpose of Medical Rehabilitation
 - regulates the professional minimum standards for balneotherapy and medicinal swimming for children and the rules of utilization
 - stipulates that services have to be prescribed by an authorized specialist (Article 3, Annex 5), and utilized at a provider with a valid contract with NHIFA (Article 12)
 - limits the number of subsidised treatment courses (2), and the number of treatment episodes per course (15) per year (Article 5 and 8)
 10. Act CXXIII of 2004 on young people starting a career, unemployed persons over the age of 50, job-seekers after maternity leave and on other specified social groups (promulgated 21/12/2004)
 - defines exemption types from different contribution payments (Article 4/A)
 11. Act CXXXV of 2004 on the budget of the Hungarian Republic for the year 2005 and amendment of the Act CLIV of 1997 on health care (Section 149/A) (promulgated 27/12/2004)
 - establishes the Regional Health Councils (Article 149/A-D)
 - endorses that priorities of the National Public Health Programme be enforced in decision making and implementation of all sectoral policy-making (Article 105, Section 2)
 12. Act CXXXVI of 2004 on the Amendment of Certain Social Care Related Acts (27/12/2004).

2005

1. Act III of 2005 on enacting the World Health Organisation Framework Convention on tobacco control (promulgated: 04/03/2005)
2. Decree No. 15/2005. (V. 2.) EüM of the Minister of Health on Professional Supervision of Health Care Providers
 - reorganizes the system of professional supervision of health care providers and establishes the National Centre for Health Care Audit and Inspection as the main entity responsible for the control of quality of care
3. Act XCV of 2005 on the Pharmaceuticals for Human Use and on the Amendment of Other Acts Regulating the Pharmaceutical Markets (promulgated: 25/07/2005)
4. Decree No. 52/2005. (XI. 8.) EüM of the Minister of Health on the Licensing of Pharmaceuticals for Human Use Article 18, section (2), point c)
5. Act CXIX of 2005 on the Amendment of Certain Acts concerning Taxes, Mandatory Contributions and Other Payments to the Central Budget (promulgated: 15/11/2005)
 - defines the obligation of the central government to cover contributions for certain social groups, such as pensioners, students, recipients of child care benefits etc (Articles 130 and 134)
6. Act CXX of 2005 on the simplified contribution to public charges (Proclaimed 15/11/2005)
 - defines entitled occupational groups (Article 3, Section 3)
 - further defines contribution levels (Articles 4)
 - further defines the new contribution as a tax-type payment and determination of its collection as tax (Articles 1 and 11)
7. Act CXXXIX of 2005 on Higher Education (proclaimed 14/12/2005)
8. Act CLXX of 2005 on the Amendment of Act III of 1993 on Social Services (19/12/2005)
 - introduces a new system for the user charge exemption scheme – a monthly personal budget of HUF 12 000 (about €47.5) (Articles 17–23)
9. Decree No. 65/2005. (XII. 22.) EüM of the Minister of Health on the Modification of Decree No. 47/2004. (V. 11.) ESzCsM of the Minister of Health, Social and Family Affairs on Certain Organizational Issues of the Continuous Operation of Health Care
 - postpones the deadline by which single-handed stand-by family doctor out-of-hours services have to be abolished and centralized either into so-called “pooled” (fixed location) or “central” (changing location) out-of-hours services from the end of 2005 to the end of 2006
10. Government Decree No. 314/2005 (XII.25) on environmental impact assessment and integrated permits
 - defines for which activities EIA is obligatory or optional (Article 3, Section 1)
 - defines relevant health aspects (Article 6)
11. Decree No. 67/2005. (XII. 27.) EüM of the Minister of Health on the Amendment of Decree No. Decree No. 51/1997 (XII. 18.) NM of the Minister of Welfare on the Preventive and Early Diagnostic Services that Can be Utilized in the Frame of Social Health Insurance System and on the Certification of Participation in Screening Programmes
 - introduces two new public health screening programmes for occult gastrointestinal bleeding and prostate cancer (for the age group 50 to 70) on a pilot basis (Article 3)

12. Act CLXXXII of 2005 on the amendment of acts regulating the services of mandatory health insurance (promulgated: 29/12/2005)
 - sets up the Care Coordination system (Article 11).

2006

1. Decree No. 5/2006. (II.7.) EüM on Emergency Rescue Services
 - describes the content and human resource and material requirements of emergency rescue services in detail
2. Act XXIV of 2006 on the New Conditional Grants of Local Governments for 2006, on the Amendment of the Original Decisions Regarding the Ongoing Investment Projects and on the Amendment of Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (promulgated on 17/2/2006)
 - provides the last round of conditional investment grants in the frame of “earmarked subsidies” (Annex 1)
 - authorizes the government to harmonize investment decisions with upcoming EU funding for the period of 2007–2013 (Article 14)
3. Decree No. 20/2006. (V.9.) EüM of The Minister of Health on the Amendment of Decree No. 76/2004. (VIII.19.) ESzCsM of the Minister of Health, Social and Family Affairs on the Definition, Collection and Processing of Certain Impersonalized Sectoral (Health, Professional) Data
 - Annex, Part A, items No. 4133/06 and 4134/0
4. Decree No. 23/2006. (V.18.) EüM of the Minister of Health on the Guideline of the Development, Editing and Professional Debate of Diagnostic and Therapeutic Guidelines
5. Government Decree No. 132/2006. (VI. 15.) Korm. on the Amendment of Government Decree No. 43/1999. (III. 3.) Korm. on the Detailed Regulations of the Social Insurance Financing of Health Services
 - introduces restrictive measures in the payment system: (1) abolishes the average marginal cost payment scheme in specialist in- and outpatient care, while fixing the output volume limit at 95% of the 2005 output (in terms of HDG and FFS points) of the provider (Article 1, Article 5, section (4)); (2) denies payment for outpatient specialist care if the average time spent on a patient falls below 5 minutes (Article 2); (3) denies payment if bed occupancy exceeds 100% (Article 3); (4) decreases the weights of bed days in chronic care considerably (Article 4)
6. Resolution No. 1103/2006. (X. 30.) Korm. of the Government on the Approval of the New Hungary Development Plan
 - formulates a development plan for the use of EU funds for the period of 2007–2013.
7. Act XCVII of 2006 on professional chambers in health care abolishing Act XXVII of 1994, Act LI of 1994 and Act LIII of 2003(29/11/2006)
 - regulates addressing medical negligence (Article 20–26)
8. Act XCVIII of 2006 on the General Regulations of Safe and Efficient Supply of Medicines and Medical Aids and Prostheses and of the Distribution of Pharmaceuticals (promulgated on 29/11/2006)

- liberalizes the retail market of pharmaceuticals, eliminates most of the restrictions on ownership (no limitations regarding the type of business entity, no minimum share of pharmacists stipulated, manufacturers and wholesalers not excluded, pharmacy chains not prohibited (Articles 74–75)), relaxes the criteria on the establishment of new pharmacies (Article 49, section (3))
 - bases taxation of companies and pharmacies on the reimbursed value of their sales and the number of employed marketing agents (Article 36, section 1–4)
 - defines the various types of pharmacies (Articles 3, 49–52)
 - Further defines the process and responsibilities for deciding whether certain pharmaceuticals are to be included in or excluded from the benefits package (Article 22–35) – before these were regulated by Government Decree No. 91/2004 (IV.6)
 - further defines reimbursement categories and the reimbursement application process for pharmaceuticals (Articles 24–30)
 - sets the rules for exclude products from the positive list administered by the NHIFA (Article 31)
 - permits the retail sale of certain OTC drugs outside of pharmacies (Articles 67–72)
 - authorizes the Minister of Health to develop and approve an IT tool that will support cost-effective prescription and to determine the date after which utilization of said tool becomes mandatory as well as the related accreditation rules (Articles 77 and 87)
9. Act CXV of 2006 on the Amendment of Certain Health Care Related Acts in Connection with the Reform of the Health Care System (promulgated: 18/12/2006)
- Curtails the social health insurance funded benefit package by introducing (1) financing protocols, whereby extra costs associated with any patient-requested deviation from the system have to be covered by the patient (Articles 1, 8), (2) co-payments for the utilization of family doctor services, outpatient specialist care (together the so-called “visit fee”) and inpatient care (the so-called “hospital per diem”) (Articles 3,7,17,18,19,40,42), (3) co-insurance for free choice of doctor and (without a valid referral) hospital (Articles 8, 11,13), and (4) the exclusion of certain services, such as health services for accidents due to extreme sports, health services connected to professional sporting (Article 7) and sex change operations (Article 11)
 - introduces the so-called “declaration of services provided”, which has to be printed and signed by the patient (Articles 6,18,43)
 - provides detailed new regulations for the administration of waiting lists (Articles 9,10)
10. Act CXVI of 2006 on the authority supervision of health insurance (promulgated: 18/12/2006)
- defines the tasks of the Health Insurance Supervisory Authority regarding quality evaluation (Article 8 Section b and c)
11. Act CXXI of 2006 on the Amendment of Certain Act for the Establishment of the Budget of 2007 of the Republic of Hungary (promulgated: 19/12/2006)
- suspends conditional capital grants for 2007–2008 (Article 3, section (2), Article 34)
 - abolishes the system of “target-type decentralized grants” (Article 29, section (3) point a)
12. Act CXXXII of 2006 on the Development of the Health Care Delivery System (promulgated on 22/12/2006)
- defines the quantity of publicly funded specialist capacities in the Hungarian health care system (Article 2, section (1), Annex 1 and 2)

- classifies capacities according to a new typology: priority capacity, capacity for special purposes, normal capacity (Article 3)
 - separates the special national institutes of health and the priority hospitals (while determining their number of beds, Annex 1) from the rest of the hospitals, whose inpatient care capacities are determined only in total at the regional level (Annex 2). The actual distribution of hospital beds among these non-priority hospitals is determined annually (Article 3 and 7)
 - designates the regional health councils as the primary decision-makers for the distribution of capacities and the designation of service delivery catchment areas under territorial supply obligation (Article 2, section (2), Article 4, section (3)), but in both cases, the approval of the owners are required (Article 2, section (2), Article 4, section (4))
 - determines the process of decision-making regarding the distribution and the decrease or increase of capacities (Article 4–11)
 - Assigns the minister of health as the final decision-maker If there is no consensus on the distribution of capacities (Article 4, section (6))
13. Government Decree No. 274/2006. (XII. 23.) Korm. on the Establishment and Operation of the Central Agricultural Office
- establishes the Central Agricultural Office by merging independent agricultural authorities dealing with e.g. plant and soil protection, animal health, hunting, fishing, forestry
 - transfers the responsibility for food safety from the NPHMOS to the Central Agricultural Office as of 1 October 2007
14. Government Decree No. 287/2006. (XII. 23.) on the detailed regulation of health services provided based on waiting lists
- appoints the National Blood Supply Institute (NBSI) as the managing institute of professional commissions for organ transplantation (Article 6–13)
 - stipulates that the Health Insurance Supervisory Authority is to be informed on waiting and reception lists by the 15th of a given month (Article 13/B)
15. Government Decree No. 295/2006. (XII. 23.) Korm. on the Hungarian Labour Inspectorate
- transfers the responsibility for occupational health from the NPHMOS to the Hungarian Labour Inspectorate as of 1 January 2007 (Article 2, section (5), Article 5, section (1))
16. Government Decree No. 317/2006. (XII. 23.) on the National Health Insurance Fund
- defines the NHIF as a government office (Article 1) to be supervised by the Minister responsible for social health insurance (Article 2)
17. Government Decree No. 320/2006. (XII. 23.) Korm. on the Amendment of Government Decree No. 284/1997. (XII.23.) Korm. on the Fees of Certain Health Services, which can be Utilised with User Fees Only
- defines the amount of user fees
 - sets the maximum amount of co-insurance for the free choice of physician and the utilization of specialist providers without a valid referral at HUF 100 000 (about €394) (Article 1, section (2))
18. Government Decree No. 322/2006. (XII.23.) Korm on the National Emergency Ambulance Service

- defines the organizational structure (Articles 1–4) and the main tasks of the National Emergency Ambulance Service (Articles 5–7)
19. Government Decree No. 323/2006. (XII. 23.) on the National Blood Supply Service
 20. Decree No. 53/2006 (XII.28.) EüM of the Minister of the Health on the amendment of Decree No. 32/2004 (IV.26) ESzCsM of the Ministry of Health, Social and Family affairs
 - substantially decreases pharmaceutical reimbursement categories to be covered by the HIF (from 90% to 85%, 70% to 55% and 50% to 25%) and establishes new categories for specific conditions which are to be prescribed for by a specialist (now 90%, 70% and 50%) (Article 2, Sections 4–8)
 - regulates step pricing for generics (Article 10, Section 2)
 21. Government Decree No. 361/2006. (XII. 28.) Korm. on the Implementation of Act CXXXII of 2006 on the Development of the Health Care Delivery System (the executive order of Act CXXXII of 2006)
 - provides detailed procedural rules regarding the decision-making process on specialist inpatient care capacities
 22. Government Decree No. 362/2006. (XII. 28.) Korm. on the National Public Health and Medical Officer Service and the Designation of the Pharmaceutical Public Administration Authority
 - regionalizes the organization of the National Public Health and Medical Officer Service (Article 4)
 - defines the tasks of the NPHMOS (Articles 5–9, 10–14/B)
 23. Decree No. 57/2006. (XII.29.) EüM of the Minister of Health on the Criteria of the Distribution of Specialist Care Capacities and of Access to Care
 - defines the availability and access criteria to be met when deciding on the distribution of specialist care capacities (Article 2)
 - stipulates that previous downsizing decisions have to be taken into account in the decision making process (Article 4).

2007

1. Decree No. 5/2007. (I. 24.) EüM of the Minister of Health on the Price Margins of Subsidized Pharmaceuticals
 - introduces a fixed retail margin for medicines over HUF 5 000 (about €20) on wholesale price (Article 2, section (2))
2. Government Decree No. 35/2007 (III. 07.) on the amendment of Government decree No.217/1997 of December 1st on the enforcement of Law LXXXIII/1997 relating to the services provided for by statutory health insurance and the amendment of the Government Decree no. 43/1999 of March 3d relating to the specified rules of financing health services from the budget of the Health Insurance Fund)
 - establishes a procedure to control the HIF registration status of patients
3. Government Decree No. 41/2007. (III. 13.) Korm. on Certain Payment, Contracting and Procedural Issues in Connection with the Implementation of Act CXXXII on the Development of the Health Care System
4. Government Decree No. 63/2007. (III. 31.) Korm. on the Amendment of Certain Health Care Related Government Decrees and on the Compensation of the Visit Fee of Patients on Job Seeking Allowance

- defines the same co-insurance (30% of the NHIFA payment) and the same ceiling (HUF 100 000) as in the case of the free choice of physician (Article 2) for the choice of an inpatient care provider other than the one the patient was referred to
5. Decree No. 18/2007. (IV. 17.) EüM of Ministry of Health on the registration and licensing of medical professionals
 6. Decree No. 23/2007. (V.18.) EüM of the Minister of Health on the Extent and Amount of Subsidies of Therapeutic Services, that can be Prescribed in the Frame of Social Health Insurance
 - lists the agreed price, the extent of social insurance subsidy and the amount of social insurance subsidy for balneotherapy and medicinal swimming for children
 7. Decree No. 58/2007. (VI. 15.) GKM on the termination of the Central Railway Hospital and Outpatient Care Provider
 8. Government Decree No. 138/2007. (VI. 18.) Korm. on the Amendment of Government Decrees Related to the Establishment of a Unified Organization for Food-Safety
 - transfers the food inspection duties of the NPHMOS to the Central Agricultural Office (Articles 4, 7; Article 8, sections (1–4))
 9. Decree No. 41/2007. (IX. 19.) EüM of the Minister of Health on the Operational, Service and Administrative Procedures of Community, Branch and Hand Pharmacies, as Well as Hospital Pharmacies
 - states the operational and administrative rules and defines minimum standards
 10. Act CXLVI of 2007 on the Amendment of Certain Act for the Establishment of the Budget of 2008 of the Republic of Hungary (promulgated: 5/12/2007)
 - makes matching capital grants (target subsidies) available only for health care for the period of 2008–2009 (Article 5)
 11. Government Decree No. 366/2007. (XII. 23.) on the amendment of Government Decree No. 195/1997 on the funding of social health insurance services
 - Regulates the contribution of the central budget to the HIF (Article 4)
 12. Government Decree No. 364/2007. (XII. 27.) Korm. on the Amendment of Certain Health Care Related Government Decrees
 - stipulates that providers' payment for medical rehabilitation depends on meeting the minimum standards set by the "professional colleges"; providers not fulfilling these requirements are reimbursed at lower (chronic, or long term care) rates (Article 10)
 - privatizes patient transfer services (Article 3).

2008

1. Act I of 2008 (II. 11.) on Health Insurance Funds
2. Act IX of 2008 (III.26.) on the implementation of the national referendum on 9 March 2008
 - eliminates visit and daily fees for various health services in outpatient and inpatient care (Article 1m Section 2)
3. Decree No. 22/2008 (IV. 12.) EüM of the Minister of Health on the Amendment of Certain Health Care Related Ministerial Decrees
 - allows providers to convert part of their billable FFS points into HDG points to support the increase of day care interventions (Article 4, Section (8))

4. Ruling No. 109/2008. (IX.26.) AB
 - finds the decision-making regarding the distribution of inpatient care capacities unconstitutional, because the criteria are too vague and leave to much discretion for the minister of health
5. Act LXI of 2008 on the Amendment of Act XXXIII of 1992 on the Legal Status of Public Employees (promulgated: 31/10/2008)
 - Articles 22, 23 and 33
6. Decree No. 52/2008. (XI. 12.) EüM of the Minister of Health on Medical Professional Colleges
7. Government Decree No. 297/2008. (XII. 11.) on the amendment of Government Decree No. 317/2006. (XII. 23.)
 - determines the regional administrative districts within the NHIFA (Sections 1 and 3)
8. Act CV of 2008 on regulating the legal status and financial management of public budgetary institutions (22/12/2008)
9. Act CVI of 2008 on the Amendment of Certain Health Care Related Acts (promulgated on 22/12/2008)
 - redefines the decision criteria and decision-making process on specialist care capacities and catchment areas under territorial supply obligation and designates the NPHMOS as the main decision-maker (Articles 47–56, 59–61)
 - enables the NHIFA (health insurer) to contract selectively on the basis of quality of care (Article 58)
 - introduces the concept of “pharmaceutical care” (Article 24, section (3))
 - eliminates the care coordination system (Article 73, Section 4/A)
10. Government Decree No. 337/2008. (XII.30.) Korm. on the Implementation of Act CXXXII of 2006 on the Development of the Health Care Delivery System (executive order of Act CXXXII of 2006)
 - replaces the previous procedural rules regarding the decision-making process on specialist inpatient care capacities, according to the provisions of Act CVI of 2008
 - designates the national chief medical officer as the final decision maker regarding capacity redistributions among regions (Article 17, section (1))
 - further designates the regional offices of the NPHMOS as the final decision-makers regarding capacity modifications within regions (Article 17, section (2), points da, dc and de) and makes them responsible for the designation of catchment areas (Article 17, section (2), point dd)
11. Government Decree No. 348/2008 (XII.31) on dissolving the managed care system
12. Government Decree No. 356/2008. (XII.31.) Korm. On the Implementation of the Provisions of Act XXXIII of 1992 on the Legal Status of Public Employees in Health Care Organizations.

2009

1. Decree No. 4/2009. (III. 17.) EüM on medical devices
2. Government Decree No. 122/2009 (VI.12.) Korm. On the System of Specialization Training in Health Care
3. Decree No. 19/2009. (VI. 18.) EüM of the Minister of Health on the Implementation of Free Diagnostic Services for the 16-year old, and on the Amendment of Various Decrees in Connection with the Introduction of the “Health Care Certification Booklet”
 - abolishes the two public health screening programmes (for occult gastrointestinal bleeding and prostate cancer) introduced in 2006 (Article 13, section (4), point a)
4. Decree No. 26/2009. (VIII.5.) EüM of the Minister of Health on the Amendment of Decree No. 20/1996. (VII.26.) NM of the Minister of Welfare on Specialist Home Care
 - introduces separate professional regulations for hospice care
5. Government Decree No. 232/2009. (X.19.) Korm. on the Amendment of Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
6. Announcement of the Ministry of Health on the Professional Guideline, Protocol and Methodological Letter of the Ministry of Health in *Official Bulletin* No. 2009/53. (30 October 2009)
7. Act CIX of 2009 on the Amendment of Certain Act for the Establishment of the Budget of 2010 of the Republic of Hungary (promulgated: 10/11/2009)
 - suspends conditional grants for new investment for the 2011–2012 period (Article 3, section (13))
8. Act CXXX of 2009 on the 2010 Budget of the Republic of Hungary (promulgated: 11/12/2009)
 - Article 72, Annex 12
9. Government Decree No. 291/2009. (XII. 18.) Korm. on the Amendment of Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - incorporates minimum standards for providers of medical rehabilitation into the decree on payment methods (three categories: A, B and C); providers in category C are paid for medical rehabilitation with a weight equivalent to chronic care (Article 12, section (1); Article 14, section, (2), Annex 2)
10. Government Decree No. 288/2009 (XII.19.) Korm. on the Data Collections and Data Transfers of the National Statistical Data Collection Programme
 - Annex 2, items No. 1639 and 1631
11. Decree No. 56/2009. (XII. 30) EüM of the Minister of Health on the Amendment of Decree No. 41/2007. (IX. 19.) EüM of the Minister of Health on the Operational, Service and Administrative Procedures of Community, Branch and Hand Pharmacies, as Well as Hospital Pharmacies
 - describes the system of “pharmaceutical care” (Article 21).

2010

1. Decree No. 5/2010. (II. 16.) EüM of the Minister of Health on the Health Care Professional Training and Continuing Education Council
 - determines the tasks of the Council (Article 4)
2. Government Decree No. 75/2010 (III.25.) Korm. on the Amendment of Government Decree No. 356/2008 (XII.31.) Korm. on the Implementation of the Provisions of Act XXXIII of 1992 on the Legal Status of Public Employees in Health Care Organizations
 - Article 10, section 1
3. Government Decree No. 180/2010. (V. 13.) on the principles of purchasing decisions of the NHIFA, regarding new technologies already reimbursed technologies
4. Decree No. 31/2010. (V.13.) EüM of the Minister of Health on the Financing Protocols
5. Decree No. 35/2010. (V. 14.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services and of Decree No. 18/1998. (VI. 3.) NM of Minister of Welfare on the Prevention and Control of Infectious Diseases and Epidemics
 - expands the list of one-day interventions (Article 6, section (8))
6. Deed of Foundation of the national institutes of the NPHMOS (*Official Bulletin [Hivatalos értesítő]* – the Annex of the *Hungarian Gazette [Magyar Közlöny]*, issue No. 39/2010, 26/05/2010)
 - National Centre for Epidemiology (pp.8692–8694)
 - National Institute for Health Development (pp.8695–8696)
 - National Institute for Food and Nutrition Science (pp.8697–8699)
 - National Centre for Healthcare Audit and Inspection (pp.8700–8702)
 - National Institute of Chemical Safety (pp.8703–8704)
 - Frédéric Joliot-Curie National Research Institute for Radiobiology and Radiohygiene (pp.8705–8707)
 - National Institute of Environmental Health (pp.8708–8709)
 - National Institute of Primary Health Care (pp.8710–8712)
 - National Institute for Child Health (pp.8713–8715)
7. Act XLII of 2010 on the Enumeration of the Ministries of the Republic of Hungary (promulgated: 29/5/2010)
 - Stipulates that the Ministry of Health becomes the State Secretariat for Healthcare within the Ministry of National Resources
8. Government Decree No. 212/2010. (VII. 1.) on the Scope of Duties and Authority of the Ministers and the State Secretary of the Prime Minister's Office
 - describes the duties and authorities of the Minister of National Resources (Articles 41 to 72)
9. Act LXXXIX of 2010 on the Amendment of Certain Health and Social Service Related Acts (promulgated: 12/08/2010)
 - suspends the establishment of new pharmacies and ban horizontal integration (Article 11)
 - abolishes the Act on the public supervision of Health Insurance (Act CXVI of 2006) (Article 25, Section 1/d)

10. Government Decree No. 225/2010. (VIII.12.) Korm. on the Amendment of Certain Government Decrees in Connection with the Abolishment of the Health Insurance Supervisory Authority
11. Decree No. 4/2010. (VIII.12.) NEFMI of the Minister of National Resources on the Amendment of Certain Ministerial Decrees in Connection with the Abolishment of the Health Insurance Supervisory Authority
12. Act CX of 2010 on annulling Act CV of 2008 on regulating the legal status and financial management of public budgetary institutions (13/08/2010)
13. Government Decree No. 151/2010 on the Amendment of the executive order of Government Decree No. 217/1997. (XII. 1.) of Act LXXXIII of 1997 on the Services of Compulsory Health Insurance
 - sets the rules for reimbursing medical aids and defines the type of reimbursement, i.e. proportional or fixed amount (Article 7)
14. Act CLXXIII of 2010 on the Amendment of Certain Health Care Related Acts (promulgated: 30/12/2010)
 - returns to the earlier, ethical model of pharmaceutical retail trade (Articles 57–89).

10. Appendices

10.1 References

- Ádány R (2008). A magyar lakosság egészségi állapota, különös tekintettel az ezredforduló utáni időszakra [The health status of the Hungarian population, with special reference to period after the turn of the millennium]. *Népegészségügy [Public Health]*, 86(2):5–20.
- Ágoston I et al. (2009). A magyar egészségügyi kapacitások törvényi szabályozásának változásai [Changes in the regulation of capacities in Hungarian health care]. *Egészségügyi Gazdasági Szemle [Journal of Health Economics]*, 2009(5):3–7 (<http://www.weborvos.hu/adat/files/2008/egsz37.pdf>, 2009/5, accessed 15 January 2011).
- Antalóczy K (1997). *A magyar gyógyszeripar versenyképessége – adatok, hipotézisek, töprengések [The competitiveness of the Hungarian pharmaceutical industry – data, hypotheses, reflections]*, Series No. 17. Budapest, Budapest University of Economics (http://edok.lib.uni-corvinus.hu/213/1/MT_17_Antalóczy.pdf, accessed 31 March 2011).
- Antonyi Zs (2011). *A Magyar Egészségpolitika Évkönyve [The yearbook of Hungarian health policy]*. Budapest, National Institute for Strategic Health Research.
- Babusik F (2004a). *A szegénység csapdájában. Cigányok Magyarországon – szociális, gazdasági helyzet, egészségi állapot, szociális és egészségügyi szolgáltatásokhoz való hozzáférés [In the trap of poverty: the Roma in Hungary – socioeconomic status, health status, access to health and social services]*. Budapest, Delphoi Consulting (<http://www.delphoi.hu/download-pdf/roma-szoc-eu.pdf>, accessed 31 March 2011).
- Babusik F (2004b). *Differences in access to primary healthcare – structure, equal opportunity and prejudice: the results of an empirical study*. Budapest, Delphoi Consulting (<http://www.delphoi.hu/engpage/enindex.html> accessed on 31 March 2011).
- Belicza É (2004). *Népegészségügyi Jelentés 2004. – Szakértői változat: Egészségügyi ellátórendszer [Public health report 2004 – version for experts: health care system]*. Budapest, Johan Béla Országos Epidemiológiai Központ [Johan Béla National Centre for Epidemiology].
- Belicza, É (2008). Minőségbiztosítási kérdések az onkológiában [Quality management issues in oncology]. Hospital Directors' Forum for Hospitals with Oncology Centres, Balatonalmádi, 23 May 2008.
- Bognár G, Gál RI, Kornai J (2000). Hálapénz a magyar egészségügyben [Gratitude money in the Hungarian health system]. *Közgazdasági Szemle*, 47(4):293–320.
- Borbás I, Mihalicza P (2011). *A Magyar Egészségpolitika Évkönyve [The yearbook of the Hungarian health policy]*. Budapest, National Institute for Strategic Health Research.
- Burány B (2007). Oxiologus-Krizis Magyarországon [Crisis of emergency physicians in Hungary]. *IME*, 6(6):20–26.

- Carey K (2000) Hospital cost containment and length of stay: an econometric analysis. *Southern Economic Journal*, 67(2):363–380.
- Csaba I (2007). Zsebből fizetve – Egészségügyi magánkiadások Magyarországon [Paid out-of-pocket – private health expenditures in Hungary]. Presentation at the X. Egészség-gazdaságtani Szimpózium, Budapest, 23 November (http://egk.tatk.elte.hu/index.php?option=com_content&task=view&id=56&Itemid=34 accessed 31 March 2011).
- Eke E, Girasek E, Szócska M (2011). From melting pot to change lab in central Europe: health workforce migration in Hungary. In: Wismar M et al., eds. *Health professional mobility and health systems*. Brussels, European Observatory on Health Systems and Policies.
- Ékes I, Bondár É (1994). *Életmód, egészségi állapot és az egészségügyről alkotott lakossági vélemények [Lifestyle, health status and opinion on health insurance]*. Budapest, SZGTI.
- European Commission (2007). *Cross-border health services in the EU – analytical report*, Flash EB No. 210. Budapest, The Gallup Organization Hungary (http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf, accessed 23 November 2010).
- European Commission (2009). *Joint report on social protection and social inclusion 2009*. Luxembourg, Office for Official Publications of the European Communities (<http://ec.europa.eu/social/main.jsp?catId=757&langId=en>, accessed 31 March 2011).
- European Commission (2010). *Hungary: macrofiscal assessment. An analysis of the January 2010 update of the convergence programme*, 7 April. Brussels, European Commission, Directorate for General Economic and Financial Affairs (http://ec.europa.eu/economy_finance/sgp/pdf/20_scps/2009-10/02_technical_assessment/hu_2010-04-07_ta_en.pdf, accessed 23 February 2011).
- European Commission (2011). Eurostat [online database]. Luxembourg, European Commission (<http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home>, accessed 23 February 2011).
- European Commission and Empirica (2008). *Benchmarking ICT use among general practitioners in Europe: final report*, April. Bonn, Empirica (http://ec.europa.eu/information_society/europe/i2010/docs/benchmarking/gp_survey_final_report.pdf, accessed 11 May 2011).
- European Opinion Research Group (2010). *Patient safety and quality of health care: special Eurobarometer*. Brussels, European Commission (http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_sum_en.pdf, accessed 31 March 2011).
- Figueras J, Robinson R, Jakubowski E (2005). *Purchasing to improve health systems performance*. Maidenhead, Open University Press.
- Foundation for the Rights of Patients, Social Service Beneficiaries and Children (2009). *Közhasznúsági jelentés 2009 [Annual Report 2009]*. Budapest, Foundation for the Rights of Patients, Social Service Beneficiaries and Children (<http://www.jogvedok.hu/www/files/5413ef0caa27c9c0cd3f8b7ba7f75962.pdf>, accessed 4 March 2011).
- Foundation for the Rights of Patients, Social Care Beneficiaries and Children (2010). 10 éves a betegjogi képviselő [The Institution of Patient Rights Representative is 10 years old]. Budapest, Foundation for the Rights of Patients, Social Service Beneficiaries and Children (http://www.jogvedok.hu/www/kozalapitvany/10evesabetegjogikepviselet/lay/articles/show/107/10_eves_a_betegjogi_kepviselet, accessed 31 March 2011).
- Gaál P (2004). *Health care systems in transition: Hungary*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

- Gaál P (2009). Study report on the impact of health financing reforms on financial protection and equity. Manuscript for the WHO BCA 2008–2009 project Assessment of the Impact of Health Financing Reform on Financial Protection and Equity in Finance and Service Delivery in Hungary. Budapest, Health Services Management Training Centre, Semmelweis University.
- Gaál P et al. (2006). Informal payments for health care: definitions, distinctions, and dilemmas. *Journal of Health Politics, Policy and Law*, 31(2):251–293.
- Gál R et al. (2003). Hungary country study. In: *Social protection systems in the 13 applicant countries*. Brussels: European Commission – Employment and Social Affairs DG (http://ec.europa.eu/employment_social/social_protection/docs/hungary_final.pdf, accessed 16 April 2011).
- Gay JG et al. (2011). *Mortality amenable to health care in 31 OECD countries: estimates and methodological issues*. Paris, OECD (OECD Health Working Papers, No. 55).
- GfK Hungaria (2007). *Lakossági egészségfelmérés és gyógyszerhasználat 2007 [Population health survey and the use of pharmaceuticals]*. Budapest, GfK Hungaria Market Research Institute.
- Gódcény S, Csath M (2008). Nemzeti minőségügyi stratégia szükségessége az egészségügyi rendszerben [The need for a national strategy for quality in health care]. *IME*, 9(8):22–29.
- Government of the Republic of Hungary (2006). *Új Magyarország. Szabadság és Szolidaritás [New Hungary: freedom and solidarity, the programme of the government between 2006 and 2010]*. Budapest, Government of the Republic of Hungary (<http://www.parlament.hu/irom38/00064/00064.pdf>, accessed 26 March 2011).
- Government of the Republic of Hungary (2010a). *A Nemzeti Együttműködés programja [The programme of national cooperation]*, May. Budapest, Government of the Republic of Hungary (<http://www.parlament.hu/irom39/00047/00047.pdf>, accessed 23 March 2011).
- Government of the Republic of Hungary (2010b). *J/1323. számú Jelentés a közforgalmú gyógyszertárak létesítésére vonatkozó, a biztonságos és gazdaságos gyógyszer- és gyógyászatisegédeszköz-ellátás, valamint a gyógyszerforgalmazás általános szabályairól szóló 2006. évi XCVIII. törvényben foglalt szabályok gyakorlati megvalósulásáról, a szabályozás elvárt és tényleges hatásainak összevetéséről [Report No. J/1323 on the implementation of the regulations of Act XCVIII of 2006 on the safe and efficient supply of pharmaceuticals and medical aids and prostheses and on the general rules of trading pharmaceuticals, regarding the establishment of pharmacies; and on the expected and real impact of the regulation]*, October. Budapest, Government of the Republic of Hungary (<http://www.orszagaz.com/j1323-a-kozforgalmu-gyogyszertarak-letesitesere-vonatkozo-a-biztonsagos-es-gazdasagos-gyogyszer-es-gyogyaszatisegedeszkoz-ellatas-valamint-a-gyogyszerforgalmazas-altalanos-szabalyairol-szolo-2006/>, accessed 31 March 2011).
- Government of the Republic of Hungary (2010c). *Updated convergence programme of Hungary 2009–2012*, January. Budapest, Government of the Republic of Hungary (http://ec.europa.eu/economy_finance/sgp/pdf/20_scps/2009-10/01_programme/hu_2010-01-29_cp_en.pdf, accessed 23 February 2011).
- Hablicsek L (2009). A népesség szerkezete és jövője [The structure and future of the population]. In: Monostori J et al., eds. *Demográfiai portré, 2009 [Demographic portrait, 2009]*. Budapest, Hungarian Central Statistical Office:133–144 (<http://www.demografia.hu/index.php/kiadvanyok/demografiai-portre/demografiai-portre-fejezetei/133-els-fejezet>, accessed 31 March 2011).

- HCSO (1981). *Statistical yearbook of Hungary 1980*. Budapest, Hungarian Central Statistical Office.
- HCSO (1988). *Vélemények az egészségügyről és az egészségügy igénybevétele [Opinion on health services and the utilization of health services]*. Budapest, Hungarian Central Statistical Office.
- HCSO (1992). *Household budget survey 1989 to 1991*. Budapest, Hungarian Central Statistical Office.
- HCSO (1993). *Household budget survey 2nd half of 1992*. Budapest, Hungarian Central Statistical Office.
- HCSO (1994). *Household budget survey 1993*. Budapest, Hungarian Central Statistical Office.
- HCSO (1998a). *Non-profit organizations in Hungary in 1996*. Budapest, Hungarian Central Statistical Office.
- HCSO (1998b). *Yearbook of health statistics 1997*. Budapest, Hungarian Central Statistical Office.
- HCSO (1999). *Yearbook of health statistics 1998*. Budapest, Hungarian Central Statistical Office.
- HCSO (2001). *Statistical yearbook of Hungary 2000*. Budapest: Hungarian Central Statistical Office.
- HCSO (2002). *Statistical Yearbook of Hungary, 2001*. Budapest, Hungarian Central Statistical Office.
- HCSO (2007). *Yearbook of health statistics 2006*. Budapest, Hungarian Central Statistical Office.
- HCSO (2008). *Yearbook of welfare statistics 2007*. Budapest: Hungarian Central Statistical Office.
- HCSO (2009a). *Statistical yearbook of Hungary 2008*. Budapest, Hungarian Central Statistical Office.
- HCSO (2009b). *Yearbook of health statistics 2008*. Budapest, Hungarian Central Statistical Office.
- HCSO (2010a). A születéskor várható élettartam területi különbségei [Regional disparities in life expectancy at birth]. *Statisztikai Tükör [Statistical mirror]*, 9 November, 4(115).
- HCSO (2010b). *Gazetteer of the Republic of Hungary*, 1 January. Budapest, Hungarian Central Statistical Office.
- HCSO (2010c). STADAT tables, employment [online database]. Budapest, Hungarian Central Statistical Office (http://portal.ksh.hu/pls/ksh/docs/hun/xstadat/xstadat_eves/i_qlf002.html, accessed 25 March 2011).
- HCSO (2010d). *Statistical yearbook of Hungary 2009*. Budapest, Hungarian Central Statistical Office.
- HCSO (2010e). *Statisztikai tükör [Statistical mirror]*, 27 April, 4(50).
- HCSO (2010f). *Yearbook of health statistics 2009*. Budapest, Hungarian Central Statistical Office.
- HCSO (2011a). *Gyorstájékoztató [Flash report]*, 21 February. Budapest, Hungarian Central Statistical Office (http://portal.ksh.hu/portal/page?_pageid=37,869081&_dad=portal&_schema=PORTAL, accessed 4 March 2011).

- HCSO (2011b). STADAT 2.1.2 [online database]. Budapest, Hungarian Central Statistical Office (http://portal.ksh.hu/portal/page?_pageid=37,592051&_dad=portal&_schema=PORTAL), accessed 23 February 2011).
- HFSÁ (2010). *A Felügyelet 2010. évi harmadik kockázati jelentése [The third report of the Authority on risks in 2010]*, November. Budapest, Hungarian Financial Supervisory Authority (http://www.pszaf.hu/data/cms2252144/kockazati_jelentes_2010_III.pdf), accessed 22 February 2011).
- HISA (2009). *Az Egészségbiztosítási Felügyelet és a Felügyeleti Tanács 2009. évi beszámolója [Activity report 2009]*, January. Budapest, Health Insurance Supervisory Authority (<http://www.ebf.hu/?m=14.5>), accessed 12 November 2010).
- Hsia DC et al. (1992). Medicare reimbursement accuracy under the prospective payment system, 1985 to 1988. *Journal of the American Medical Association*, 268(7):896–899.
- Hungarian Financial Supervisory Authority (2009). *Feülgyelt szektorok működése és kockázatai [Risk outlook]*. Budapest, Hungarian Financial Supervisory Authority (http://www.pszaf.hu/data/cms2102635/Risk_Outlook_09Dec.pdf), accessed 5 May 2011).
- Hungarian Financial Supervisory Authority (2010a). *Aranykönyvek 2009 [Golden books 2009]*. Budapest, Hungarian Financial Supervisory Authority (<http://www.pszaf.hu/>), accessed on 5 May 2010).
- Hungarian Financial Supervisory Authority (2010b). *Statisztikák, Idősorok [Statistical database, Time series]*. Budapest, Hungarian Financial Supervisory Authority (<http://www.pszaf.hu/>), accessed on 5 May 2010).
- Information for Health Care (2010). *Statistical database*. [Online database]. Budapest, Information Centre for Health Care (<http://www.gyogyinfok.hu/magyar/szoveges.html>)
- International Health Accounts Team (2011). *A system of health accounts, version 2.0, chapters 1 to 15, pre-edited version*. Paris, OECD, Eurostat, WHO (<http://www.oecd.org/dataoecd/27/51/47406956.pdf>), accessed 31 March 2011).
- Józán P (2009). Csökkenő kardiovaszkuláris mortalitás, javuló életkilátások, új epidemiológiai korszak kezdete Magyarországon [Decreasing cardiovascular mortality, starting the new epidemiological age in Hungary], *IME*, 8(4):21–25.
- Kámán A (2010). Fogászati turizmus mint az egészségügyi turizmus húzóága [Dental tourism as the driving force of health tourism]. Vezető Magyar Fogorvosi Rendelők Egyesülete [Association of Leading Hungarian Dental Clinics] Presentation at Utazás 2010. – 33. Nemzetközi Idegenforgalmi Kiállítás [Travel 2010 – 33rd International Tourism Expo], HUNGEXPO, Budapest, 4–7 March.
- Kaposvari Cs, Vitrai J (2008). *Snapshot of health inequities in Hungary – Small area-level and social inequities in health care needs*. Budapest, HealthMonitor Research and Consulting Non-Profit Public-Benefit Ltd (http://www.egeszsegmonitor.hu/dok/HU_mortality_inequity_en.pdf), accessed 31 March 2011).
- Kornai J (2000). Hidden in an envelope: gratitude payments to medical doctors in Hungary. In: Darendorf R, Elkana Y, eds. *The paradoxes of unintended consequences*. Budapest: CEU Press.
- Kósa K (2009). A társadalmi egyenlőtlenségek népegészségügyi hatásai [Public health effects of social inequalities in Hungary]. *Népegészségügy [Public Health]*, 87(4):329–335.
- Kósa K, Daragó L, Ádány R (2009). Environmental survey of segregated habitats of Roma in Hungary: a way to be empowering and reliable in minority research. *European Journal of Public Health*, 21(4):463–468.

- Kósa Z et al. (2007). A comparative health survey of the inhabitants of Roma settlements in Hungary. *American Journal of Public Health*, 97(5):853–859.
- Legido-Quigley H et al. (2008). *Assuring the quality of health care in the European Union – a case for action*, Observatory Studies Series No. 12. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.
- Makai P et al. (2009) Quality management and patient safety: survey results from 102 Hungarian hospitals. *Health Policy*, 90(2–3):175–180.
- Medián (2008). Zsebből menő egészség [Health out-of-pocket] (<http://www.median.hu/object.5f0ad37d-6ea6-4483-8e8c-fd851cabf721.ivy>, accessed 31 March, 2011).
- Medinfo (2000). *National interest protection and self-help NGOs for people with chronic health conditions*. Budapest, Medinfo.
- Mester D, ed. (2010). *A szociális szolgáltatási rendszer folyamatai 2002-2007 között. [Trends in the social service system between 2002 and 2007]*. Budapest, Szociálpolitikai és Munkaügyi Intézet [Labour and Social Policy Institute].
- Mihályi P, Petru R (2000). Health care in the Czech Republic, Hungary and Poland – the medium-term fiscal aspects. In: Dabrowski M, Rostowski J, eds. *The eastern enlargement of the European Union*, Boston, MA, Kluwer Academic.
- Ministry of Health (2006). *Zöld könyv az egészségügyről [Green book on health care]*, July. Budapest, Ministry of Health (http://www.allamreform.hu/letoltheto/egeszsegugy/hazai/kiemelt/zold_konyv-magyar_egeszsegugy.pdf, accessed 26 March 2011).
- Ministry of Health (2008). *Tájékoztató az Egészség évtizedének népegészségügyi programja 2008. évi előrehaladásáról [Report on the progress of the implementation of the Decade of National Public Health programme in 2008]*. Budapest, Ministry of Health (<http://www.eum.hu/archivum>, accessed 14 March 2011).
- Ministry of Health (2009a). *Jelentés az Országgyűlés Egészségügyi bizottsága számára az OEP biztosítási jogviszony-ellenőrzés működésének tapasztalatairól [Report to the Health Committee of the National Assembly on the outcome of control of the entitlement status for health services financed by the NHIFA]*. Budapest, Ministry of Health.
- Ministry of Health (2009b). *SZ.É.P. Szűréssel az életért program [Screening for life programme]*, 30 June. Budapest, Ministry of Health (<http://www.eum.hu/archivum/eum-2009/sz-2009/szuressel-eletert-program>, accessed 31 March 2011).
- Ministry of Health (2009c). *Tájékoztató a az egészségügyben dolgozók létszámhelyzetének alakulásáról [Report on the trends of the numbers of health professionals]*. Budapest, Ministry of Health.
- Ministry of Health, Social and Family Affairs (2002). *Nursing and nursing policy*. Budapest, Ministry of Health, Social and Family Affairs (<http://www.eum.hu/>, accessed 2 August 2004).
- Ministry of Health, Family and Social Affairs (2003). *Magyar Információs Társadalom [Hungarian information society]*. Budapest, Ministry of Health Family and Social Affairs.
- Ministry of National Development (2010). *Digitális megújulás, Cselekvési terv 2010–2014 [Digital renewal, action plan 2010–2014]*. Budapest, Ministry of National Development (<http://www.kormany.hu/hu/nemzeti-fejlesztési-miniszterium>, accessed 11 May 2011).
- Ministry of National Resources (2010). *Újraélesztett egészségügy, Gyógyuló Magyarország, Semmelweis Terv az egészségügyi megmentésére, Szakmai konzultáció – vitairat [Resuscitated health care – recovering Hungary, Semmelweis Plan for saving health care, Discussion Paper]*, October. Budapest, Ministry of National Resources. (<http://www.weborvos.hu/adat/files/EgpolVitairat2010%5B1%5D.pdf>, accessed 4 April 2011).

- Ministry of National Resources (2011). *Jelentés az Országgyűlés Egészségügyi Bizottsága számára az ŰMFT egészségügyi fejlesztéseinek aktuális helyzetéről [Report to the Health Care Committee of the National Assembly on the actual state of health care developments related to the New Hungary Development Plan]*, 9 May. Budapest, Ministry of National Resources.
- National Health Council (2010). A Nemzeti Egészségügyi Tanács 2010. június 17-i tanácsülésén elhangzott referátumok és vita összefoglalása [Protocol of the meeting on 17 July 2010]. Budapest, National Health Council (<http://www.eum.hu/szakmai-civil/nemzeti-egeszsegugyi/net-2010-06-17>, accessed 15 January 2011).
- NHIFA (2003). *Szabálykönyv az OEP által külön finanszírozott egynapos ellátások minőségbiztosítási és ellátó-szervezési feltételeire [Rule book on the quality assurance and organizational requirements of day-care procedures carried out within the framework of separate NHIFA contracts]*. Budapest, National Health Insurance Fund Administration (<http://www.eum.hu/egynapos-szabalykonyv>, accessed 31 March 2011).
- NHIFA (2008). *Statistikai évkönyv 2007 [Statistical yearbook 2007]*. Budapest, National Health Insurance Fund Administration.
- NHIFA (2009a). *Jelentés az otthoni szakápolási tevékenységről, 2008 [Report on the provision of specialist home care in 2008]*. Budapest, National Health Insurance Fund Administration.
- NHIFA (2009b). *Statistical yearbook, 2008*. Budapest, National Health Insurance Fund Administration.
- NHIFA (2010). *Kórházi ágyszám- és betegforgalmi kimutatás, 2009 [Hospital beds and patient turnover, 2009]*. Budapest, National Health Insurance Fund Administration.
- NHIFA (2011). *A magyar társadalombiztosítás története [The history of Hungarian social health insurance]*. Budapest, National Health Insurance Fund Administration (http://www.oep.hu/portal/page?_pageid=34,32914&_dad=portal&_schema=PORTAL, accessed 15 March 2011).
- NISHR (2007). *Hungarian health system scan*. June. Budapest, National Institute for Strategic Health Research (<http://www.eski.hu/new3/politika/healthscan-hu.php>, accessed 10 January 2011).
- NISHR (2009). *Hungarian health system scan*. December. Budapest, National Institute for Strategic Health Research (<http://www.eski.hu/new3/politika/healthscan-hu.php>, accessed 10 January 2011).
- NISHR (2011a). *Összefoglaló tájékoztató az egészségügyben dolgozók létszám- és bérhelyzetéről [Summary report on the number and wages of health professionals]*. Budapest, National Institute for Strategic Health Research (<http://www.eski.hu/new3/adatok/berstatisztika/OSAP1626-eves-CD/index.htm>, accessed 7 May 2011).
- NISHR (2011b). Tables of basic data on Hungarian health care. Budapest, National Institute for Strategic Health Research (http://www.eski.hu/alaptabla/Ealapki_p.xls, accessed on 5 May 2011).
- Nolte E, McKee M (2004). *Does health care save lives? Avoidable mortality revisited*. London, Nuffield Trust.
- OECD (2009a). *Health at a glance 2009: OECD Indicators* [web book]. Paris, Organisation for Economic Co-operation and Development (http://www.oecd-ilibrary.org/content/book/health_glance-2009-en, accessed April 2010).

- OECD (2009b). OECD Health Data 2009 [online database]. Paris, Organisation for Economic Co-operation and Development. (<http://www.oecd.org/healthdata>, accessed 16 April 2010).
- OECD (2010). OECD Health Data 2010 [online database]. Paris, Organisation for Economic Co-operation and Development. (<http://www.oecd.org/healthdata>, accessed March 2011).
- OECD (2011). *National health accounts*. Paris, Organisation for Economic Co-operation and Development.
- Office of the Parliamentary Commissioner (2010). *Report on the activities of the Parliamentary Commissioner for Civil Rights in the year 2009*. No. J/11903. Budapest, Office of the Parliamentary Commissioner (<http://www.obh.hu/allam/eng/index.htm>, accessed 31 March 2011).
- Orosz É, Holló I (2001). Hospitals in Hungary: the story of stalled reforms. *Eurohealth*, 3:22–25.
- Orosz É, Ellena G, Jakab M (1998). Hungarian health care system in transition: the unfinished agenda. In: Bokros L, Dethier J, eds. *Public finance reform during the transition: the experience of Hungary*. Washington, DC, World Bank.
- Papp P, Eöry F (2004). The state of infrastructure of our hospitals. *Egészségügyi Gazdasági Szemle [Journal of Health Economics]*, 42(5):17–21.
- Péntek E (2009). A betegszervezetek eredményessége – civilek az egészségesebb életért [The performance of patient organizations – NGO for healthier living]. *Népegészségügy [Public Health]*, 87(3):233–242.
- PPRI (2007). *Report on Hungary* (June 2007). Vienna, Pharmaceutical Pricing and Reimbursement Information (http://ppri.oebig.at/Downloads/Results/Hungary_PPRI_2007.pdf, accessed 13 November 2010).
- P.Kiss G, Szemere R (2009). Apples and oranges? A comparison of the public expenditure of the Visegrád countries. *MNB Bulletin*, May:35–47.
- Research Institute of the State Audit Office of Hungary (2009). *A megváltozott munkaképességű személyek támogatási rendszere társadalmi-gazdasági hatékonyságának vizsgálata [The study of the social and economic efficiency of the support system for people with altered work capabilities]*. October. Budapest, State Audit Office.
- Rosenberg M, Browne MJ (2001). The impact of the inpatient prospective payment system and diagnosis related groups: a survey of the literature. *North American Actuarial Journal*, 5(4):84–94.
- Saltman R, Busse R, Figueras J (2004). *Social health insurance systems in western Europe*. European Observatory on Health Systems and Policies Series, Maidenhead, Open University Press.
- Sándor J (1997). A betegek jogainak kodifikálásáról [On the codification of patient rights]. *Fundamentum*, 1997/I (<http://157.181.181.13/dokuk/97-1-10.pdf>, accessed 16 January 2011).
- Sárdi G (2003). *A magyar társadalombiztosítás története [The history of Hungarian Social Security]*. Budapest, National Health Insurance Fund Administration.
- Schneider F, Klinglmaier R (2004). *Shadow economies around the world: what do we know?* Basel, Forschungsinstitut zur Zukunft der Arbeit/Institute for the Study of Labor (IZA DP No. 1043, Discussion paper series) (<http://www.crema-research.ch/papers/2004-03.pdf>, accessed 12 March 2010).

- State Audit Office (2005). *Jelentés a címzett támogatásból finanszírozott egészségügyi beruházások, rekonstrukciók ellenőrzéséről [Report on the control of the investments in and reconstruction of health care infrastructure from target subsidies]*, No. 0523, June. Budapest, State Audit Office.
- State Audit Office (2006). *Jelentés az egészségügyi szakellátások privatizációjának ellenőrzéséről [Report on privatization of secondary and tertiary care health services]*, No. 0609, May. Budapest, State Audit Office ([http://www.asz.hu/ASZ/jeltar.nsf/0/7F143A AFC2634C53C125717F00452968/\\$File/0609J000.pdf](http://www.asz.hu/ASZ/jeltar.nsf/0/7F143A AFC2634C53C125717F00452968/$File/0609J000.pdf), accessed 12 November 2010).
- State Audit Office (2008a). *Jelentés a Magyar Köztársaság 2007. évi költségvetése végrehajtásának ellenőrzéséről [Report of the State Audit Office on the implementation of the national budget of the Republic of Hungary in 2007]*, No. 0824, August. Budapest, State Audit Office ([http://www.asz.hu/ASZ/jeltar.nsf/0/E8B19DEC4EE01E22C12574B70 01EE101/\\$File/0824J000.pdf](http://www.asz.hu/ASZ/jeltar.nsf/0/E8B19DEC4EE01E22C12574B70 01EE101/$File/0824J000.pdf), accessed 14 November 2010).
- State Audit Office (2008b). *Jelentés az önkormányzati kórházak és szociális bentlakásos intézmények ápolásra, gondozásra fordított pénzeszközei felhasználásának ellenőrzéséről [Report on the review of expenditures of local government hospitals and residential social homes on long-term nursing care]*, No. 0820. Budapest, State Audit Office.
- State Audit Office (2009a). *Jelentés a sürgősségi betegellátás kialakítására, fejlesztésére fordított pénzeszközök felhasználásáról [Report on the money spent on the reorganization and development of emergency care]*, No. 0924, August. Budapest: State Audit Office.
- State Audit Office (2009b). *Jelentés az egyes kórházi tevékenységek kiszervezésének ellenőrzéséről [Report on outsourcing specific hospital services]*, No. 0921, July. Budapest, State Audit Office ([http://www.asz.hu/ASZ/jeltar.nsf/0/41F5B0BD0EB6BBAE C1257603004C30B3/\\$File/0921J000.pdf](http://www.asz.hu/ASZ/jeltar.nsf/0/41F5B0BD0EB6BBAE C1257603004C30B3/$File/0921J000.pdf), accessed 13 November 2010). *ch3 and 6*
- State Audit Office (2010). *Jelentés az egynapos ellátásra fordított pénzeszközök felhasználásáról [Report on the money spent on day care]*, March. Budapest, State Audit Office.
- Szabó L, Németh Gy, Berkó P (2009). Disadvantaged health conditions of Roma children. A matter of culture of poverty? Unpublished manuscript. Miskolc, Borsod County Teaching Hospital, Institute of Health Science, University of Miskolc.
- Széles G et al. (2005). A preliminary evaluation of a health monitoring programme in Hungary. *European Journal of Public Health*, 15(1):26–32.
- Szende Á et al. (2002). A magyar egészségügy finanszírozásának tehermegoszlása [The distribution of the financing burden of the Hungarian health care system]. *Egészségügyi Gazdasági Szemle*, 40(3).
- Szinapszis Kft (2007). *Átfogó egészségpolitikai kutatás Magyarországon a 2007-es törvényi változások tükrében [Comprehensive health policy research in Hungary in light of the legal changes of 2007]*. Debrecen, Szinapszis Kft.
- Szucs S et al. (2005). Could the high level of cirrhosis in central and eastern Europe be due partly to the quality of alcohol consumed? An exploratory investigation. *Addiction*, 100(4):536–542.
- Tarsoly I (ed.) (2000). *Magyarország a 20. században [Hungary in the 20th century]*. Szekszárd, Babits Kiadó (<http://mek.niif.hu/02100/02185/html/index.htm>, accessed 15 February 2011).
- Tóth I (ed.) (2008). *TÁRKI European social report*. Budapest, TÁRKI (http://www.tarki.hu/en/research/european_social_report/20080701.pdf, accessed 1 March 2011).

- Tóth Á (2008). Regionalitás az egészségügyben-helyzetkép [Rationalistic approach in health care – situation analysis]. *IME*, 7(4):7–10.
- Vas G et al. (2009). A 2007.áprilisi 1-jei egészségügyi reformintézkedések hatása az összes kórházi ágyszámra [The impact of the reform measures as of 1 April 2007 on the total number of hospital beds], *Egészségügyi Gazdasági Szemle [Journal of Health Economics]*, 2009(4):5–11 (<http://www.weborvos.hu/adat/egesz/2009jul/5-11.pdf>, accessed 16 January 2011).
- Vitrai J, ed. (2007). *Inequalities in health systems' responsiveness: a joint World Health Survey report based on data from selected central European countries. Study report.* Copenhagen, World Health Organization (<http://www.egeszsegmonitor.hu/dok/JointReport.pdf>, accessed 31 March 2011).
- Vitrai J, Kiss N, Kriston Vizi G (2010). *A magyar egészségügyi szektorban jelenleg használt tervezési eszköztár áttekintése, kritikai értékelése.[Critical review of the currently used methodology for planning in the health care sector]*, September. Budapest, EgészségMonitor Kutató és Tanácsadó Nonprofit Közhasznú Kft (http://www.egeszsegmonitor.hu/dok/Egeszsegugyi_szolgaltatasok_tervezese.pdf, accessed 25 November 2010).
- Vokó Z (2009). A nemzeti népegészségügyi program menedzsment problémái [The management problems of the National Public Health Programme]. *Népegészségügy [Public Health]*, 87:341–348.
- Vokó Z et al. (2009). Does socioeconomic status fully mediate the effect of ethnicity on the health of Roma people in Hungary? *Journal of Epidemiology and Community Health*, 63(6):455–460.
- WHO (2006). *Building foundations for eHealth: progress of Member States.* Geneva, World Health Organization.
- WHO (2011) Hungary, *National Health Accounts* data (last updated April 2011). Geneva, WHO (<http://www.who.int/nha/country/hun/en/>, accessed on 9 May 2011).
- WHO Regional Office for Europe (2010). European Health for All database (HFA-DB) [online database]. Copenhagen, WHO Regional Office for Europe (<http://www.euro.who.int/hfadb>, accessed 23 February 2011).
- WHO Regional Office for Europe (2011). European Health for All database (HFA-DB) [online database]. Copenhagen, WHO Regional Office for Europe (<http://www.euro.who.int/hfadb>, accessed March 2011).

10.2 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: <http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010>.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

- 1 Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.

- 2 Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
- 3 Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.
- 4 Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
- 5 Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
- 6 Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
- 7 Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
- 8 Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
- 9 Appendices: includes references, useful web sites and legislation

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

10.3 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

10.5 About the authors

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- to describe accurately the process, content and implementation of health reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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Key

All HiTs are available in English.
When noted, they are also available in other languages:

^a Albanian

^b Bulgarian

^c French

^d Georgian

^e German

^f Romanian

^g Russian

^h Spanish

ⁱ Turkish

^j Estonian

^k Polish

^l Tajik



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