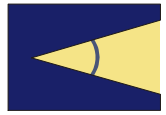


European

Observatory

on Health Care Systems



Health Care Systems in Transition

Hungary



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine

Health Care Systems in Transition

Hungary

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By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
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Keywords

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European Observatory on Health Care Systems

WHO Regional Office for Europe

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Foreword

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

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Norway and Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- 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 the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) health data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at <http://www.observatory.dk>.

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The HiT on Hungary was written by Péter Gaál (Health Services Management Training Centre, Semmelweis University of Medicine, Budapest), Balázs Rékassy (Health Care Research Institute, Budapest) and Judith Healy (European Observatory on Health Care Systems).

Péter Gaál took primary responsibility for the following sections: Organizational structure and management, Health care finance and expenditure and Financial resource allocation. Balázs Rékassy undertook the following: Health care delivery system, Aims and objectives, and Reforms and reform implementation.

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The current series of the Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, 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, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The regional editors are Anna Dixon, Judith Healy and Elizabeth Kerr.

The research director for the Hungarian HiT was Martin McKee.

Administrative support, design and production of the HiTs has been undertaken by a team led by Phyllis Dahl and comprising Myriam Andersen, Sue Gammerman and Anna Maresso. Special thanks are extended to the Regional Office For Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices that have provided national data.

Introduction and historical background

Introductory overview

The Republic of Hungary is located in the Carpathian basin, which lies in central Europe. The country covers a territory of 93 000 km² (1% of the size of Europe) with more than half the area being lowlands surrounded by mountain ridges and hills. The Duna (Danube) and Tisza rivers, and Lake Balaton, the biggest freshwater lake in central Europe, are the country's main sources of water. Its neighbours are Slovakia to the north, Ukraine and Romania to the east, the Federal Republic of Yugoslavia and Croatia to the south, and Slovenia and Austria to the west.

The Republic of Hungary has 10.1 million inhabitants, while another approximately 5 million Hungarians live in neighbouring countries or overseas. The population is decreasing since the birth rate has been below reproduction level since 1981. Children under 15 years comprise 18% of the population and people aged 65 years and over comprise 14% (Table 1).

Budapest, the capital, has 1.9 million inhabitants and almost half the country's population live in communities of less than 20 000 inhabitants. In 1998, Hungary had 23 large cities ("county rank" cities), 195 other towns and 2913 villages. There are three administrative levels: the central government and two tiers of local government (counties and settlements). The 19 counties each cover a population between two hundred thousand and one million (29).

The official language, *Magyar*, is part of the Finno-Ugric language group. The largest ethnic minority group, the Roma or Gypsy community, numbered 150 000 in 1990, while other national minorities (Croatians, Germans, Serbians, Slovaks, Slovenians and Romanians) together numbered 100 000 (29). In 1996 the number of gypsies was estimated to be over 450 000 (64). Over two thirds (68%) of the population is Catholic by religion, 20% Calvinist, 5% Lutheran and 7% other and non-religious.

Fig. 1. Map of Hungary¹

Source: Central Intelligence Agency, The World Factbook, 1997.

Table 1. Population indicators, 1949–1997

Indicators	1949	1970	1980	1990	1992	1994	1996	1997
Population (millions)	9.2	10.3	10.7	10.4	10.3	10.3	10.2	10.1
Live births per 1000 inhabitants	20.6	14.7	13.9	12.1	11.8	11.3	10.3	9.9
Deaths per 1000 inhabitants	11.4	11.6	13.6	14.1	14.4	14.3	14.0	13.7
Population change per 1000 inhabitants	9.2	3.1	0.3	-2.0	-2.6	-3.0	-3.7	-3.8
% under 15 years	24.9	21.1	21.8	20.5	19.4	18.6	18.0	17.7
% 65-year olds and over	7.5	8.9	13.5	13.2	13.6	13.9	14.2	14.3

Source: Hungarian Central Statistical Office *Statistical Yearbook of Hungary* selected years.

After more than 40 years of communist rule under the sphere of influence of the Soviet Union, Hungary regained its sovereignty and declared itself an independent republic on 23 October 1989. Since then, Hungary has experienced a stable political system with organized political parties and coalition governments. The unicameral Parliament has 386 seats and a four-year election

¹ All notes are listed in the section *Endnotes*.

cycle. The electoral system combines majority and proportional systems. People choose a candidate (in 176 single-candidate constituencies) and also cast their vote for a political party under a proportional voting system. Local government elections are held after the general election.

Historical and economic background

Hungarians trace their descent from Finno-Ugric groups from Central Asia. The *Magyar* tribes settled in the area in the late ninth century, from where they conducted raids throughout Europe before they adopted a more settled way of life and converted to Christianity. Hungary's first king and patron saint, *I. István* (Stephen the First), was crowned in the year 1000. Hungary was a large and powerful state throughout the mediaeval period. The largest part of the country was occupied by the Turks in the early sixteenth century and remained part of the Ottoman empire for 150 years. After the expulsion of the Turks in 1686, Hungary came under the Austrian Habsburg empire. A national revolution in 1848 was unsuccessful, but a dual Austro-Hungarian monarchy was formed in 1867. After the First World War and the collapse of the Habsburg empire, Hungary gained its independence but lost two thirds of its territory in the 1920 Treaty of Trianon.

Hungary was a German ally in the Second World War until 1944, when the country was taken over by German troops and then liberated by the Soviet army. It lost its sovereignty again and its opportunity to develop a civil democracy in 1948, when the communist party took exclusive power, backed by the USSR, ruling the country from 1948 until 1989. A revolution in 1956 was put down by Soviet troops. From 1968, Hungary partially liberalized its command economy, which distinguished its development from other communist countries in the region. Hungary achieved a peaceful transition to a multi-party democracy when, at a party congress in 1989, the Communist Party agreed to give up its monopoly on power, allowing free elections in March 1990. The last Soviet troops left in June 1991 with the ending of the Warsaw Defence Agreement.

The Hungarian Democratic Forum formed the first post-communist government in March 1990 (under Prime Minister Antall) in coalition with the Independent Smallholders' Party and the Christian Democratic People's Party. In May 1994 this government was replaced by the Hungarian Socialist Party in coalition with the Alliance of Free Democrats (under Prime Minister Horn). After winning the general elections in May 1998, the Fidesz-Hungarian Civic Party formed a coalition government with the Hungarian Democratic Forum

and the Independent Smallholders' Party (under Prime Minister Orbán).² The main political parties all advocate economic reforms, which has helped to achieve a relatively quick, but not easy transition to a stable market economy.

Hungary became a full member of the Council of Europe in 1990 and the Organisation of Economic Cooperation and Development (OECD) in 1996. Membership of the European Union (EU) and the North Atlantic Treaty Organization (NATO) has been a top priority of each new government. Negotiations with the European Union are in progress and Hungary is in the first wave of 'pre-accession' countries to the European Union. Hungary became a member of NATO in March 1999.

Earlier liberalization in Hungary allowed a more gradual approach to economic and public sector reform, but the transition has proved to be challenging. GDP dropped sharply by nearly 12% in 1991 and did not regain growth until 1994. A growth rate of 5.1% was achieved in 1998 (Table 2). Inflation peaked at 35% in 1991. Real wages in 1997 were only 76% of the 1989 level. A stabilization package was introduced in 1995, accompanied by further privatization of state enterprises and, along with increasing foreign investment, this has created a solid base for economic growth. In 1998, GDP continued to grow, unemployment fell, real wages increased and inflation fell.

Table 2. Macro-economic indicators, 1980–1998

Indicator (%)	1980	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
GDP growth rate	-0.3	0.7	-3.5	-11.9	-3.1	-0.6	2.9	1.5	1.3	4.4	5.1
Public expenditure as % of GDP ^a	61.2	64.6	61.3	66.3	71.8	72.5	74.0	63.8	57.0	56.8	–
Annual inflation (CPI)	9.1	17.0	28.9	35.0	23.0	22.5	18.8	28.2	23.6	18.3	14.3
Inflation in health care	–	26.3	23.6	44.0	54.4	23.3	20.3	31.4	25.1	18.3	–
Annual change in real wages	-1.6	0.9	-3.7	-7.0	-1.4	-3.9	7.2	-12.2	-5.0	4.9	3.6
Rate of registered unemployment	–	0.5	2.0	8.2	13.9	14.0	12.0	11.7	11.4	11.0	7.8

Source: Hungarian Central Statistical Office; Ministry of Health, 1998a.

^a including transfer payments.

Evolution of the Hungarian health care system

Hungary has a long-standing tradition of health services that dates back to infirmaries attached to monasteries in the eleventh century. After the early

period of private medicine and church-dominated charities, the state began to provide health care for the poor, such as the employment of town physicians in the fifteenth century, which was required of every county in 1752. The first Hungarian act on public health was passed in 1876 (*Act XIV of 1876*). Hospitals were separated from almshouses in 1856 and the eligible poor obtained free health care at special surgeries. The National Fund of Patient Care was established in 1898 to reimburse health care costs for the poor. A system of insurance began for those unable to pay for health services. *Act XVI of 1840* legitimized voluntary self-help funds for industrial workers. In 1870 the General Fund of Sick and Disabled Workers was established, and *Act XIV of 1891* required compulsory insurance for industrial workers. At the turn of the century, a national insurance fund for agricultural workers was set up. A National Social Insurance Institute was formed in 1927, and 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. Insurance funds employed medical doctors and also owned health care facilities. Rural areas were not well served despite the efforts of the Green Cross Service, staffed mainly by nurses.

The mixed economy Hungarian health care system was restructured by the communist government (established in Hungary in 1948) in line with other sectors of the economy. Health policy decisions under the socialist system were thereafter made centrally. Private health enterprises, such as insurance companies and private general practices, were dismantled and highly centralized state services were set up in their place. The expectation was that disease would disappear under communism, given a free and universal health care service together with improved socioeconomic conditions. Measures to improve public health and to control infectious diseases produced substantial achievements through better sanitation and the immunization of children.

The 1949 Constitution of Hungary declared health to be a fundamental right for which the state is held responsible.³ Throughout the communist period this was interpreted to mean that the state was exclusively responsible for both the financing and delivery of health services. The Ministry of Health funded and delivered the whole spectrum of health services including hospitals, polyclinics and also district doctor services that were established in 1952. The hierarchical administrative model allowed the health services providers little management or professional discretion.

The improvements made in the 1950s in the health status of the population slowed in the 1960s. The Soviet (Semashko) model allocated resources such as hospitals and doctors according to strict population planning norms. While initially achieving a good distribution of health services, this allowed little

flexibility in response to changing situations and weighted the health sector heavily towards achieving quantitative input goals such as large numbers of hospital beds. Although the *Act II of 1972 on Health* confirmed that access to health services was a right linked to citizenship and promised comprehensive coverage free-of-charge at the point of use, an increasing gap developed between rhetoric and reality. The system was underfunded and unable to meet the level of demand, one consequence being the growth of informal payments (gratitude payments).

The need for radical health care reforms became increasingly apparent in the 1980s. The widening gap in health status between Hungary and western European countries called for change and the softening political climate opened the way for reform. The first steps were taken in 1987 when the Ministry of Social Affairs and Health established a reform secretariat to produce policy proposals. The legislative measures implemented in this communist reform era included the establishment of the Social Insurance Fund and recognition for private providers.⁴ The head of this reform secretariat stayed on under the new government in 1990. This allowed a degree of continuity in health sector reform.

Health status of the population

During the 1950s and 1960s, Hungary achieved improvements in the historically poor health status of its population given active public health measures (which mainly reduced infectious disease mortality), and given improved socioeconomic conditions (2). While life expectancy improved in western European countries during the 1980s – due partly to dropping rates of cardiovascular disease – these rates continued to worsen in Hungary, as did deaths from cancer, liver cirrhosis and from external causes such as accidents and suicide. Hungary has now passed through the epidemiological transition and must plan health services for an older population structure and also for different health needs, since the major causes of mortality and morbidity now are noncommunicable diseases rather than communicable diseases.

Mortality rates remain among the highest in western Europe. Life expectancy at birth in Hungary in 1996 was 74.7 for women and 66.1 for men (Table 3), compared to 80.8 and 74.2 respectively in the European Union. The mortality rate for Hungarian males aged 40–59 years, for example, has continued to rise from 8.4 deaths per 1000 in 1970 to 15.2 in 1997. Age-standardized mortality rates from ischaemic heart disease remain high, with 25.7 deaths per 1000 population in 1996 compared to a European Union average of 11.4 (70). Age-

Table 3. Health indicators, 1949–1997

Indicators	1949	1970	1980	1990	1992	1994	1996	1997
Male life expectancy at birth (years)	59.3	66.3	65.5	65.1	64.6	64.8	66.1	66.4
Female life expectancy at birth (years)	63.4	72.1	72.7	73.7	73.7	74.2	74.7	75.1
Mortality 40–59 year-old males per 1000	10.0	8.4	12.5	14.3	15.6	15.9	14.2	15.2
Infant mortality (per 1000 live births)	91.0	35.9	23.2	14.8	14.1	11.5	10.9	9.9
Induced abortions per 100 live births	–	126.7	54.4	71.9	71.5	64.4	72.8	74.3
Maternal mortality (per 100 000 live births)	156.5	42.2	20.1	9.9	10.4	10.4	11.4	20.9
Communicable diseases mortality (per 1000 population)	1.3	0.27	0.14	0.09	0.09	0.09	0.08	0.07
Number of new AIDS cases	–	–	–	17	31	22	41	25
Mortality due to accidents (per 1000 population)	0.29	0.56	0.67	0.85	0.83	0.79	0.72	0.70
Suicide mortality (per 1000 population)	0.24	0.35	0.45	0.40	0.39	0.35	0.34	0.32
SDR ischaemic heart disease, all ages/1000 (b)	–	24.8	22.9	23.9	24.9	25.0	25.7	–
SDR cerebrovascular diseases, all ages/1000 (b)	–	18.4	21.8	17.7	17.2	16.1	16.3	–
SDR malignant neoplasms, all ages/1000 (b)	–	2.2	2.4	2.7	2.8	2.8	2.8	–
SDR chronic liver diseases, all ages/1000 (b)	–	2.7	2.7	5.1	6.8	8.1	6.2	–

Source: Hungarian Central Statistical Office, (11), (12), (13), (15), (18), (20), (22), (28), (29).
 (b) WHO Regional Office for Europe health for all database.

standardized mortality rates from cerebrovascular disease have fallen to 16.3 deaths per 1000 population in 1996 compared to a European Union average of 7.4. Cancer mortality appears to have slowed during the 1990s with 2.8 deaths per 1000 population in 1996 compared to a European Union average of 1.9. Deaths from chronic liver diseases and cirrhosis have risen dramatically, although with some improvement to 6.2 deaths per 1000 population in 1996, which was still over four times higher than the European Union average of 1.5.

Maternal mortality has improved substantially since the 1950s although the rate began to increase again in the late 1990s. In 1996, there were 11.4 maternal deaths per 100 000 live births, compared to 7.1 in the European Union and 15.7 in central and eastern Europe. Infant mortality in Hungary has continued to improve but at 9.9 deaths per 1000 live births in 1997 was still higher than the European Union (1996) average of 5.7. Death rates due to accidents and

suicides were among the highest in Europe, but these also began to improve in the later half of the 1990s.

Mortality and morbidity due to unhealthy lifestyles, such as high consumption of alcohol, increasing rates of smoking and a high fat and high sugar diet, are thought to be important causative factors. The factors contributing to the health status of a population are complex, however, and include social and economic factors (including historical antecedents) as well as access to good health services.

Hungary has the lowest life expectancy in western and central Europe for most adult age-sex groupings, especially for males aged between 40 and 60 years. Life expectancy for males appears to have improved in 1998. It remains to be seen whether this improvement will continue. Some other health indicators are also showing signs of improvement. The poor health indicators in Hungary have added to the pressures for health system reform.

The health status of the Roma minority, who numbered around 450 000–500 000 in 1998, is of particular concern. The largest groups live in the three northern counties but the population has become increasingly urbanized. The Roma have lower income than the rest of the Hungarian population, many live in slum conditions, infant mortality rates are high and life expectancy is ten years less than for the rest of the population (41).

Organizational structure and management

The organizational base of the current Hungarian health care system was laid at the end of the 1980s. The 1989 amendment to the Hungarian Constitution⁵ defined the principles and basic democratic structure of the new Republic, including the right to private property⁶ and the establishment of a market economy with both public and private property.⁷ The Constitution guarantees the fundamental rights of peaceful assembly and association,⁸ and sets out the governing institutions of the state including Parliament, the President of the Republic, the Constitutional Court and both national and local government.

The Constitution recognizes the right to a healthy environment,⁹ to an optimal level of physical and mental health¹⁰ and to income maintenance through social security.¹¹ The right to health should be implemented through labour safety, health care, regular physical activity and the protection of the environment.¹² The Constitution assigns overall responsibility for state social welfare and health care provisions to the national Government.¹³

The Government prepares its overall governmental policy that sets the policy framework for particular ministries. The ministerial structure is determined by *Act XXXVI of 1998 on the Enumeration of the Ministries of the Republic of Hungary*.¹⁴ Bills are submitted to Parliament for approval and governmental and ministerial decrees are issued.

Parliament¹⁵ debates, proposes amendments and votes on bills after their passage through parliamentary committees. The President of the Republic must sign a bill before it is promulgated and has the right to send the bill back to the Parliament for further debate, or ask for a constitutional examination, but cannot withhold a signature after these options are exhausted. Citizens have the right to challenge laws and regulations in the Constitutional Court.¹⁶ Constitutional

rights are also protected through the institution of the Ombudsman¹⁷ who can investigate any abuse.¹⁸

National policy determines the framework for local policy. The Constitution guarantees the right of local governments to make decisions on local affairs, however, which cannot be overruled by central authorities unless it is for legal reasons.¹⁹ The policy process, at both central and local level, is open to input from interest groups at various points. They therefore have opportunities to influence the decision-making process.

Fig. 2 summarizes the current national-level decision-making process through which any major reform of the health care system must pass.

Organizational structure of the health care system

The current structure of the Hungarian health care system represents a considerable departure from the previous, highly centralized, socialist model. Over the last ten years the system has become more pluralist with responsibilities divided between various players, while the previous hierarchical relationships have partly been replaced by contractual relationships.

Health services in Hungary are funded chiefly from the compulsory National Health Insurance Fund for recurrent costs and from taxation for capital costs. Health services are delivered predominantly by public providers in facilities owned mainly by local governments. Providers contract with the National Health Insurance Fund Administration. The government is the dominant regulator of health services, exercises statutory supervision over the National Health Insurance Fund, provides capital costs, finances and delivers public health services and provides most tertiary care services.

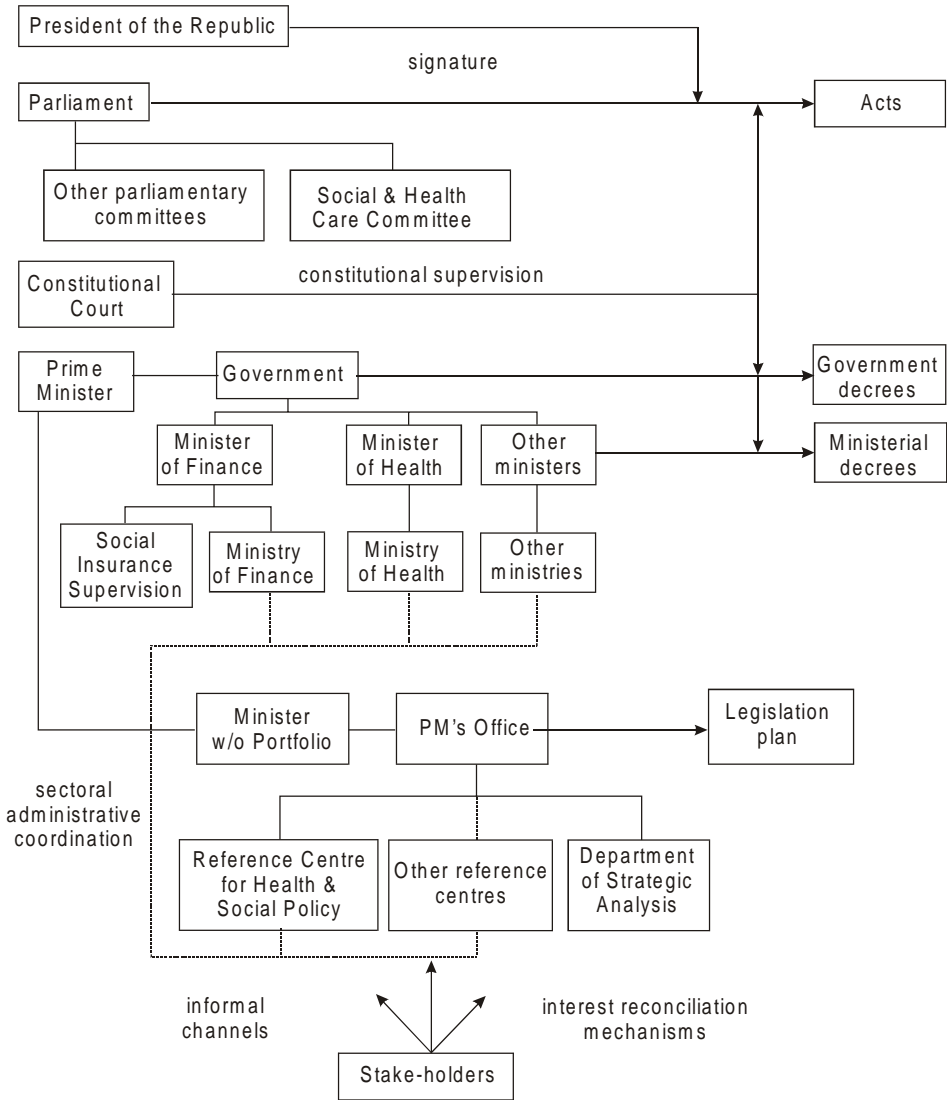
Fig. 3 outlines the current organizational structure of the health care system within the three-tier public administration system. Relationships may be either hierarchical (including ownership and direct control) or contractual.

The Government

Act CLIV of 1997 on Health assigns responsibility for health services to Parliament, the Government, the Ministry of Health, the National Public Health and Medical Officer Service, while local governments administer many of the health facilities.²⁰

The ministerial structure (defined by *Act XXXVI of 1998*) and the division of responsibilities between ministers (defined by government decrees) gives

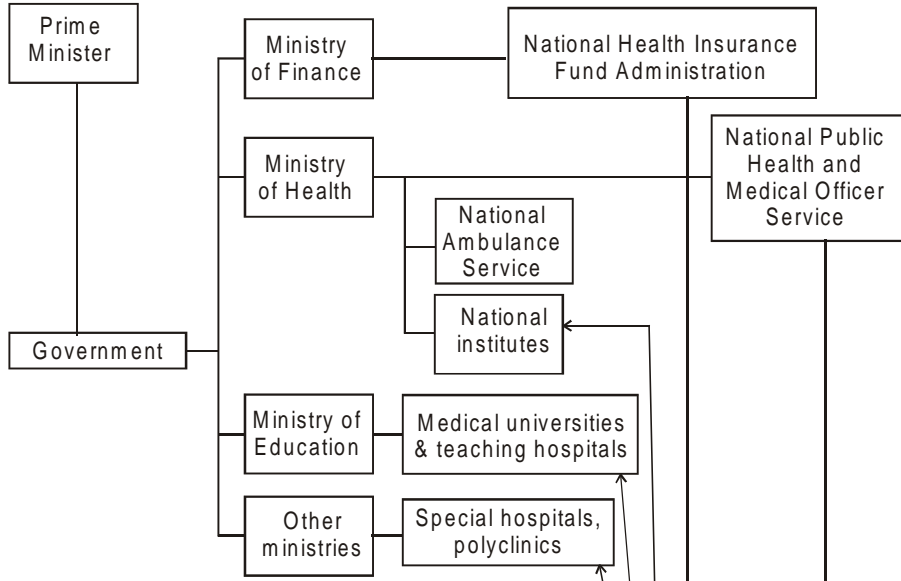
Fig. 2. Decision-making process under the 1998 government (PM Orbán).



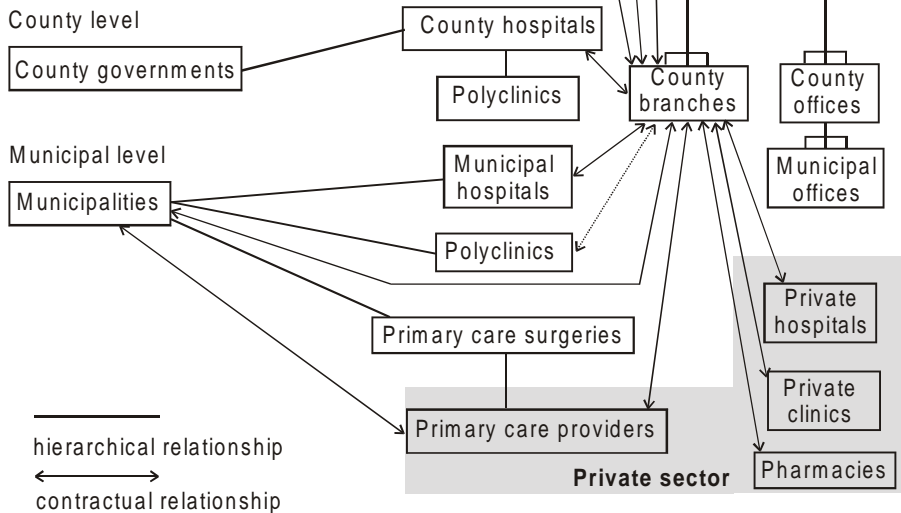
the Ministry of Health primary responsibility for health services.²¹ After the May 1998 election, however, the Prime Minister's Office became more active in health policy and the Minister of Health's veto on health matters²² was excluded from the 1998 decree. Since June 1999 the Ministry of Finance has become more significant by taking over the supervision of the NHIF from the Prime Minister's Office.

Fig. 3. Organizational chart of the health care system

National level



Sub-national level



The national Government funds or provides health services in the following ways:

- provides tertiary health care through medical universities and national institutes;
- provides capital grants for renovating health care facilities, replacement of equipment and new investment through earmarked subsidies;²³
- funds and provides public health and emergency services through the National Public Health and Medical Officer Service, the National Ambulance Service and the National Service of Blood Supply;
- covers the “health care contribution” for special social groups such as the unemployed;
- covers the co-payment for certain medicines, medical aids and prostheses²⁴ for the poor (defined by means testing);²⁵
- covers the deficit of the Health Insurance Fund;²⁶
- subsidizes and provides undergraduate and postgraduate health sciences education (but not further education);
- funds research and development;
- gives tax rebates on the purchase of voluntary sector health insurance.²⁷

Ministry of Health

The Ministry of Health regulates and controls the health care system. Between 1990 and 1998 during the Antall and Horn governments, the Ministry was also responsible for social issues (Ministry of Welfare) but the Orbán government has set up a new Ministry of Social and Family Affairs. The Ministry of Health shares responsibility for education and training with the Ministry of Education and for social insurance with the Ministry of Finance.

In 1995 the Government set up an intersectoral body, the National Public Health Committee, to help achieve the 1994 health targets.²⁸ This forum for coordination is headed by the Minister of Health, and includes all ministers whose areas influence the health status of the population. The dominant role of the Ministry of Health in policy formulation, coordination, regulation and planning was confirmed by the 1997 Health Act.²⁹ A number of other organizations come under the control of the Minister of Health. These are discussed below.

The National Public Health and Medical Officer Service was formed in 1991 to replace the State Supervision of Public Hygiene and Infectious Diseases.³⁰ The tasks of the reorganized Service were determined according to the modern concept of public health. Besides traditional public hygiene and

infectious disease control, the Service is now responsible for health promotion and for licensing health care providers. The Service is headed by the National Chief Medical Officer and has offices at county and municipal levels. The county offices are responsible for organizing the county conciliation forums which determine hospital and outpatient capacities, according to the 1996 "Capacity Act".⁷³

The National Ambulance Service has a long history in Hungarian health services. It provides emergency services and patient transfers for the whole country.³¹ Emergency services are funded from the Government budget and patient transfers are funded chiefly from the Health Insurance Fund. The National Blood Supply Service³² was recently reorganized with a central institute and regional coordinators who each cover three counties. The cost of blood and blood products are financed by the National Health Insurance Fund Administration.

The Ministry provides tertiary care services through the specialist national institutes. These undertake technical development, continuing education, scientific research, curative-preventive functions and supervise and support clinical work across the country. National institutes issue clinical guidelines which set out protocols and standards. Some national institutes are attached to university departments such as the National Institute of Surgery, while the others are independent institutes with their own buildings (such as the National Institute of Oncology). Their clinical work is financed from the Health Insurance Fund, while other activities are covered by government. The 1997 Health Act confirmed national institutes as organizations assisting the Minister of Health.³³ The Ministry of Health also runs seven state hospitals (mainly sanatoria) that accept patients from the whole country and are partly financed by the Health Insurance Fund.

Several national institutes are selected for mention here. The National Institute of Health Promotion coordinates health promotion activities and convenes the National Public Health Committee.³⁴ The Ministry of Health's Information Centre for Health Care (GYÓGYINFOK)³⁵ has the key role in developing health services payment mechanisms and has developed relevant information systems. The National Institute of Pharmacy and the National Institute of Hospital and Medical Engineering regulate medicines and medical technology.³⁶

The Minister of Health has a range of professional advisory boards including the Professional Colleges,³⁷ the Scientific Council of Health Care,³⁸ and the Health Care Specialist Training and Continuing Education Council (the latter defined in the 1997 Health Act³⁹). The members of the Professional Colleges are elected by representatives of the particular specialty. The Scientific Council

of Health Care spans the spectrum of health services and is run by an Executive Board, various committees and the Council of Presidents of Professional Colleges.

A Health Development Research Institute is being established by the Minister of Health (6). Its main functions will be the determination of the information needs of health policy, the collection of relevant data and coordination of research activities.

Ministry of Education

The Ministry of Education and Ministry of Health both supervise higher health education institutions. Before the 1993 *Act on Higher Education*⁴⁰ the Ministry of Health was responsible for medical universities and their health services. The Minister of Education then took over responsibility, except for the supervision of clinical work which remained with the Minister of Health. The division of responsibilities was further clarified by *Act LXI of 1996 on the Amendment of Act LXXX of 1993 on Higher Education*, which designates the Ministry of Health as the main funder, coordinator and supervisor of health research and development. Hungarian higher education institutions enjoy considerable autonomy in education and research.

Hungary now has four medical universities, in Budapest (two have recently merged), and in Debrecen, Pécs and Szeged. The present government aims to integrate higher education institutions and the medical universities have become medical faculties within the new multi-faculty universities.

Ministry of Finance

The Ministry of Finance now plays a bigger role in determining the health budget. Under the previous regime, health services were financed from the Government budget through the Ministry of Health. At the end of the 1980s, the Social Insurance Fund was separated from the Government budget, thus restricting the discretion of the Government, which nonetheless remains responsible for the Fund's impact on fiscal balance and must cover any deficit. The transfer of ownership of health care facilities to local governments in 1990 also reduced central Government control over health expenditures.

The Ministry of Finance is responsible for fiscal policy and the state budget and for the macro-economic implications of health care financing. It now determines the health care budget and that of the Health Insurance Fund, in negotiation with the Ministry of Health, before the budget is presented to Parliament.

Other ministries

Other ministries are also involved in the health system. Three large state employer ministries have retained their health care facilities. The origin of these parallel systems dates back to the first half of the twentieth century, when several private and public insurance funds employed medical doctors and owned health care institutions. The Ministry of Transport, Communication and Water Management (which runs the Hungarian State Railways) provides a comprehensive health service and has its own insurance fund, although railway health care is integrated into the main system of financing and provision of health services. The Ministry of Internal Affairs and the Ministry of Defence have their own health care services, but utilization is restricted for the general population. Recurrent costs of services are financed from the Health Insurance Fund. Ministry of Justice health services for prisoners are totally separate from the main system of finance and provision.

The Ministry of Internal Affairs deals with issues for local governments, which are the owners of most secondary and primary care facilities.

Prime Minister's Office

The Prime Minister's Office, which coordinates government legislation, has been strengthened and restructured since the 1998 elections with the establishment of "reference centres" according to a chancellery model.⁴² The Reference Centre for Health and Social Policy is responsible for sectoral administrative coordination. The Prime Minister's Office takes a more active role in health policy via the Department of Strategic Analysis, and it supervised the social insurance funds from mid 1998 until June 1999, when this role was transferred to the Ministry of Finance.

The National Health Insurance Fund

The National Health Insurance Fund is the most important source of financing for the recurrent costs of health services. The Fund also provides cash benefits such as the sickness allowance and disability pension. The Fund is separate from the government budget; the Government cannot use any surplus for other purposes but is obliged to cover any deficit.⁴³ The supervision of National Health Insurance Fund, from June 1999, was moved to the Ministry of Finance. The nineteen NHIFA branches, at the county level, administer the contracts with local health care providers. The collection of health insurance contributions was moved to the Tax Authority in 1998.

The present structure has evolved gradually. Some elements of social insurance had persisted during the communist era: payroll-related social insurance premiums were collected, and cash benefits were administered via the National Social Insurance Administration (OTF) of the National Council of Trade Unions (SZOT). This structure formed the base upon which the health insurance fund was built. The *Act XXI of 1988 on the Social Insurance Fund* separated the Social Insurance Fund from the Government budget. In 1990, financing of health services was transferred to the Fund (“fund exchange”).⁴⁴ In 1992, the Social Insurance Fund was divided into two: the Health Insurance Fund and the Pension Insurance Fund.⁴⁵

The supervision of the Funds also developed incrementally. The Minister of Welfare was responsible until 1991. *Act LXXXIV of 1991* defined a self-governance structure consisting of representatives of the employers, of the employees (trade unions) and the pension funds. The election and the formation of the two new bodies took place in 1993. The new quasi government bodies were granted extensive rights concerning budgetary decisions and given a veto on Government decisions on social insurance. Between 1994 and 1998, the Horn Government tried to curtail these rights⁴⁶ but a restructure of these bodies⁴⁷ was found unconstitutional.⁴⁸ The new Government in 1998 abolished Health Insurance Self Government (and its pension counterpart) and passed the supervisory role to the Prime Minister’s Office⁷⁴ and then to the Ministry of Finance in 1999.

Local government

Since the establishment of the two-tier local government system in 1990 (which replaced the “council” system of the communist regime), local governments have become key actors in the health sector. *Act LXV of 1990 on Local Governments* defined the basic structure, rights and duties, sources of funds and properties of local governments. The municipal local governments (3131 in 1998) and the county local governments (19 plus the capital) divide up responsibilities on the principle of subsidiarity. This means that county governments only take over public services that municipal governments cannot undertake and are willing to transfer.

The 1990 Local Government Act assigned responsibility for local health services to local governments⁴⁶ but they are allowed to contract out the provision of health services to private providers. The same Act transferred the ownership of the bulk of primary care facilities, polyclinics and hospitals from central Government to local government. As a result, local governments have become

the main health care providers in the Hungarian health system. Municipalities own primary care facilities and outpatient clinics, and municipal hospitals provide secondary care (at least in the larger municipalities). County governments own large county hospitals that provide secondary and tertiary care.

The supply of health care to local residents is further regulated by *Act LXIII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms* and also by the 1997 Health Act.⁵¹ The 1996 “capacity law” defines the number of outpatient specialist consultation hours and the number of hospital beds to be provided by local governments. It also makes the owners of the facilities (contracted providers or local governments) responsible for the maintenance of facilities. The Health Insurance Fund finances agreed recurrent costs, while capital costs are met by the owners. Since capital costs are higher than the revenue capacity of local government, central Government provides earmarked subsidies.

Professional organizations, associations and unions

Voluntary associations were restricted under the previous communist regime except for trade unions. A notable feature of the last decade has been the rapid growth in the number of voluntary organizations, trade unions and other interest groups.

The Hungarian medical chamber, abolished by the communist regime, began to function again in 1988. In 1994 the *Act on the Hungarian Medical Chamber*⁵² made membership compulsory for practising physicians and dentists and defined its structure, tasks and responsibilities, including issuing a code of ethics. The Medical Chamber can discipline those who violate its rules, can express an opinion on a range of medical issues and can veto contract conditions between medical doctors and the National Health Insurance Fund Administration. In 1994, a chamber of pharmacy was also established.⁵³

The large number of professional and scientific associations include the Hungarian Hospital Association, the Society of Health Care Financial Directors, the Association of Nursing Directors, the Hungarian Nursing Association, the Hungarian Medical Association, the Hungarian Pharmacists’ Association and the Hungarian Dental Association. The largest professional organization in Hungary – the Federation of Hungarian Medical Societies – has 83 member societies and more than 25 000 individual members.

Patient associations are growing, with over 70 in various fields of health services. For example, an association of patients with kidney disease is involved in defining criteria for kidney transplantation waiting lists. The new National

Health Council and the new hospital supervisory councils will include representatives of patient associations.⁵⁴

The health sector trade union of the communist regime has lost its monopoly. There are now several unions, the largest being the Health Workers' Democratic Union. Representatives of trade unions and employer organizations participate in the Welfare Interest Reconciliation Council, which was set up in 1995 by the Minister of Welfare. The main objective of the Council is to handle labour relations in the health and social sector.

Private and voluntary sector

Private medical practice was not forbidden under the previous regime but full private employment or enterprise was not allowed. *Decree No. 113/1989 (XI. 15.) MT on Health Care and Social Enterprises* opened the way for private enterprise. Although legal since 1990, there are still few private providers; only 6% of beds are privately owned including church-owned hospitals (46).

The Health Insurance Fund currently does not contract with private providers except family practices and in specialties with shortages, such as some diagnostic services and kidney dialysis. Some primary care and also specialist private clinics have been established where people pay for services, while many physicians also offer part-time private clinics in addition to their public sector employment.

Occupational health services have become the responsibility of employers,⁵⁵ who increasingly purchase these from the private sector.

Some hospitals have been returned to their original church owners. These hospitals are integrated in the public system in that they contract with local governments to provide services for the local population and are eligible for capital grants from the Government budget.

Since 1994, about 30 health sector "non-profit corporations"⁵⁶ have been established by public institutions (32).

Most pharmacies have been privatized, with 91% of a total of 2030 pharmacies becoming private by 1997 (55).

Family physicians can choose to work as private entrepreneurs under contract with local governments and the Health Insurance Fund. The building remains the property of the local government, which is responsible for covering capital costs, while the family physician receives capitation payment from the Health Insurance Fund to run the practice. This scheme is called "functional privatization". By the end of 1997, 71% (of 6855 family doctors) had contracted with the Health Insurance Fund (55).

Act XCVI of 1993 Voluntary Mutual Insurance Funds created the legal conditions for the establishment of private non-profit health insurance, which the Government encourages through tax relief to contributors. So far the number of funds and the number of enrollees are limited, as is private for-profit insurance.

The number of charities is growing rapidly. In 1996, there were 1536 charities in the area of health (9% of all charities in Hungary). In addition, there were 337 non-profit associations with 40 569 members, but these constitute only a very minor source of funds to the health sector (32).

Planning, regulation and management

Health care reforms in the 1990s, in theory, changed the Hungarian health care system to a split funder-provider contract model. The two main elements are the public sector third-party payer (Health Insurance Fund) and local government health care providers. The formal central planning system of the previous regime has been abolished. In practice, however, the Health Insurance Fund is supervised by central government.

Act LXIII of 1996 regulates service contracts and requires the Health Insurance Fund to contract for the health services defined by the law, which are mainly the responsibility of local governments. The Health Insurance Fund, for legal and also political reasons, is restricted in its ability to engage in selective purchasing.

Act CLIV of 1997 on Health set up the National Health Council in June 1999 to advise the Government on health policy.^{57,58} The members are representatives of the relevant stakeholders including professional and patient organizations.

In 1994, the Government set targets for health development in its long-term strategy.⁵⁹ The 1997 Health Act introduced the concept of a National Health Plan, to be prepared by the Government, accepted by the Parliament and revised every four years.⁶⁰ Local planning is becoming more important, however. The Health Plan of Pécs,⁶¹ for example, built on the principle of voluntary participation, has been taken up by other settlements. In 1998 more than 350 small settlements participated in training sessions.

Regulation is the prime responsibility of the Government and relevant ministries but other actors (such as the professional chambers, national institutes, and the National Public Health and Medical Officer Service) are also involved. Aspects of the production process are being regulated (inputs, process and

outputs) as well as quantity, distribution and price. Regulation has been problematic, however, as discussed later in the section on hospital payments.

Regulation of health workers mainly applies to medical doctors, but has been extended to other health workers as well.⁶² Regulatory measures include:

- control of the number of health personnel to be trained by determining the number of students financed from the Government budget;⁶³
- control of recognition of foreign diplomas;⁶⁴
- compulsory registration and licensing of health workers through the Ministry of Health and the professional chambers;⁶⁵
- control of the income of health workers who are public employees;⁶⁶
- regulation of the behaviour of health care workers including rights and duties and ethical considerations.⁶⁷

Pharmaceuticals, medical aids and equipment come under a registration and licensing system administered by the National Institute of Pharmacy and the National Institute of Hospital and Medical Technology.⁶⁸ *Act XXV of 1998 on the Pharmaceuticals for Human Use* regulates the pharmaceutical industry in accordance with standard European Union practices.

Health care providers must obtain a licence to practice⁶⁹ from the National Public Health and Medical Officer Service,⁷⁰ which maintains the registration database.⁷¹ Before issuing the licence, medical officers inspect the facilities and ascertain whether the minimal building, hygienic requirements, personnel and material standards are fulfilled (set by *Decree No. 21/1998. (VI. 3.) NM of the Minister of Welfare*). Providers also are obliged to take out liability insurance.

Special rules are applied to certain services, such as human fertility treatment, sterilization procedures and organ transplantation. Provision of non-conventional medical treatment is regulated by *Government Decree No. 40/1997 (III.5.) Korm. on the Practice of Alternative Medicine* and *Decree No. 11/1997. (V. 28.) NM of the Ministry of Welfare* including the scope of activities, educational, infrastructure and administration requirements.

Health services are supervised by the National Public Health and Medical Officer Service. Regular monitoring of providers includes checking personnel and material minimum standards and the quality of provided services.⁷² The system of professional supervision consists of supervisor chief medical doctors at the county (and in some cases regional) level for various medical specialties, and at the municipal level for family doctors. These are appointed by the county and municipal chief medical officers, in collaboration with the National Public Health and Medical Officer Service and the professional colleges and national institutes.

As far as the regulation of financing is concerned, in the frame of social insurance, the scope of benefits and the level of contribution are predetermined. The payment system is prospective insofar as the relative point value of various hospital and outpatient specialist interventions are defined in advance.

Decentralization of the health care system

Health sector reform at the beginning of the 1990s sought to move away from central government control. Some measures of central control, however, have recently been restored. The regulation of service contracts has been strengthened,⁷³ and the Health Insurance Fund was returned to government control in 1998.⁷⁴

Health policy making and regulation have remained with central Government, while some functions have been delegated to quasi-public organizations and others deconcentrated. Regulation of the medical profession was delegated to a new statutory body, the Hungarian Medical Chamber.

From 1990, responsibility for the provision of certain public services was devolved to local government along with the ability to raise and spend revenues. The ownership of most health care facilities was transferred to local governments in 1990. Financing of health services was delegated to the Health Insurance Fund in 1992 and the administration of its contracts and payments was deconcentrated to the county level.

The legal framework now exists for further privatization and expansion of the private sector. Privatization has mostly taken place in primary care including the functional privatization of family doctor services and privatization of pharmacies. A few hospitals have been given back to their original church owners and the “non-profit corporation” form has been established. The current financing system is a major obstacle to the expansion of private providers, however, since the Health Insurance Fund does not cover depreciation. The new Government plans to resolve this problem by including depreciation costs in the reimbursement fees (6).

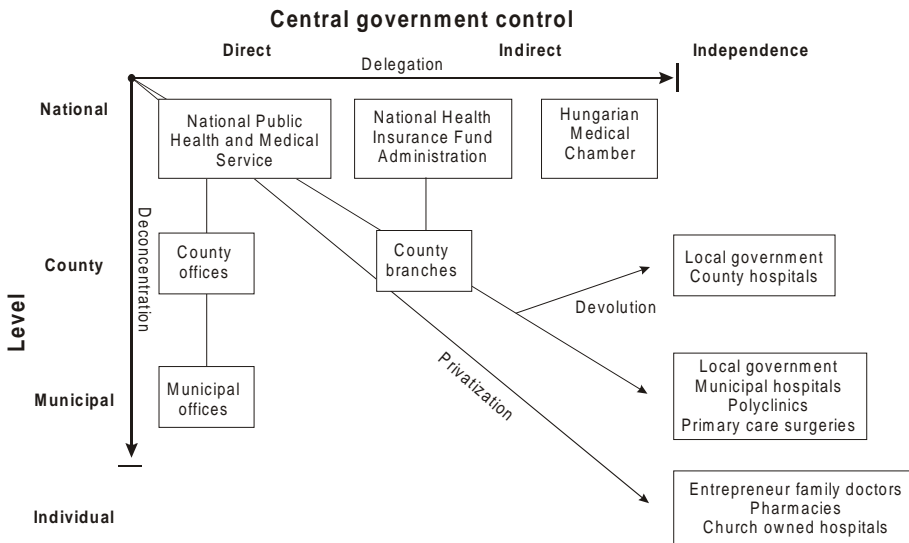
Fig. 4 summarizes the current state of decentralization in the health care sector.

The Orbán Government (6) is considering various policy options: privatization of the National Health Insurance Fund; facilitating further private ownership in primary and outpatient secondary care; while privatization of primary care clinics (including family doctor and primary paediatrician services)

is expected. The Government wishes to encourage more private investment in the health sector. The intention is that health facilities such as hospitals will become more autonomous in managing their own budgets and services.

In summary, the organizational structure of the Hungarian health care system has changed considerably since the end of the 1980s. Decentralization has been the dominant tendency throughout the restructuring process. At present, health services are still primarily publicly financed and provided, but the role of the central government has decreased significantly which raises new regulatory problems. The health care sector has become more pluralist with responsibilities divided between several organizations. According to the policy of the current Government, further decentralization can be expected.

Fig. 4. Decentralization in the Hungarian health care system



Health care finance and expenditure

Public financing remains dominant with 83% of total health revenue in Hungary from public sources in 1996 (Table 4). Estimating the overall amount and the share of various sources of finance is difficult, however. The estimates of the magnitude of informal payment, for instance, vary considerably with different surveys and expert opinions. The Health Insurance Fund is the main source (about 70% in 1996) of health care finance. The Fund covers the recurrent costs of services, while capital costs are financed from the central and local government budget. Since 1990, the insurance share of public expenditure has fallen slightly, the state budget share has risen, and out-of-pocket spending by individuals has increased substantially (58).

Table 4. Main sources of finance (%), 1991–1996

Source	1990	1992	1994	1995	1996
Public	85.7	88.2	86.7	83.3	82.6
Taxes	12.7	17.1	16.8	16.6	11.9
Statutory health insurance	73.0	71.1	69.9	66.7	70.7
Private	14.3	11.8	13.7	16.7	17.4
Out-of-pocket*	14.3	11.8	13.7	16.7	17.4
Private insurance	–	–	–	–	–
Other	–	–	–	–	–
External sources	–	–	–	–	–

Source: Orosz et al. 1997.

Note: Out-of-pocket payments by consumers are likely to be an underestimate.

There is also a funding division between types of health services. The central government budget covers both recurrent and capital costs of emergency

ambulance services, public health, compulsory immunization, prenatal care and expensive tertiary care services, such as positron emission tomography, lung, heart, liver and pancreas transplantation.

Main system of finance and coverage

The reforms of the past decade have transformed a primarily tax-based system to a social insurance system in a return to the earlier Bismarckian tradition of Hungary.

Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services determines the entitlement for in-kind and cash benefits and the obligation and rules of paying the contribution (premium). As a general rule, entitlement for health insurance benefits is linked to paying the premium; but certain exceptions are stipulated in the Act, such as pensioners and the unemployed who are on income supplement.⁷⁵ Membership in the health insurance scheme is compulsory and opting out is not permitted. Population coverage is virtually universal with only about 1% of the population not covered.

Health services are provided on the basis of the health insurance personal identification number. There is currently no system in operation to check the payment of contributions at the providers.

The health insurance premium is split between employer and employee and is, in effect, a payroll tax. The proportional contribution rates are fixed and universal. In 1998, employers paid 15% of the employee's gross salary, and employees paid 3%. There is an upper contribution limit for the employee premium which is determined annually by the Parliament.⁷⁶ In 1998, the income above which no employee contribution was paid was 4290 HUF per day (USD 20).

The self-employed are also obliged to participate in the scheme, but there is considerable evasion, even though they must pay the premium at least according to the centrally determined minimum wage. Special rules are applied to small farmers, who must pay at least 11% of the actual minimum wage, but they are not entitled to cash benefits.⁷⁷ They can choose to pay a higher contribution to get full coverage including cash benefits.⁷⁸

Provisions for non-contributing groups are shared between the Health Insurance Fund and the Government. Those who are on sickness and disability

benefits should be covered by the Fund, while the Government transfers the revenue from the so-called “health care contribution” or health care tax to the Fund to cover pensioners, the unemployed and socially indigent.

The high rate of social insurance represents a large burden for employers and is an incentive for evasion. The new government has decided to reduce employer rates from 15% to 11% for health, and from 24% to 21% for pensions (Table 5).⁷⁹ Hungary has experienced considerable problems with tax evasion, including non-payment and under-reporting of income. Collecting premiums from the self-employed is difficult, especially in countries with a large informal economy. In 1995, for example, the annual per capita total contribution of the self-employed was one fifth that of salaried employees, suggesting widespread tax avoidance (62).

Table 5. Social insurance (% of gross salary)

	1993	1996	1997	1998	1999	2000
Health	23.5	22	19	18	14	14
employer	19.5	18	15	15	11	11
employee	4	4	4	3	3	3
Pension	30.5	30.5	30	31	30	30
employer	24.5	24.5	24	24	22	21
employee	6	6	6	7	8	9
Total	54	52.5	49	49	44	44

Source: Act II of 1975, Act LXXX of 1997.

The budget of the Health Insurance Fund has been in deficit since its inception so that the government has sought extra sources of revenue. A new hypothecated tax (the so-called “health care contribution” or health care tax) was passed by Parliament in the economic stabilization programme of 1995 and 1996.⁸⁰ This health tax originally was a lump sum tax paid by the employer in addition to the social insurance premium. The first health tax was paid in 1997 and in 1999 was equal to HUF 3600 per month per person.

The measure was prompted by the anticipated 1997 revenue crisis of the Health Insurance Fund. The Pension Fund stopped paying contributions for pensioners, the contribution rate was slightly decreased and central government transfers for certain population groups stopped. The health care tax was paid into the Health Insurance Fund to compensate for these shortfalls. In order to compensate for the decreased social insurance premium for 1999, the new Government expanded the health care tax by *Act LXVI of 1998*. In addition to the lump sum tax, the health care tax has a new income-related element. From

the first of January 1999, an 11% tax has been levied on the portion of income previously exempt from the social insurance premium. The employer and employee social insurance premium and the health care tax now constitute the two major revenue sources of the Health Insurance Fund. In 1998, 94% of the revenue of the Health Insurance Fund came from private contributions (premiums and the health tax from employers, employees and the self-employed) and the remainder from the state. From 1999, the Tax Office took over collection of the health insurance premium.

The capital costs of health services are met by the state. In principle, owners, who since 1990 are mainly local governments, are responsible for the maintenance of health care facilities. Local government revenue for health capital costs come from four sources: transfers of central tax revenues on a capitation basis, local taxes, earmarked and target subsidies and other projects. The third and new element is specific purpose payments to local government under *Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments* which also determines the components and processes of application.

Earmarked subsidies can be applied to large projects (exceeding 200 million HUF) but the upper limit and local contribution is not specified. Project proposals prepared by local governments are submitted to the Ministry of Internal Affairs, which makes a priority list, taking into account recommendations from the relevant ministries. Parliament then considers these proposals. Target subsidies allow local government less discretion in that both the purposes and conditions are predetermined by Parliament. Target subsidies to purchase medical equipment require a 30–40% local share. A budget is devolved to the county councils to decide between applicants. Private providers who supply services under contractual obligation to local government can also apply. The Ministry of Health also runs various programmes for the replacement of medical equipment, such as X-ray machines.

The future reform direction of health care financing is being debated. The Government (6) has defined the following main objectives:

- to maintain the principle of solidarity and universal coverage in health insurance;
- to further decentralize the Health Insurance Fund;
- to decrease the overall social insurance contribution to 25% over four years;
- to reform the collection system.

Health care benefits and rationing

The previous communist system upheld the principles of universal and comprehensive coverage. Health services were free-of-charge except for very small co-payments for medicines, medical aids and prostheses. These principles conflicted with the scarcity of resources but this problem was not confronted. Rationing occurred through waiting lists, the dilution of services and probably through the informal payments.

In the early years of reform, more emphasis was put on structural reform than setting priorities in terms of health care benefits. Parallel to the establishment of health insurance, a list of free services was defined in amendments to *Act II of 1975 on Social Insurance*.⁸¹ These were broad enough to cover virtually everything, although the principle of co-payment (for prescribed medicines, medical aids and spa treatments) was upheld.

The first steps towards the definition of a benefit package were taken during the economic crisis of 1995, when the Health Insurance Fund deficit called for urgent action. *Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization* curtailed in-kind and cash benefits. The main exclusions were many dental services and many sanatoria treatments. Co-payment for patient transfer (ambulance) services was introduced, and sickness benefit was decreased.

The adverse effects (for example, a sharp drop in the use of dental services) forced the Government to retreat so that dental services were reintroduced with some co-payment.⁸² *Government Decree No. 89/1995. (VII. 14.) Korm.* ordered occupational health services to be fully financed by employers on a capitation basis.

In 1997, new legislation addressed the issues of rationing and priority setting in a more systematic manner. *Act CLIV of 1997 on Health* introduced the concept of waiting lists. The selection of patients from waiting lists must be made without discrimination, on the basis of uniform and explicit criteria, taking into account the health status of patients. *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance* explicitly prohibits giving priority to those prepared to pay extra. Waiting lists have been set up for organ and tissue transplantation and for other services that cannot be provided within two months. Patient selection and priority criteria are defined by the “professional colleges” on the basis of the need for the service and the expected outcome. Waiting lists are supervised by committees in each institution, comprising representatives from patient organizations, the financing organization, the professional director and the department head of the provider organization.⁸³

Act LXXXIII of 1997 and related decrees define health services in the frame of statutory health insurance, which are free-of-charge, are subsidized or require a co-payment. Most primary, secondary and tertiary care services are covered. Co-payment is required for certain dental services,⁸⁴ medicines and medical aids,⁸⁵ treatment in a sanatorium,⁸⁶ some 'hotel' aspects of hospital services, and specialist services obtained without a referral from authorized medical doctors (except in the case of emergency). Special rules apply to a few services, such as infertility treatments, where the number of attempts is limited.⁸⁷ The costs of medical examinations for certificates required for activities such as driving and holding certain jobs are not covered.

The Act explicitly excludes treatments for aesthetic or recreational purposes and those not proved effective in improving health. These (listed in *Decree No. 46/1997. (XII. 17.) NM of the Minister of Welfare*) include services not classified in the International Classification of Medical Interventions plus cosmetic surgery, massage, abortion or sterilization without medical indication, and the prostate specific antigen test in general screening.

Complementary sources of finance

Public funding as a percentage of total health care expenditure decreased slightly between 1990 and 1996, while the share of out-of-pocket payments increased.

Out-of-pocket payments

Out-of-pocket payments are made for services and products that are not covered, or are only partially covered by the Health Insurance Fund. Out-of-pocket payments in 1996 were estimated at 17.4% of total health care revenue (Table 4). Since the establishment of social insurance in 1990, out-of-pocket payments have risen partly due to increased co-payments and as the benefits available from statutory health insurance have been reduced. While the overall magnitude of informal payment is debated, it seems that its share has been decreasing throughout the 1990s (Table 6).

Significant co-payments are made for certain dental treatments, specialist services sought without a referral, services additional to those ordered by the specialist, and extra 'hotel' aspects of hospital services. Co-payments also are paid for chronic care and treatment in a sanatorium.⁸⁸ Patients make a co-payment for the cost of materials used in a tooth filling. Co-payment for long-term care was 400 HUF per day.⁸⁹

The largest out-of-pocket payments are for medicines, and for medical aids and devices such as wheelchairs and incontinence pads. Ambulatory care patients pay a percentage of the price of the medicine or medical aid, or the difference between the price and a fixed amount subsidy.⁹⁰ The patient is eligible only for subsidised prescription items according to rules defined in various regulations, and purchased in a pharmacy under contract with the National Health Insurance Fund. Inpatient care includes the cost of medications. Before 1990, drugs were heavily subsidised by the state and consumers paid only a symbolic amount. In contrast, patients paid 35% of their medication costs in 1997, which constitutes a six-fold rise since 1991 (29). The exemption system helps the socially indigent to get the necessary medicines without co-payment, with eligibility based on a means test administered by local government. A survey in 1994, however, found that 20% of prescriptions went unfilled, which suggested an inability to pay the rising prices of drugs (36).

Informal payment (gratitude, under-the-table or envelope payment) constitutes the other main out-of-pocket expenditure. Informal payment in Hungary were tolerated throughout the communist regime and included in the calculation of salaries, despite official campaigns to decrease their prevalence. Since 1989 these payments are meant to be declared for income tax. Household surveys of the Hungarian Central Statistical Office have estimated gratitude payments as almost 6 billion HUF in 1997 (Table 6), equivalent to about 10% of out-of-pocket payments and over 1% of total health expenditure. Other surveys provided much higher estimates (5), and the overall magnitude is debated by experts as well. Findings are more consistent that most payments go to medical doctors, and to particular medical specialities, obstetrics-gynaecology, births and surgical procedures being the best “paying”. For example, a 1984 population survey carried out by the Hungarian Central Statistical Office found that 70% of women giving birth in hospital paid the doctor, while over 60% of patients paid their surgeon.

Table 6. Out-of-pocket payments

Category	1992 %	1993 %	1994 %	1995 %	1996 %	1997 %
Medicines	49	58	64	66	72	70
Medical aids	17	13	10	9	8	10
Health service	22	13	12	14	10	11
Informal payment*	13	16	12	10	9	8
Total percent	100	100	100	100	100	100
Total amount (HUF million)	19.029	24.112	32.333	44.910	59.365	68.840

Source: Hungarian Central Statistical Office, 1992, 1993b, 1994b, 1995b, 1996c, 1998a, 1998e.

Note: Findings concerning the full extent of informal payment are controversial.

The practice of informal payment for health services is deeply embedded and will be difficult to remove. The low salaries of medical doctors and other health workers compared to other sectors of the economy are a major contributing factor, but higher salaries alone will not solve the problem. The elimination of informal payment needs concerted action aimed to restore lost confidence that one can get good quality services without payment. However, most medical doctors say that informal payment has no effect on the quality of the care provided (66). The new Minister of Health has set up a committee to explore the phenomenon and propose solutions.

Voluntary health insurance

Voluntary health insurance was non-existent under the previous regime. *Act XCVI of 1993 on Voluntary Mutual Insurance Funds* created the legal framework for non-profit insurance plans, according to the model of the 'mutualité' movement. Although the Government subsidises the purchase of voluntary health insurance from mutual funds with a 25% tax rebate up to a certain limit, so far few voluntary funds have been established in Hungary. The existing plans usually provide services not covered, or not fully covered by the Health Insurance Fund, including preventive health services, dental services, co-payments for drugs and medical aids and rehabilitation in sanatoria. In 1998, the nearly 30 voluntary health insurance funds covered approximately 30 000 persons, with revenue of 600 million HUF (USD 2.8 million, ECU 2.5 million).⁹¹ Some funds insure against lost income with cash benefits.

Private for-profit voluntary insurance is even more limited. Some companies offer insurance at the upper end of the market, mainly in the form of cash benefits as a supplement to life insurance, or against certain risks such as travel insurance.

The low demand for voluntary health insurance can be attributed to two factors. First, services are accessible and are mostly covered by statutory health insurance. Second, informal payments may be a cheaper solution than private insurance for wealthier patients wishing to obtain quicker or better quality services.

External and other sources of funding

External sources of funding have flowed into the Hungarian economy to support the reform process. Government aid and loan programmes to support the reform of health services include the PHARE programme of the European Union, partnership programmes supported by the USAID and World Bank loans for

supporting the restructuring of the health care system. There have been many bilateral programmes as well.

Voluntary donations channelled through charities have also flowed into the health and welfare sectors. In 1996 there were 1913 non-profit organizations in Hungary. Total revenue (for the health and welfare sectors) in 1996 was more than 6 billion HUF (USD 28 million, ECU 25 million), of which only 20% was state subsidy (32).

Since 1996, taxpayers can decide which charity should receive 1% of their income tax.⁹² In the income tax declaration, the taxpayer can designate a non-profit organization. All non-profit organizations that carry out public purpose activities are eligible, except for political parties and organizations representing the interests of employers and employees. Health care is defined as a public purpose activity, so non-profit health providers are eligible. *Act CXXIX of 1997 on the Amendment of Act CXXVI of 1996* extended this scheme by another 1% of income tax to be offered to churches.

Health care expenditure

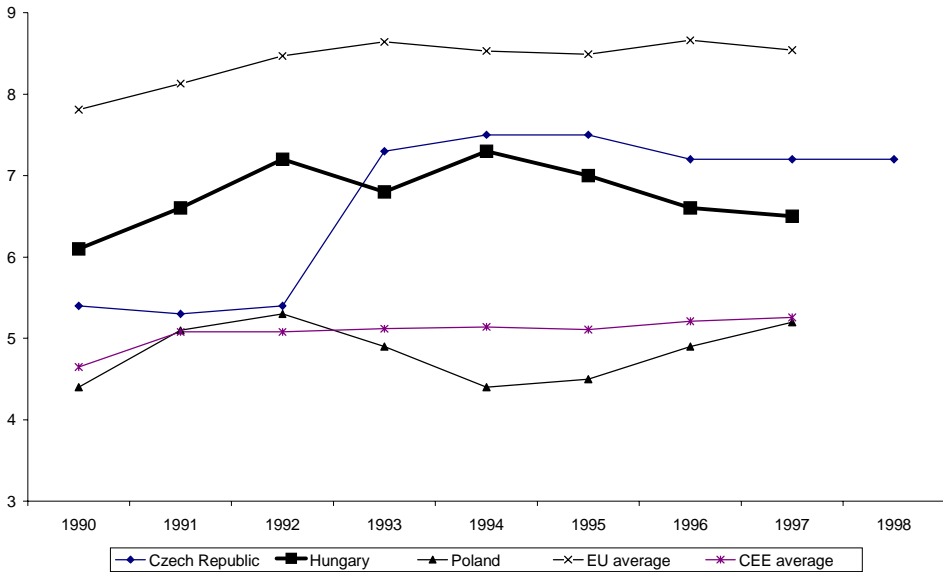
Total health care expenditure is difficult to estimate, due to the problem of estimating expenditure by local government, by the voluntary sector and, in particular, by the people. Under the previous regime, the GDP share of health care expenditure was low. Expenditure rose in 1990 when social insurance was established, but the economic recession followed by the stabilization policies of 1995 have constrained growth in the health care budget. Between 1989 and 1996, health expenditure decreased (after applying the health sector price deflator) by 21% (62).

Table 7. Trends in health care expenditure, 1989–1997

	1990	1991	1992	1993	1994	1995	1996	1997
Value in current prices (billion HUF) (a)	138.0	165.0	212.2	240.5	318.2	388.3	451.9	555.0
Value in constant prices (1990) (c)	138.0	121.3	129.3	120.3	133.7	128.6	123.1	128.2
Share of GDP (%) (a)	6.1	6.6	7.2	6.8	7.3	7.1	6.7	6.5
Value PPP \$ per capita (b)	–	391	424	406	459	562	602	–

Source: (a) OECD health data; (b) WHO Regional Office for Europe health for all database; (c) Applying World Bank GDP deflator series.

Fig. 5. Trends in health care expenditure as a share of GDP (%) in Hungary and selected European countries, 1990–1998



Source: WHO Regional Office for Europe health for all database.

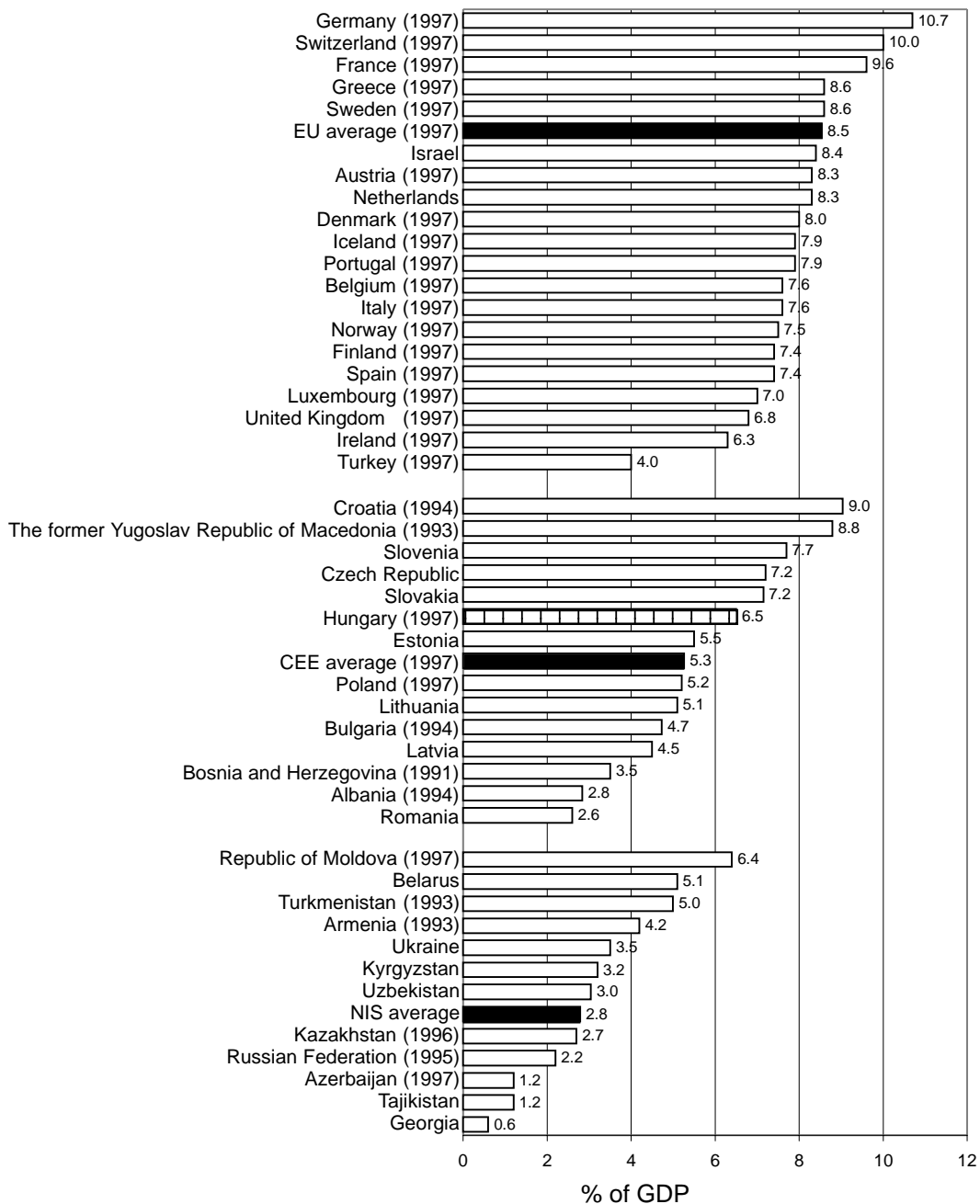
Total health expenditure as a percentage of the GDP in Hungary (6.5% in 1997) is similar to the European Union average. Expenditure in terms of purchasing power parity has grown steadily from PPP \$510 in 1990 to PPP \$642 in 1997, the latter being lower, however, than the European Union average of PPP \$1771 (also see Fig. 7).

After several years of economic stabilization policies, the economic growth in 1997 may create the conditions for an increase in health expenditure. Future health expenditure must address the effectiveness, quality and efficiency problems of the health services, in the light of the health status of the population.

Structure of health care expenditures

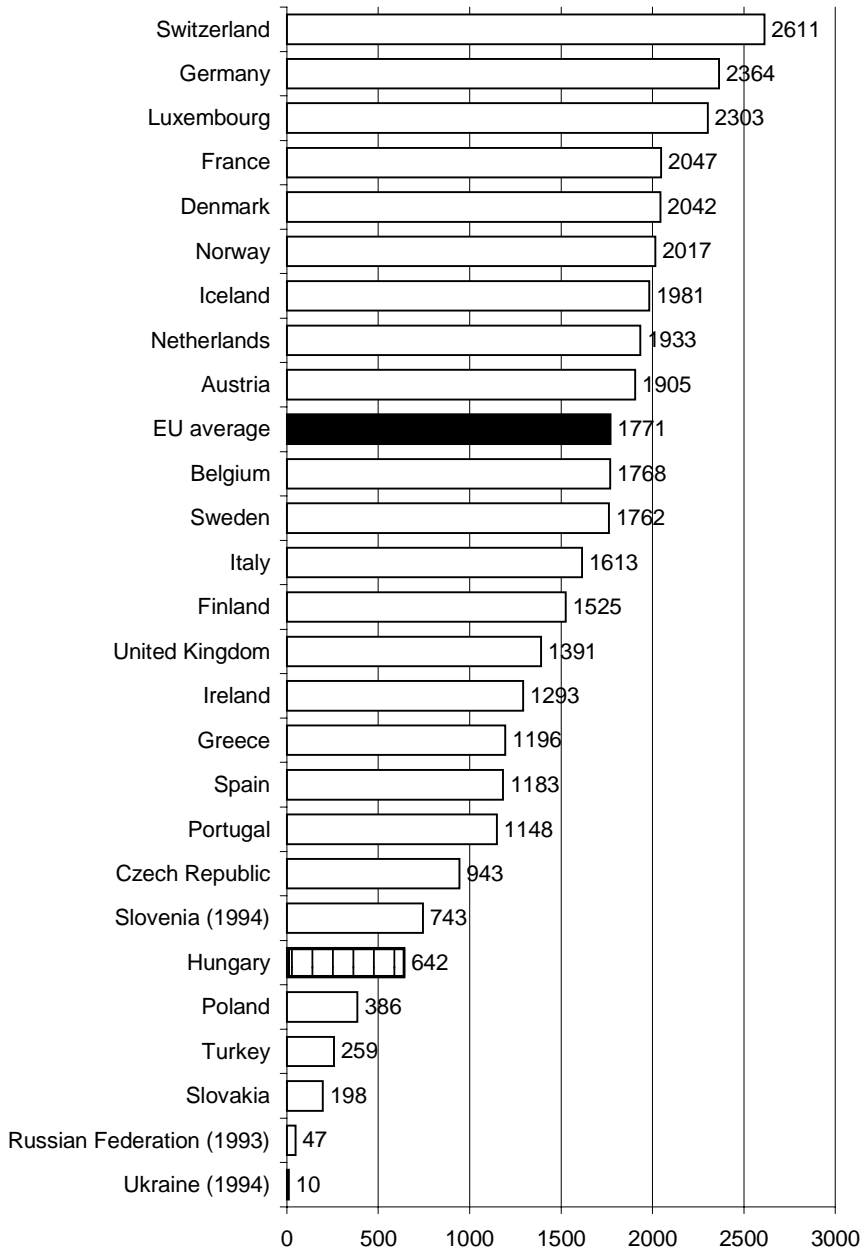
The expenditure of the Health Insurance Fund Administration is well documented. Since this is the largest share of health expenditure, around 70% of known health expenditures (Table 8), it serves as a reasonable proxy for overall health care expenditure. The budget of the Health Insurance Fund was HUF 556.6 billion in 1997 (55). Cash benefits, however, account for 25% of the Fund's expenditure. The following set of tables (Tables 8–10) give trends for

Fig. 6. Total expenditure on health as a % of GDP in the WHO European Region, 1998 (or latest year)



Source: WHO Regional Office for Europe health for all database.

Fig. 7. Health care expenditure in US \$PPP per capita in the WHO European Region, 1997 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

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the types of expenditure within the health budget. It should, however, be noted that some budget items are capped and some are open-ended so that trends are difficult to interpret. Table 8 gives slightly different estimates of health expenditure as a % of GDP; statistics vary depending on the source and in part upon the estimated amount of private expenditure.

Public expenditure on health care as a percent of GDP, and as a percentage of total health expenditure, has fallen since 1994 (Table 8). This is mainly because health insurance expenditure fell as private expenditures rose (Table 8).

The share of expenditure on inpatient care was just below 30% in 1996 (Table 9). Inpatient services take 40% of Health Insurance Fund expenditure (Table 10). The share of the Health Insurance Fund allocated to primary care dropped slightly from 13% in 1994 to 10.7% in 1997 but remained stable for outpatient specialist services and inpatient services. A decrease in the real value of hospital revenue and an increase in the number of cases has resulted in a downward spiral in financing inpatient care services, with some hospitals in a severe financial crisis and running 15%–20% annual budget deficits (1).

Table 8. Health care expenditure categories (as % of GDP), 1991–1997

Expenditure categories	1991	1992	1993	1994	1995	1996	1997
Public expenditure (a)	6.5	6.8	6.8	7.3	6.3	5.9	5.5
of which Health insurance	5.2	5.4	5.4	5.5	4.9	4.8	4.8
Private co-payments for drugs	0.3	0.3	0.3	0.5	0.7	0.7	0.6
Total health expenditure	6.8	7.2	7.4	7.9	7.1	6.8	6.4

Source: Orosz in OECD 1999, citing Health Insurance Fund Administration.

Note: (a) Recurrent and investment.

The fast growth of pharmaceutical expenditures has increased the deficit of the Health Insurance Fund.⁹³ Total pharmaceutical expenses are equivalent to 2.3% of national GDP (reimbursement is 1.7% of GDP), or 176 billion HUF in 1997 (44). In contrast, developed countries spend about 0.7%–1.4% GDP on drugs. Pharmaceuticals in Hungary took nearly 30% of total health care expenditure in 1996 compared to less than 20% in most western European countries (57). A modern health care system requires a certain level of pharmaceuticals, which therefore take a larger share in low health budget countries. In terms of per capita spending, Hungary spends less on drugs than some of its neighbours: PPP \$152 in 1995 which was lower than the PPP\$193 in the Czech Republic and PPP\$230 in Austria (70).

Public investment fell from 0.6% to 0.3% of GDP between 1991 and 1997, and from 7.9% to 4.0% of total health expenditure between 1990 and 1996 (Table 9). The lack of sufficient capital expenditure has meant continuing deterioration in health sector facilities and equipment.

Table 9. Health care expenditure by categories in Hungary (as % of total expenditure on health care), 1990–1997

Expenditures	1990	1991	1992	1991	1994	1995	1996	1997
Inpatient care (%) (a)	-	-	-	-	28.0	27.1	29.0	-
Pharmaceuticals (%) (b)	5.0	30.1	28.5	32.5	32.0	27.0	28.5	-
Public investment (%) (a)	7.9	-	7.9	-	7.2	5.1	4.0	-

Source: (a) Orosz et al., 1997; (b) WHO Regional Office for Europe health for all database.

Table 10. Expenditures of the National Health Insurance Fund, 1994–1997

Expenditures	1994	1995	1996	1997
In-kind benefits (current prices, billion HUF)	241.395	275.618	326.102	389.964
Curative & preventive services (%)	70.2	69.3	68.9	68.2
Primary Care (%)	13.0	11.5	11.0	10.7
family doctor services (%)	7.6	6.9	6.9	6.6
other (%)	5.4	4.6	4.1	4.1
Outpatient specialist services (%)	10.6	10.7	10.7	10.7
Special services (%)	2.3	2.8	3.3	3.2
dialysis (%)	1.1	1.4	1.7	1.7
CT, MRI (%)	-	-	1.4	1.4
home care (%)	-	-	0.0	0.1
other (%)	1.2	1.4	0.2	0.0
Inpatient services	40.1	40.6	41.0	40.2
active (%)	34.6	35.1	35.6	34.7
chronic care (%)	4.4	4.2	4.2	4.1
special (%)	1.1	1.3	1.2	1.4
Other (%)	4.8	3.8	3.0	3.1
Medicines (%)	25.8	25.7	26.2	25.9
Medical aids (%)	3.0	3.9	3.7	4.3
Other (%)	0.9	1.0	1.2	1.7
Administration (current prices, billion HUF)	15.409	14.052	23.729	23.813
Cash benefits (current prices, billion HUF)	107.971	118.242	121.959	141.809

Source: National Health Insurance Fund Administration, 1995, 1996, 1997, 1998.

Health care delivery system

The Hungarian health care system provides care of a quality below, but generally not much below that of western Europe to a relatively sick population, while spending only one sixth to one tenth that spent in those countries (10). Current reform measures are attempting to shift more policy attention and more resources from secondary and tertiary to primary health care.

Primary health care and public health services

Decree No. 6/1992 (III. 31.) NM of the Minister of Welfare on the Family Physician Service endorsed family physicians. Choice of family doctor (previously determined by place of residence under the district physician service) was introduced with health insurance cards in 1995. The 1990 Local Government Act had earlier placed an obligation on local government to develop primary care services for their local population.⁹⁴ Later legislation confirmed the principles of patient choice and continuous primary care in an ongoing doctor–patient relationship.⁹⁵

The ultimate objective is to deliver comprehensive primary and preventive health care in local communities. In 1997, primary health care was provided by 5157 physicians, 1559 paediatricians, 5792 district nurses and 5245 mother and child health nurses (29). The total number of registered family physicians was 6876 in July 1998.⁹⁶

An early achievement of the communist regime was to make primary health care available to every citizen. From the 1970s, however, the emphasis switched to hospital care and, with the aim of integrating health services, ambulatory care was brought mainly under hospital management from 1975. Theraputists (for adults), paediatricians, dentists and nurses worked from polyclinics that served a district population, or from doctors' clinics in rural areas. In urban

areas, general physicians treated adults and paediatricians treated children (0–14 years old); in rural areas this separation was less feasible.

The 1990 health sector reforms aimed to strengthen primary health care. *Decree No. 6/1992 (III.31.)* removed primary health care from hospital administration and re-titled district physicians ‘family physicians’, who were to provide health care to all family members. The decree endorsed the family physician as the key to primary health care and as the gatekeeper to specialist care. Most specialist care was to be available only with a family physician referral. The exceptions were certain specialties (such as obstetrics–gynaecology; ear, nose and throat; ophthalmology; and surgery) where patients could still go directly to specialists.

In 1991, the National Institute of Family Medicine was established to train family physicians in postgraduate specialist courses. This credential is being phased in as a minimum requirement for practice as a family physician from 1999 onwards.⁹⁷

The staffing standard set for primary care was 1600–1800 patients per family physician. The number of inhabitants served by one family doctor averaged 1815 in 1995 (47). Primary care remains the overall responsibility of local government. The 4500 primary care districts in 1990 increased to 5011 in 1995 due to a reduction in the size of each district.

The share of the Health Insurance Fund budget for family doctors is just below 7% (Table 10). In 1997, the Fund spent HUF 25.8 billion on family doctors which averages about 3 million HUF for each family doctor practice (55). Other expenditure on primary care includes dental care, mother and child health services, school health care services and occupational health care services.

Family physicians now have four employment options. First, local government employs 21% of family doctors on a monthly salary via the Health Insurance Fund. The second option, chosen by 77%, is a semi-privatized model (functional privatization). These doctors work on a contract basis with local government, are paid an (adjusted) capitation fee directly from the Health Insurance Fund based on their registered patient list, and rent local government premises (mostly for no fee or a symbolic fee). Local government covers the maintenance and capital costs of the surgery, and the doctor covers recurrent expenses (such as employing staff and purchasing disposables). Under the third option, 3% of doctors work as independent private practitioners receiving a patient capitation amount directly from the Health Insurance Fund but have no responsibility for a catchment area. Lastly, a few family doctors are employed by the local hospital.

A ministerial commission has been appointed to consider further privatization. Several problems have to be solved. For example, privatized doctors must

be able to buy and sell their practices. Also, the capitation payment from the Health Insurance Fund must be increased to cover depreciation and investment costs (previously met by local government). Family physicians have welcomed the government policy intention to extend privatization since they wish to own their practices.⁹⁸

Most general practitioners work in single-handed practices. The Horn government (1994–1998) initiated a project to encourage group practice but due to limited financial resources this was not fully implemented. The intention is to extend several pilot primary care projects, such as local initiatives in managed care, in multi-fundholding practices and in budget management in order to enhance cost containment.⁹⁹

The aim of the family physician system to treat more patients at the primary care level has not happened for several reasons. Family physicians still refer patients to higher levels of care due to their limited training, lack of financial incentives to retain the patient, and the strong preferences of patients themselves. The gatekeeping role of family physicians is weak, since no referral is required for a number of specialities. While capitation payments provide a predictable income, they do not reward additional work but instead create an incentive to transfer work to other providers. Many family physicians treat only minor problems, their main activities being to refer to polyclinics and to write sickness certificates (40).

The Ministry of Health aims to reduce the number of patients in family practices, to increase the number of practices, to increase the level of services provided to each patient, and to encourage group practice. However, the current financing structure (weighted capitation payment) does not encourage family doctors to enter into a group practice. Training is being upgraded, new administrative structures put in place, and new ways of working are slowly being developed.

Hungary has developed a well-regarded network of mother and child health nurses and the planned reforms envisage their wider primary care role. In 1997, there were 5245 mother and child health nurses. *Decree No. 5/1995 (II.8.) of the Minister of Welfare* required local governments to provide mother and child health nurse services within geographic districts and to offer preventive and primary care services in women's health, antenatal care, maternity care and care for children aged 0–16 years. Mother and child health nurses and county/capital city nursing officers are employed by local governments with professional supervision from the National Public Health and Medical Officer Service. The chief nursing officer and the chief mother and child health nurse are on the staff of the Executive Office. With the declining birth rate and widening socio-economic divisions, mother and child health nursing may need to take on a

broader role, including the prevention and identification of risk, physical and mental health services and assistance with social problems. Their training must be improved in relation to promoting family planning, safe childbearing and healthier lifestyles and in preventing addictions.

Home nursing services in Hungary are facing several challenges: a growing number of older people, more people with chronic and mental illnesses and more demand for home nursing as the average length of stay in hospital decreases. Home nursing services are being developed to facilitate earlier discharge from hospital, with a separate budget line in the National Health Insurance Fund for home care. This budget line has increased from 120 million HUF in 1995 to 1000 million in 1999. But this meets only about one fifth of the demand for home nursing.

Public health services

The National Public Health and Medical Officer Service formed in 1991 had its origins in the earlier Hungarian health care system. According to *Act IX of 1936* and *Decree No. 900/1936 of the Minister of Internal Affairs on the execution of the Act* "... public health and epidemiology, social medicine and health promotion as well as health administration are the tasks of the State which are partly performed by civil servants: chief medical officers and medical officers and partly, as a temporary solution, local government officers: town doctors, village and district doctors". In the 1950s, regional centres covering a population of about 100 000 dealt with public hygiene and the control of communicable diseases. Immunization programmes were successfully developed, as were public hygiene programmes to do with food, the environment and occupational hazards. From the late 1960s, however, the Service failed to respond to new circumstances: the deterioration of the health of the population was no longer caused by infectious but by chronic and noncommunicable diseases.

Act XI of 1991 on the National Public Health and Medical Officer Service reorganized the former Public Health Stations run by local governments into a state agency, and gave it a broad range of tasks. This service is responsible for population health surveillance (particularly infectious diseases), immunization logistics (such as supply of vaccines), health and safety and environmental hazards (testing air, water and soil), food safety and other areas. Recently the list of responsibilities was widened to licensing, professional supervision, setting standards and accrediting health care facilities. The service also formulates and coordinates national and county public health policies but their limited capacity has caused some tensions amongst other health organizations. The

National Public Health and Medical Officer Service, despite some changes, remains a traditional sanitary and epidemiological service rather than a modern public health institution.

The service is headed by the Chief Public Health Officer, appointed by the Ministry of Health (previously Ministry of Welfare) to run the national department, which has seven national level institutes. The middle level of public administration is organized into 19 county and the capital city institutions, all with laboratories. At the third level, there are 114 municipal centres and 22 district centres, which have close links with local governments. These institutions are staffed mainly by environmental health and public hygiene specialists, who require retraining to undertake new functions such as health promotion (45). This service takes 15% of the budget of the Ministry of Health. Recently, it has embarked upon revenue-generating activities such as charging for laboratory tests in order to complement their insufficient central budget allocation.

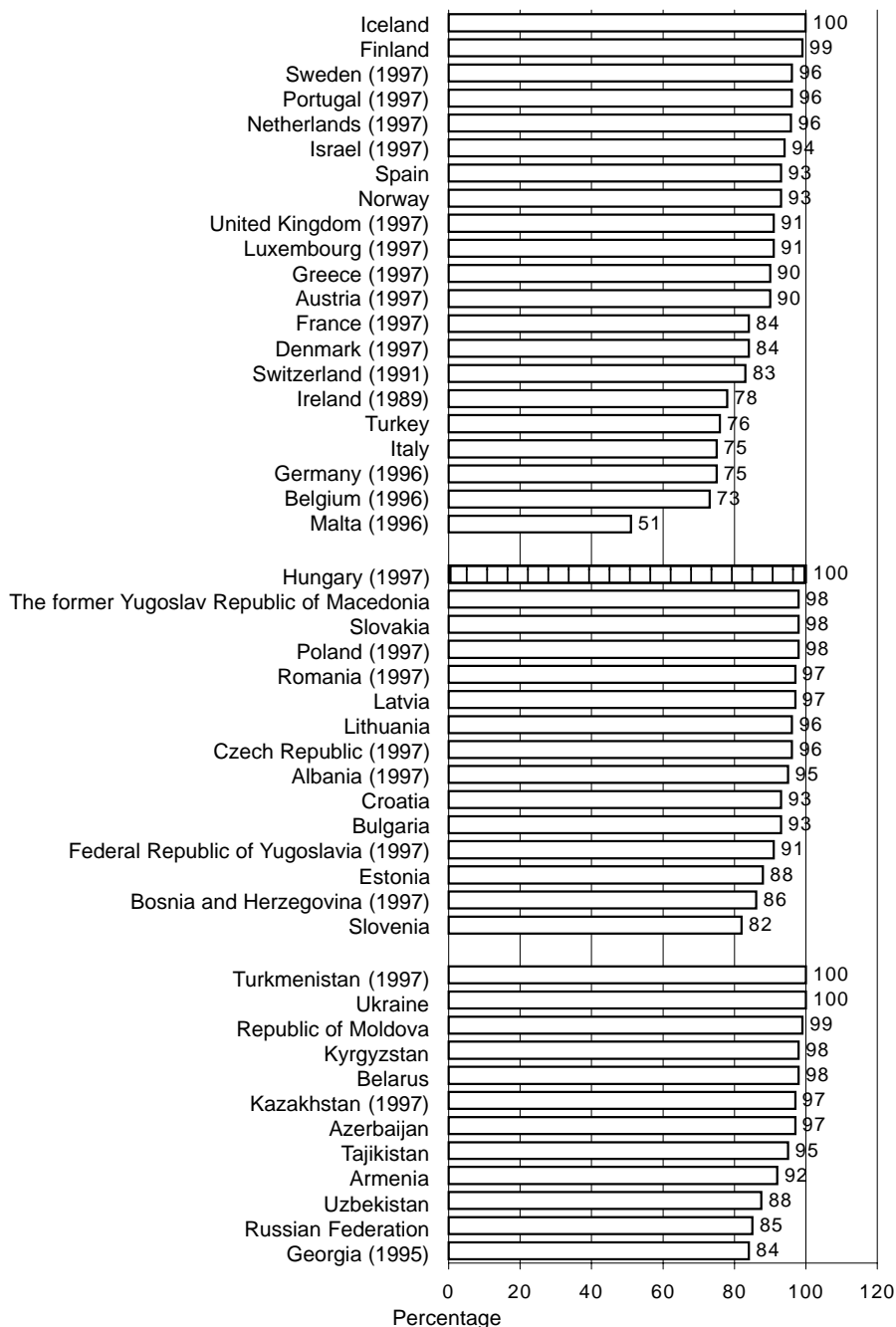
The Occupational Safety Act stipulated that all employers should ensure occupational health services for all employees, but these services were in 1995 excluded from the Health Insurance Fund. All costs are borne by the employer, although prices for occupational health services are regulated by government order. Enterprises are required to purchase or provide their own occupational health services, such as screening and health checks for job fitness, and work-related prevention, treatment and continuous health care. Occupational health creates an opportunity for the growth of private health care. Occupational health supervision remains the responsibility of the National Public Health and Medical Officer Service.

The school health service is part of the National Public Health and Medical Officer Service. In 1997 it employed 3500 mother and child health nurses, 1700 family physicians and 1400 family paediatricians (some of these part-time from primary care). The school health network provides check ups for all Hungarian school students as well as screening programmes and immunization.

Public health services have a good record in immunization programmes, especially in childhood diseases. For example, Hungary immunizes practically all children against measles (Fig. 8). Hungary has a low HIV/AIDS infection rate, partly due to prevention programmes begun as early as 1986, such as screening blood donors for HIV, and also education programmes. Screening programmes for other conditions are being expanded, such as for tuberculosis, and for breast and cervical cancer among women.

Health promotion and disease prevention programmes are coordinated by the National Institute for Health Promotion, set up in 1994, which also provides health policy and health promotion advice to the Ministry of Health. An ongoing

Fig. 8. Levels of immunization for measles in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

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problem is the lack of interest and involvement in health promotion by local governments and the public.

As part of the strategy to tackle the poor health status of the Hungarian population, more attention is being paid to differences in health status between districts and between social groups. Health indicators in more prosperous districts are similar to European Union averages in contrast to very poor indicators in other districts. For example, life expectancy at birth in some poor villages with large Roma communities is under 60 years (41). The health status of the Roma and their access to health services therefore requires particular attention.

Secondary and tertiary care

Hungary developed a hospital-centred system of health care prior to the 1990s, which is beyond the current economic capacity of the country and beyond the level of care required. Reforms aim to move more treatment from inpatient to outpatient services and to expand day surgery as well as non-invasive and micro-level diagnostic and therapeutic procedures.

Outpatient specialist services

Outpatient expenditures by the Health Insurance Fund have decreased in constant currency. In 1996, there were 263 specialist ambulatory care institutions in Hungary; 155 were affiliated to hospitals, and over 100 were free-standing polyclinics providing diagnostic and therapeutic services (46). The intention is that polyclinics should undertake more procedures previously performed in hospitals but their future is still being debated.

Most public outpatient facilities are owned by the local governments since the 1990 Local Government Act, and *Act XX of 1991 on The Responsibilities of the Local Governments and its authorities*.

Private outpatient clinics do not contract with the Health Insurance Fund and do not get government support, except in special cases like diagnostic or dialysis services. The private sector received 80% of the total kidney dialysis budget (5.4 billion HUF in 1996), 75% of the CT equipment budget, and 57% of the MRI budget (38). The number of private specialty clinics is not substantial (around 50 clinics in 1997) but is increasing and many public sector specialist doctors also offer out-of-office hours private consultations (38). Private clinics provide services to fee-paying patients and also offer occupational health services to employers.

Inpatient services

Hungary had 162 hospitals in 1996 at national/regional, county and municipal level and although their number has remained stable, their size and structure has changed. Many large hospitals have been reduced from over 1000 beds to around 800 beds. Geographic inequalities still exist despite attempts to redress these (35). For example, the 40 hospitals in Budapest represent almost 40% of the total facilities in Hungary, although only 20% of the population live in the capital. Many hospitals need major repairs since investment has been neglected for decades.

There are three main levels of inpatient care. Municipal hospitals serve a local population. Municipal and county hospitals provide secondary care to a regional population. Tertiary care is provided on a regional or national basis by some county hospitals and by medical universities and national institutes. In addition, dispensaries treat long-term conditions and hospice care also is being developed.

Municipal hospitals of around 370 beds on average in 1997 offer basic specialities such as internal medicine, surgery, obstetrics and gynaecology, and usually paediatrics. They cater for around 100 000 people within a distance of about 25–30 kilometres. Municipalities have owned these hospitals since the early 1990s, and investment and maintenance are financed by local taxes and by central state grants. Support and diagnostic services include general laboratory services, ECG, X-ray, diagnostics, ultrasound, defibrillators, histological and pathological examination and anaesthesiology. One source of financial tension for the municipality is that its hospital may also be used by the whole county.

County hospitals had around 1200 beds on average in 1997 and offer the main specialities plus secondary care such as diagnostic imaging services, cardiology, haematology, immunology, endocrinology, dialysis, oncological diagnostic and crisis intervention/psychiatry.

Tertiary care is provided by five medical universities and by 18 national institutes. National institutes provide services that require extensive equipment and specialists. Hungarian tertiary care specialists aspire to international standards of professional knowledge and technology. Access to technology is variable, however, since state-of-the-art equipment and decades old machines co-exist in the same hospital. The National Institutes include Oncology, Traumatology, Cardiology, Neurosurgery, Hematology, Rehabilitation, Rheumatology and Physiotherapy, Neurology and Psychiatry, Tuberculosis and Pulmonology. Tertiary care is also provided by some county hospitals, by hospitals owned by the Ministry of Health and by several other Ministries. These institutes offer

national expertise in particular specialities, act as referral centres, as teaching hospitals and conduct research activities.

Hospices have been established to provide palliative care and care during the terminal phases of dying. Since the establishment of the Hungarian Hospice Foundation in 1991, seven palliative care hospital departments and a dozen hospice home care teams have begun (7). By the end of 1997, they had served more than 3000 patients. The rising number of deaths from noncommunicable diseases has increased the need for hospice care. A clause in the 1997 Health Act calls for palliative care to improve the quality and dignity of life of the patient during the last stage of life. As financing from the National Health Insurance Fund is insufficient, hospices also depend on public appeals. The hospices have difficulties with acceptance by the medical profession; for example, some physicians regard hospice staff as interfering with their job, while some hospitals attempt to refer elderly but not terminally ill people to hospices.

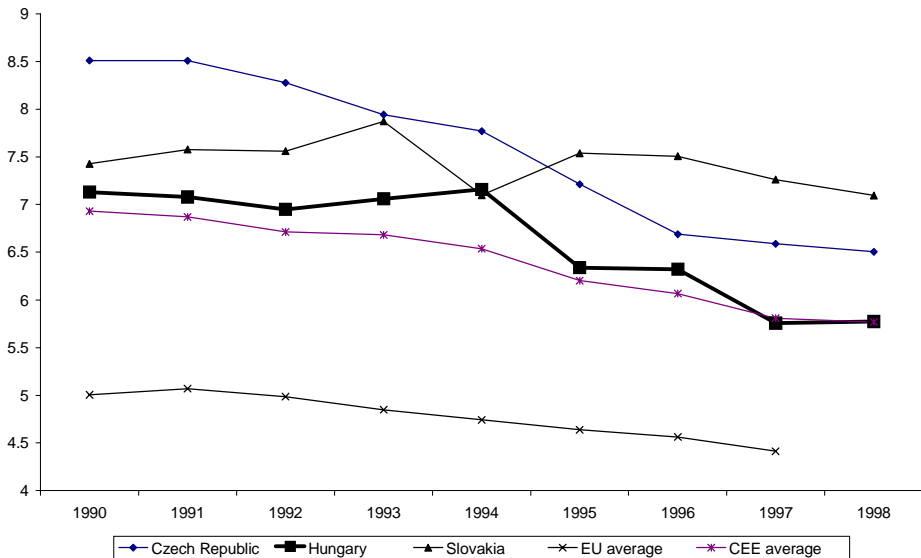
About 160 pulmonary disease dispensaries, 130 clinics for sexually transmitted diseases, and 68 oncology clinics provide specialist preventive services, as well as clinics to treat alcohol abuse and mental health problems. In 1996, pulmonary disease dispensaries screened nearly 2 million people, 5% more than the previous year, and the effectiveness of screening and the diagnosis of positive TB cases also has improved (28).

The number of hospital beds per 1000 population increased in Hungary between 1980 and 1990 in contrast to the European Union average (Fig. 9) but have dropped since 1995 (Table 11). The rate dropped in most other central and eastern European countries between 1990 and 1996 (Fig. 10). In 1994, the 9.6 hospital beds per 1000 population in Hungary was higher than the western European average of 7.8 (Table 13). Admissions per 100 population also were among the highest in Europe. The average length of stay of 11.3 days was lower than the western European average. (Lengths of stay in acute beds were 8.0, and 26.0 days on chronic beds in 1996.) The occupancy rate (in acute care hospitals) remained below 75% throughout the 1990s. This pattern of short stays and high admissions suggests a high readmission rate (35). The total number of hospital beds dropped by over 8800 between 1990 and 1995, and another 18 000 beds were closed during 1996 and 1997, an 18% decrease in total beds between 1990–1996 (Table 12). It should be noted, however, that the original distinctions made by hospitals as to which of their beds were ‘acute’ and which ‘long-term’ was somewhat arbitrary.

The Government aims to reduce excess capacity in order to enhance the efficiency and ultimately the quality of health services. The change to performance-based financing for hospitals was not successful in producing

structural reorganization in the early 1990s. The government next attempted to tackle the issue through regulation (62).^{100,101} The 1996 Act and decree have resulted in a significant reduction in both hospital inpatient and outpatient capacity. The maximum number of beds per county and the share of each specialty have been defined. The implementation of these guidelines was left to local County Consensus Committees. These are convened by the local offices of the National Public Health and Medical Officer Service and comprise representatives of local health organizations such as hospitals, the Medical Chamber and county branches of the Health Insurance Fund.

Fig. 9. Hospital beds in acute hospitals per 100 000 population in Hungary and selected European countries, 1990–1998



Source: WHO Regional Office for Europe health for all database.

The intention is to produce a more equitable geographic distribution of hospital beds and a better distribution of medical specialities to fit regional morbidity patterns. Minimum standards are set in terms of equipment and staff that institutions must meet for registration. In addition, hospitals are to be closed where the success rates and number of procedures are substantially under the national average. This legislation is intended to ensure better quality

control and to set standards for hospital accreditation. Institutions were given time to meet the new standards so that their effect is not yet clear.

Table 11. Inpatient facilities utilization and performance, 1989–1997

Inpatient	1989	1990	1991	1992	1993	1994	1995	1996	1997
Hospital beds per 1000 population	9.9	9.8	10.0	9.8	9.8	9.6	9.1	9.0	8.3
Number of hospitals per 100 000 population	–	–	–	–	1.63	1.64	1.64	1.59	1.63
Admissions per 100 population	21.9	21.8	22.0	22.0	22.2	22.8	23.3	24.2	23.7
Average length of stay in days	12.8	12.7	12.4	12.0	11.7	11.3	10.8	10.3	11.0
Occupancy rate (%) (acute care hospitals)	76.4	74.9	74.0	73.6	67.6	71.6	71.9	74.4	–

Source: WHO Regional Office for Europe health for all database.

The hospital rationalization strategy has had mixed results including some negative outcomes. First, few hospitals were closed (as opposed to bed closures) so that no substantial savings were achieved in fixed costs. Second, bed reductions mainly occurred in small local hospitals (where local communities were less able to exert political power to oppose these closures), and no major changes have yet been made in Budapest hospitals despite a substantial oversupply of beds. Third, a reduction in hospital beds (and not all of these were ‘real’ beds) was not followed by a proportionate reduction in personnel. Fourth, since hospital admissions rose by 11.3% between January 1996 and January 1997, the reduction in beds did not stop increasing hospitalization (62).

Table 12. Number of hospital beds, 1990–1997

Beds	1990	1991	1992	1993	1994	1995	1996	% Change 1990–1996
Acute	72 551	72 004	70 639	72 690	73 456	64 847	58 733	-19%
Long-term	29 403	28 743	27 893	27 748	28 346	28 300	25 104	-15%
Total	101 954	100 747	98 532	100 438	101 802	93 147	83 837	-18%

Source: Information Centre for Health Care (GYÓGYINFOK) database.

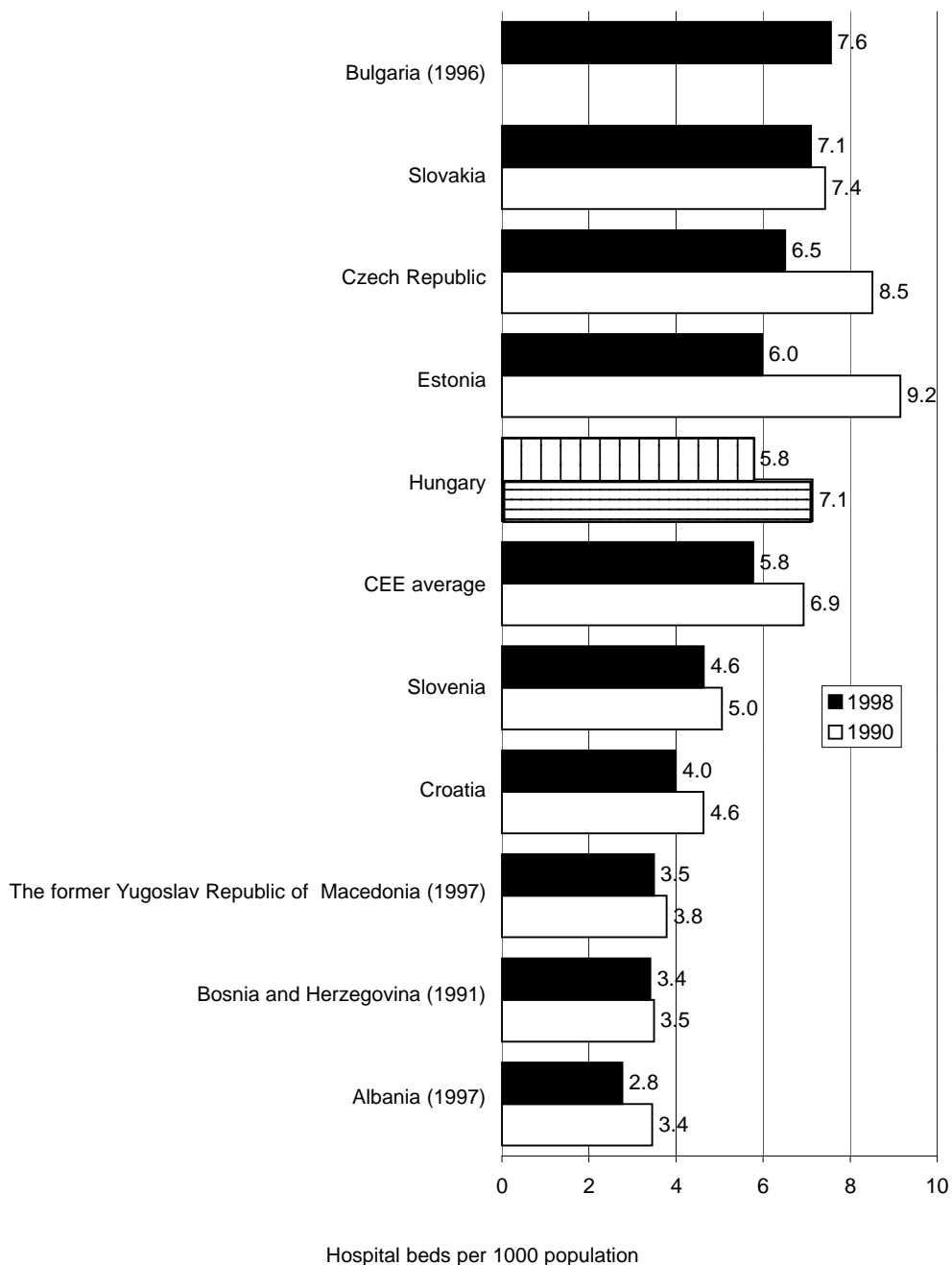
Table 13. Inpatient utilization and performance in the WHO European Region, 1998 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	6.4 ^a	24.7 ^a	7.1 ^a	74.0 ^a
Belgium	5.2 ^b	18.0 ^b	7.5 ^b	80.6 ^c
Denmark	3.6 ^b	18.8 ^b	5.6 ^b	81.0 ^b
Finland	2.4	20.5	4.7	74.0 ^c
France	4.3 ^a	20.3 ^c	6.0 ^b	75.7 ^a
Germany	7.1 ^a	19.6 ^a	11.0 ^a	76.6 ^a
Greece	3.9 ^f	—	—	—
Iceland	3.8 ^c	18.1 ^c	6.8 ^c	—
Ireland	3.4 ^a	14.9 ^b	6.7 ^b	82.3 ^b
Israel	2.3	18.4	4.2	94.0
Italy	4.6 ^a	16.5 ^a	7.0 ^a	76.0 ^a
Luxembourg	5.6 ^a	18.4 ^d	9.8 ^b	74.3 ^d
Malta	3.9 ^a	—	4.5	72.2 ^a
Netherlands	3.4	9.2	8.3	61.3
Norway	3.3	14.7 ^b	6.5 ^b	81.1 ^b
Portugal	3.1	11.9	7.3	75.5
Spain	3.1 ^c	10.7 ^c	8.5 ^b	76.4 ^c
Sweden	2.7 ^a	16.0 ^b	5.1 ^b	77.5 ^b
Switzerland	5.2 ^b	14.2 ^e	11.0 ^a	84.0 ^a
Turkey	1.8	7.1	5.5	57.3
United Kingdom	2.0 ^b	21.4 ^b	4.8 ^b	—
CCEE				
Albania	2.8 ^a	—	—	—
Bosnia and Herzegovina	3.4 ^g	7.4 ^g	9.7 ^g	70.9 ^g
Bulgaria	7.6 ^b	14.8 ^b	10.7 ^b	64.1 ^b
Croatia	4.0	13.4	9.6	88.2
Czech Republic	6.5	18.4	8.8	70.8
Estonia	6.0	17.9	8.8	74.6
Hungary	5.8	21.7	8.5	75.8
Latvia	—	—	—	—
Lithuania	—	—	—	—
Poland	—	—	—	—
Romania	—	—	—	—
Slovakia	7.1	19.3	10.3	77.9
Slovenia	4.6	15.9	7.9	75.4
The former Yugoslav Republic of Macedonia	3.5 ^a	8.1	8.9	66.5
NIS				
Armenia	6.0	6.0	10.7	30.2
Azerbaijan	8.0	5.6	—	—
Belarus	—	—	—	88.7 ^d
Georgia	4.6 ^b	4.8 ^b	8.3 ^b	26.8 ^d
Kazakhstan	6.6	14.9	13.0	91.2
Kyrgyzstan	6.7	15.8	12.9	81.7
Republic of Moldova	9.1	16.9	15.4	77.6
Russian Federation	9.0	19.9	14.0	82.5
Tajikistan	6.2	9.7	13.0	59.9 ^b
Turkmenistan	6.0 ^a	12.4 ^a	11.1 ^a	72.1 ^a
Ukraine	7.4	17.9	13.4	88.1
Uzbekistan	—	—	—	—

Source: WHO Regional Office for Europe health for all database.

Note: ^a 1997, ^b 1996, ^c 1995, ^d 1994, ^e 1993, ^f 1992, ^g 1991, ^h 1990.

Fig. 10. Hospital beds per 1000 population in central and eastern Europe, 1990 and 1998 (or latest available year)



Hospital beds per 1000 population

Source: WHO Regional Office for Europe health for all database.

Social care

Social care under the communist regime was supported through cash and non-cash benefits distributed to those with greater needs. Social problems, however, were kept hidden from the public; for example, long-term care often took place in old castles isolated from everyday life. Social care for the elderly and for physically and intellectually disabled people remains a neglected area. Further, the health sector has not considered the health needs of special groups, and social services and health care are not coordinated (67).

The current policy intention is to shift social and long-term care out of hospitals and into residential and nursing homes, and to support dependent people in their own homes. The number of elderly people (above age 60) receiving home care support was 41 200 in 1997, a decrease from around 50 000 in the early 1990s, due to budget cuts in the economic stabilization package, and despite growing numbers of older people.¹⁰² Social care in Hungary is funded through the welfare not the health sector and provides the following types of direct support to those in need:

- home care nursing mainly for medical problems
- home care social support
- cash benefits for carers
- special higher family allowance
- full pharmaceutical reimbursement
- financial contribution to expenses associated with handicap.

Municipalities acquired responsibility for the elderly and disabled and for social care under the 1990 *Local Government Act* and *Act III of 1993 on Social Services*. These services are funded from several sources: central funds from the Ministry of Internal Affairs, grants from the Ministry of Health, direct taxes levied on the municipal population, and charges paid by the care recipients themselves. Despite positive achievements, the boundaries between health and social care remain rigid and many respective responsibilities have yet to be clarified.

Long-term care of the mentally ill takes place mainly in large psychiatric homes. The intention is to move more psychiatric care into the community accompanied by efforts to change public attitudes to mental illness.

The number of voluntary sector organizations has grown rapidly during the 1990s. Residential and nursing homes are being established by nongovernment organizations (NGOs). Local voluntary groups also are setting up community care facilities. These services, however, are still unable to meet the demand;

for example, homes for the elderly have long waiting lists. Residential homes for the elderly and for the handicapped had 60 000 beds in 574 institutions in 1997. Most care of dependent people in the community depends upon the Hungarian tradition of family care.

There were an estimated 25 000 homeless people but only 7000 beds in shelter institutions in 1997. There were 41 public canteens (meals services) for the poor with a daily meals capacity of just under 5000.

Human resources and training

Hungary had about 172 000 health care personnel working in the public sector in 1996, and a small but unknown number in the private sector. Although the overall number of personnel in the Hungarian health sector is not excessive compared to OECD countries this workforce is biased towards high-skill and high-cost professionals, with a high proportion of specialists (62).

Hungary has more doctors as a population ratio than most countries in Europe. The number of physicians increased by 30% between 1980 and 1996. There were 35 000 active physicians in 1996. There were 3.4 doctors per 1000 population in 1995 (Table 14), which was at the level of the European Union average (Fig. 11). Despite these high numbers, there is no evidence of substantial medical unemployment in Hungary, although many are under employed and perform tasks that in other countries would be performed by nurses. The Ministry of Health proposes to reduce the number of doctors to 27 000. More than 16% of practising doctors are over age 65 years and their eventual retirement should help reduce the number (35).

The inequitable geographic distribution of doctors in Hungary also must be addressed. There are shortages, however, in certain specialities such as primary health care, public health, diagnostic specialities, and health care management. A high proportion of doctors work as hospital specialists. There are also geographic inequities with most doctors working in urban areas. Incentive strategies are needed to attract doctors to neglected specialities and to deprived geographic areas.

Five Medical Universities (one providing only postgraduate training) train doctors, dentists, and pharmacists, under the Ministry of Education, with professional oversight from the Ministry of Health. University medical education takes six years, the dental course five years, and pharmacy takes 4.5 years. Universities are funded on a student capitation basis. There is no central mechanism to control the number of medical graduates but the Ministry of Health

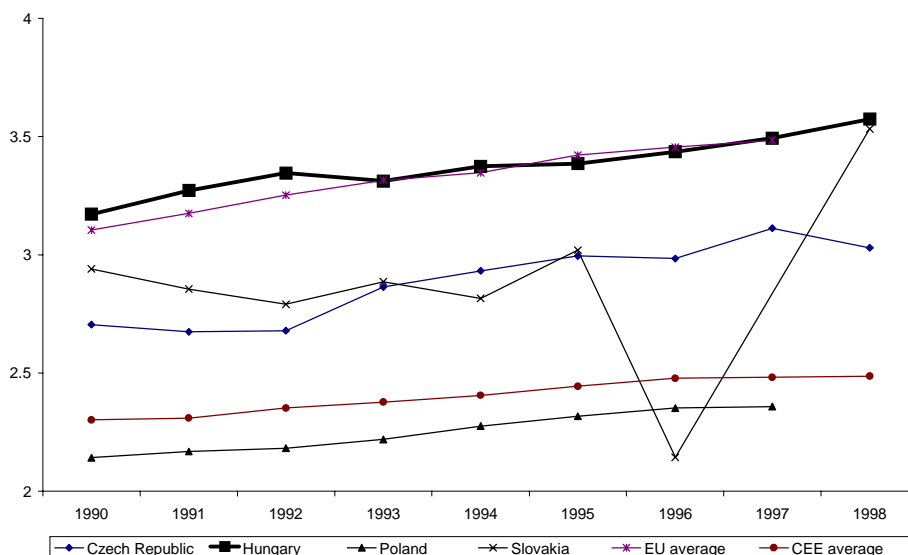
proposes an upper limit of 700 medical graduates per year, although around 850 students graduated in medicine in 1997 (35). Postgraduate specialist training is carried out through the universities and the national institutes.

Table 14. Health care personnel, 1985–1997

Number per 1000 population	1985	1990	1991	1992	1993	1994	1995	1996	1997
Physicians (a)	3.10	3.17	3.27	3.35	3.31	3.37	3.39	3.44	3.49
Dentists (a)	0.38	0.41	–	–	0.46	0.48	0.49	0.47	–
Registered nurses (b)	4.0	4.5	–	4.8	4.9	5.0	4.9	–	–
Midwives (a)	0.25	0.26	0.26	0.26	0.26	0.27	0.24	0.24	–
Pharmacists (a)	0.42	0.33	–	–	0.32	0.32	0.33	–	–
Physicians graduating (a)	0.08	0.08	0.09	0.09	0.09	0.09	0.09	0.09	–
Nurses graduating (a)	0.39	0.04	0.05	0.05	0.05	0.06	0.07	0.06	–

Source: (a) WHO Regional Office for Europe health for all database. (b) OECD health database, 1998.

Fig. 11. Physicians per 1000 population in Hungary and selected European countries, 1970–1996



Source: WHO Regional Office for Europe health for all database.

Hungary

A general practice specialty has been offered in Hungary since 1975 but had never secured an influential position in the health care system. Family doctor training now is offered during the undergraduate course, in two post-graduate residency training to young doctors, and in retraining of practising physicians (equivalent to about five months). A family doctor specialist qualification is required in order to be licensed. General physicians can participate in various retraining programmes including distance learning, regional continuing education courses, and consultations and practice oriented tutorials.

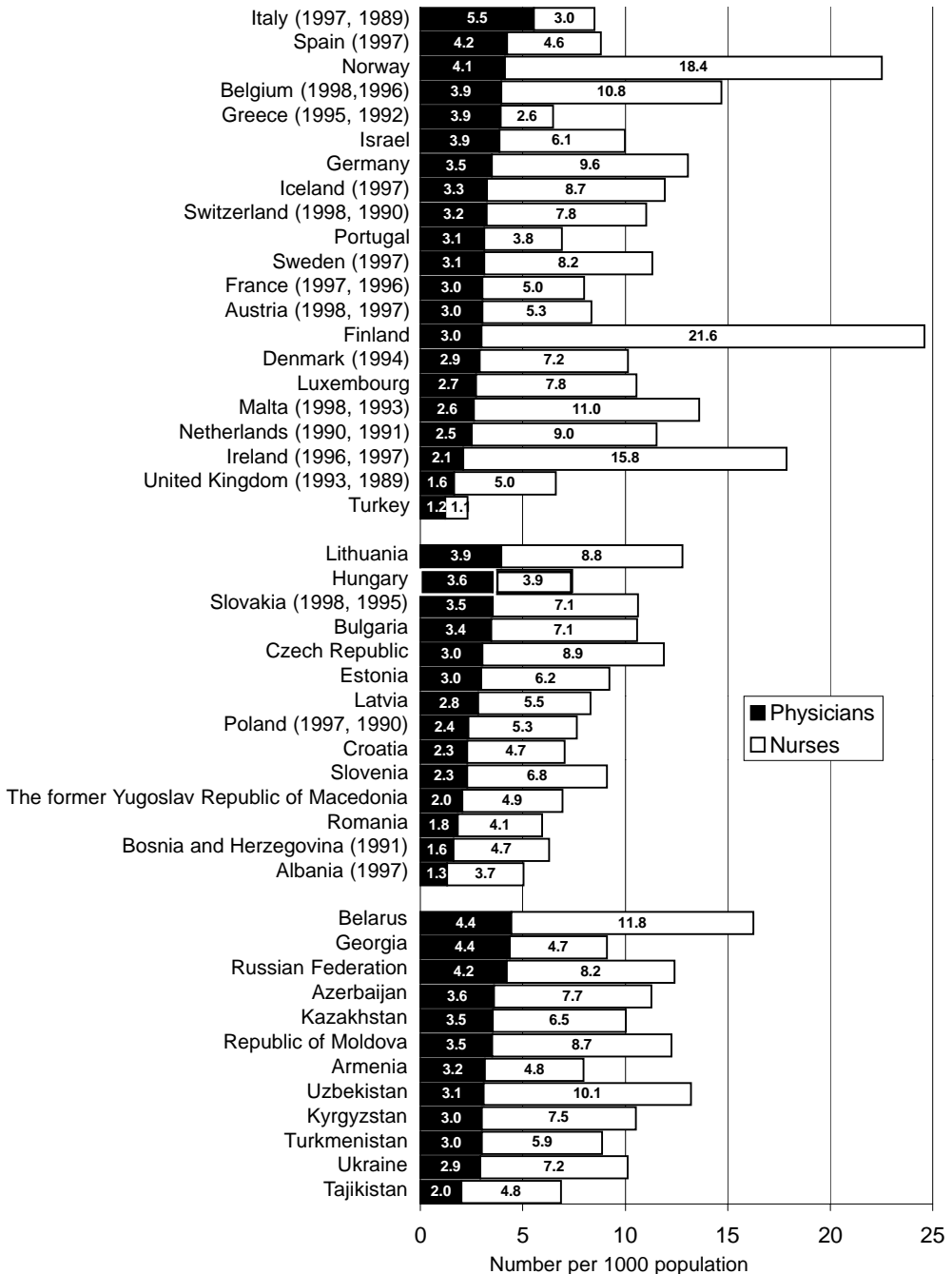
Hungary had 5.1 nurses per 1000 population in 1995, which is lower than in many western European countries (Table 14 and Fig. 12). More qualified nurses are needed to staff the reorganized health care system. Nurses usually work as assistants to doctors and not as nurse practitioners in their own right. Low status and low pay has not made nursing an attractive career. Registration is now compulsory (under the 1997 Health Act) with a license to practice issued by the Central Training Institute for Qualified Health Workers.

Nurse training is being reorganized, however, in line with recommendations on nursing education in the European Union. Nursing policy in Hungary promotes nursing as an essential part of the country's health care delivery system and as a link to the welfare system. Nursing training has been neglected, however, in comparison to medical education so that a large gap has arisen between medicine and nursing.

Nurse training takes place at several levels. Most nurses currently practising were trained in four-year vocational courses at secondary school (between ages 14–18 years). Entry to nurse training now requires a secondary school leaving certificate. The three-year training course gives a diploma in nursing. Basic nursing education can be followed by post-basic courses (clinical specialization) in the form of on-the-job training in various nursing specialities (such as midwifery, paediatric nursing, critical care nursing, oncology nursing and operating theatre nursing). Nine colleges of nursing offer a four-year baccalaureate diploma in nursing, and graduates can continue their studies in university-level programmes. Graduates of the three-year programme can upgrade at a college of nursing. The Ministry of Health now funds bridging programs in order to bring those with out-dated nurse qualifications up to the current training level (in line with European Union standards).

Qualified health workers now include the baccalaureate nurse, dietician, physiotherapist, sanitary inspector, mother and child health nurse (health visitor), social worker, health care information technician, ambulance officer and optometrist. The Central Training Institute offers a large range of postgraduate specialities for qualified health workers.

Fig. 12. Number of physicians and nurses per 1000 population in the WHO European Region, 1998 or (latest available year)



Source: WHO Regional Office for Europe health for all database.

The Ministry of Health has two continuing education institutes for health care support personnel, and is primarily responsible for the coordination of specialist training. The new government has proposed a “central trainee system” (6) whereby graduates are financed from the government budget for the first years of their specialist training.

Hungary had no training courses in public health or health administration (42). New centres and courses are being developed. These include the Health Services Management Training Centre¹⁰³ at Semmelweis Medical University and the School of Public Health at Debrecen Medical University, both supported by a World Bank loan agreement and by the Ministry of Health. The Health Services Management Training Centre offers MSc level training and also continuing education programmes for hospital managers. The Centre is a regional partner of the World Bank Institute in offering an the international course on Health Sector Reform and Sustainable Financing,¹⁰⁴ designed to provide an intensive training opportunity for senior decision makers in the region. Other postgraduate courses are offered at the Economics University and the Jozsef Attila University in Szeged.

Health sector workers were paid low wages under the previous communist regime and this legacy has continued. With the austerity packages of the mid 1990s, the salaries of nurses and physicians have fallen further, and compare unfavourably to people with similar level qualifications in the private sector.

Pharmaceuticals and health care technology assessment

Pharmaceutical manufacture is an important Hungarian industry that previously supplied most of the domestic market and exported to countries in the former socialist block. The market share of domestic products decreased from 74% in 1980 to 42% in 1997, however, with the liberalisation of imports. In addition to the decreasing share of the domestic market, the collapse of drug exports to the former USSR severely affected Hungarian companies. By 1997, six out of the seven Hungarian pharmaceutical companies were owned by multinationals. Over 90% of the wholesale trade in pharmaceuticals is now controlled by five private companies and one state company. The retail industry has mostly been privatised. In 1998, there were 40 large wholesalers, 1 960 retail pharmacies and 550 branches. The number of marketed pharmaceutical products has increased substantially since 1991 from 860 to 4 715 products.

Although pharmaceutical prices in Hungary remain low in comparison to other European countries, increases during the 1990s resulted in a ten-fold increase in pharmaceutical expenditure for an average family budget. The annual rise in the government drug reimbursement budget (with increasing prices and consumption) is also a political issue. In 1997, Hungary spent 30% of its health budget on pharmaceuticals (see earlier Table 9). The Health Insurance Fund over-runs its pharmaceuticals budget each year, which in 1999 was capped at HUF 122.9 billion.¹⁰⁵

A government committee undertakes price negotiations with producers (after consultation with health professional bodies). International prices and the Hungarian situation are considered in arriving at a production or import price and also the insurance reimbursement figure. All new prices are announced in the Health Gazette of the Ministry of Health. The current government reimbursement system was introduced in 1995, drug costs to consumers being reimbursed at either 0/50/70 or 90%. The pharmaceuticals benefits list contains 321 generic products (on the 'positive' or subsidised list), with 90% reimbursement for the 60 most common conditions, while other registered products are on the 'negative' or non-subsidised list. The policy is to encourage the use of less expensive generic drugs. Individuals on public assistance and those with chronic diseases receive drugs either free or reimbursed at 90%.

Hungary signed up in 1992 to the European Free Trade Area (EFTA) agreement and the Pharmaceutical Inspection Convention. Hungary now follows European Union drug registration conventions and intercountry notification practices, and regulates and inspects mandatory standards on Good Laboratory Practice, Good Manufacturing Practice and Good Clinical Practice. Parliament passed an Act in 1998 on medicines for human use to cover their manufacturing, production, distribution, marketing and application.

The Government is considering further reforms of the National Drug Scheme. Despite serious problems of overspending and over-prescribing, there are few control mechanisms. A 1998 interministerial report suggested professional protocols on drug use, fixed reimbursement for each therapeutic group, an annual reimbursement limit to be defined by the company and the Health Insurance Fund during price negotiation, and full reimbursement only for certain chronic medical problems. At present, prescribing physicians have no financial incentive to limit drug costs but are influenced by consumer pressure and the marketing power of pharmaceutical companies. For example, in terms of per capita prescriptions, Hungary is surpassed only by France.

Medical aids and prosthesis

Medical devices and prostheses can be very cost-effective in assisting disabled people, but they represent a small proportion of the health budget compared to western European countries. The medical aids budget was capped at 22.5 billion HUF of the total Health Insurance Fund budget in 1999. Health care staff receive only limited training on medical aids. Reimbursement of medical aids is based on the list (with product names) published annually in the Health Bulletin of the Ministry of Health

Health care technology assessment

Health care technology was neglected during the communist regime when the standard fell seriously behind the international level. Cost effective health care requires that technology be assessed and funded on the basis of objective criteria. During the 1990s, state-of-the-art expensive diagnostic and therapeutic equipment started to flow to Hungary. Individual hospitals have bought a wide variety of products with no standardized assessment and no controls on regional distribution.

The national government funds some health care institutions in improving their health care technology (such as radio-diagnostic equipment modernization) after a central assessment of needs, a cost-benefit analysis and a central bidding procedure.

Some Hungarian health care institutions have state-of-the-art medical technology. Kidney dialysis stations are able to deliver services of a European standard, mainly through private providers and fee-for-service financing. Kidney transplantation has become a routine procedure and the number of liver and heart transplants is growing, as are *in vitro* fertilization centres. The growth of modern one-day surgery techniques is limited, however, by professional and consumer conservatism, and by the lack of incentive to reduce unnecessary hospitalization.

Financial resource allocation

Third-party budget setting and resource allocation

The direction of financial resource allocation has been from historical payments based on inputs to more performance oriented payments based on outputs. This has been a long process during the 1990s involving much trial and error. The health care budget is made up of three components:

- the Health Insurance Fund derived mainly from social insurance (employer and employee) premiums and from the health care tax (“health care contribution”);
- from the central government budget derived from general taxes;
- from local government budgets that come from central Government on a capitation basis, from central earmarked and target subsidies for investment, and from local taxes.

An overview of the flow of funds in the Hungarian health care system is given in Fig. 13, and a more detailed description in Fig. 14.

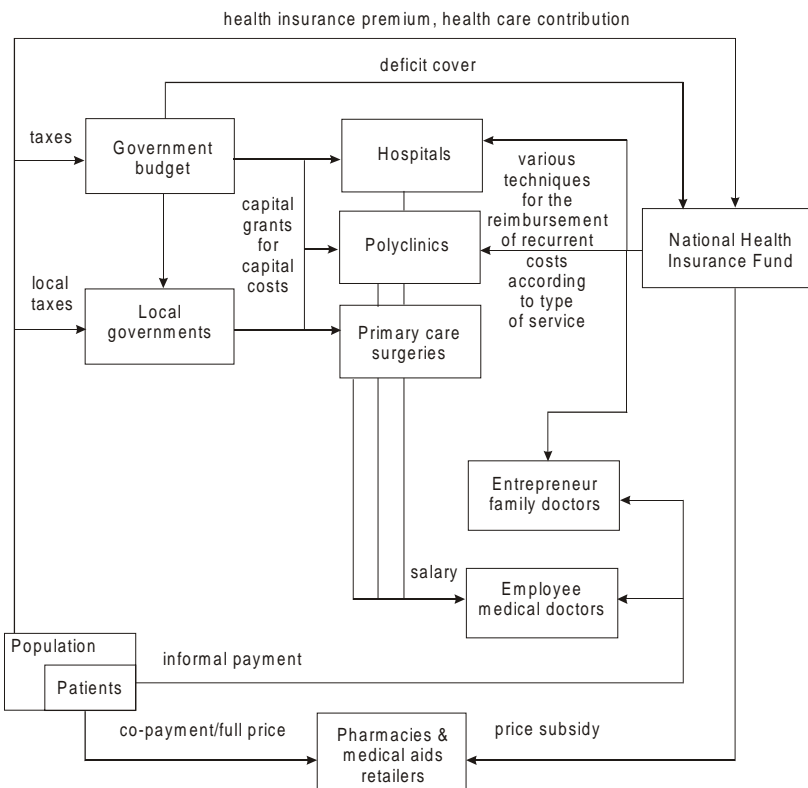
The budget processes at central and local level are virtually independent except for earmarked and target subsidies. Most key budget decisions (such as the levels of health insurance premiums) are made by central Government and Parliament.

A key principle is the separation of capital and recurrent costs. The main source of recurrent financing is the National Health Insurance Fund, which is divided into over twenty capped budget lines (“kassza”) according to service types; for example, for primary care, outpatient specialist care and inpatient care. Health services providers are reimbursed from these budgets by various methods: family physicians are paid by capitation, outpatient specialist services by fee for service points, and acute and chronic inpatient services by diagnosis-related groups and bed days respectively.

Another key principle is the attempt to protect the Health Insurance Fund, and also the funding sub-categories, from a demand and/or cost explosion. A national capped budget ceiling was set for most lines and transfers not permitted. Notably until 1999 the pharmaceutical budget line was not capped, which contributed to the large expenditure overrun. Providers contract with the National Health Insurance Fund. Consultation hours of outpatient services and hospital beds are determined by law for the county level.¹⁰⁶

The owners (mostly local governments) of health care facilities are responsible for capital costs. Such investment costs are usually beyond the financial capabilities of local governments, so the central Government provides subsidies via conditional and matching grants. Given that most capital investment comes from these funds, this system allows the Government to control health care investment. Local governments are in principle responsible for the debts incurred by their hospitals. The NHIFA made loans to many of these hospitals that has enabled them to roll over their debts to the next financial year.

Fig. 13. Financing flow chart



The Government budget covers public health services, compulsory immunization, prenatal care, emergency ambulance services, catastrophe-medicine, high cost medical technologies (organ transplantation), blood supplies and clinical medical research.¹⁰⁷ The Government is also the main funder of higher education and research and development activities.

Payment of hospitals

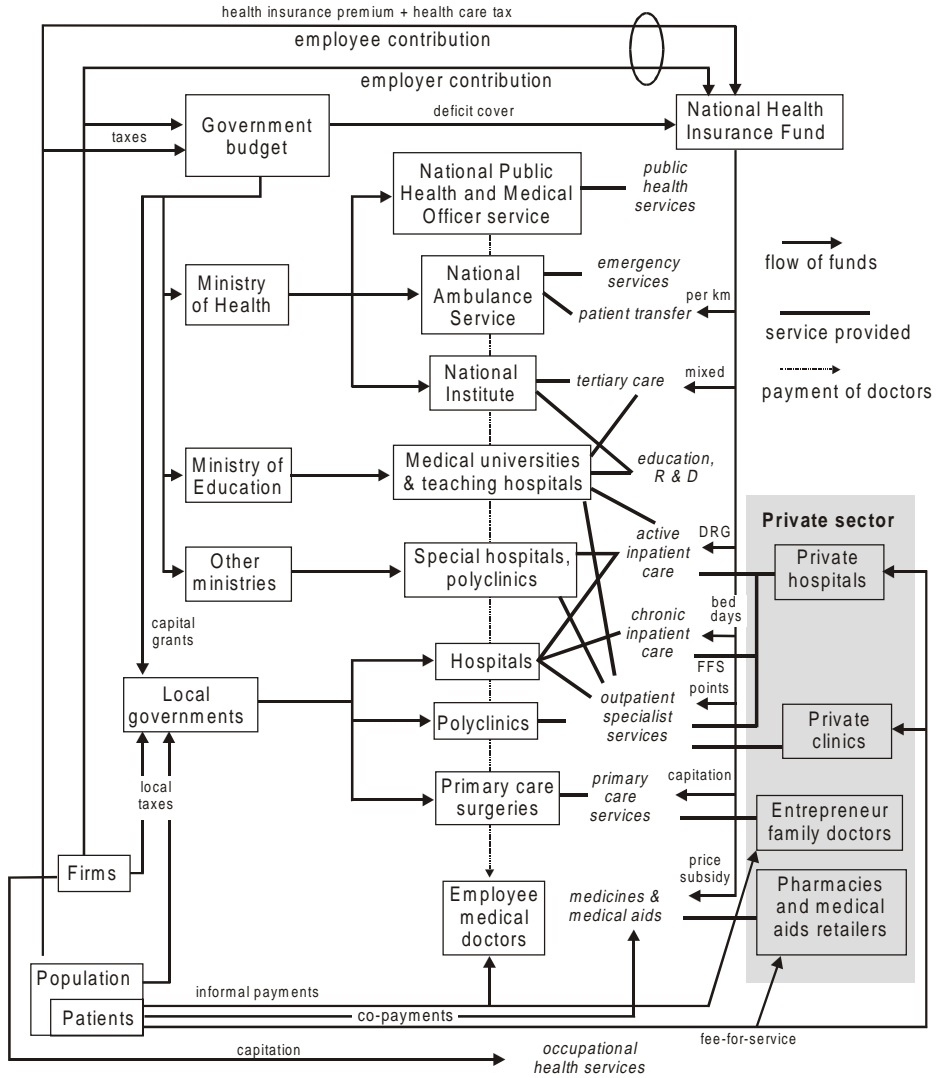
Under the previous state-socialist model, health care institutions received a fixed annual budget that was raised by a certain percentage each year. The size of the budget was not linked to performance but to input norms and political influence. The reforms of the 1990s have brought about significant changes. The payment system has become more performance-related and payment mechanisms are geared to the type of service rather than the type of institution. Patient capitation was introduced for family doctor services in 1992, a fee-for-service point system for outpatient specialist care in 1993, followed by prospective payments for acute inpatient services, and payment per bed days for chronic care.

Initially individual Diagnosis-related groups (DRGs) point values were calculated for each institution on the basis of their previous budget and performance, and the differences were gradually decreased until the national average was reached in 1998. A transition period of financing allowed outpatient specialist care units to retain most of their previous historical budget (initially 90%) and the rest of their income was calculated according to the collected fee-for-service points. The share of the historical budget was decreased from year to year, until the total income came from fee-for-service points. These gradual changes allowed hospitals to phase in the new system of payment in a more acceptable and less disruptive way. It has to be noted, however, that the transitional system of individual point values have punished the most efficient hospitals.

The Information Centre for Health Care (GYÓGYINFOK) (founded in 1987¹⁰⁸) has implemented a Hungarian version of a diagnosis related group (DRG) system for financing hospital services, and it collects and processes performance data from health care providers. Since the countrywide introduction of the prospective payment system in 1993, two new DRG versions have been developed, the latest of which comprises 758 diagnosis related groups (50).

Payment mechanisms for various services now are determined by *Act CLIII of 1997 on the 1998 Budgets of the Funds of Social Insurance*, detailed

Fig. 14. Flow of funds in the Hungarian Health Care System



regulation in *Government Decree No. 103/1995. (VIII. 25.) Korm. on Certain Issues of Social Insurance Financing of Health Services*, the actual DRG classification and the list of point values of outpatient specialist services in *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare*.

Most outpatient specialist services are financed by fee-for-service points; that is, points for procedures performed (the so-called “German Point System”). Each procedure is assigned a point value on the basis of complexity and use of resources. Providers report their monthly sum of points to the county branches

of the National Health Insurance Fund. Performance points are added up nationally and the monetary value of one point is calculated by dividing the predetermined budget line (“kassa”) by the total number of points. Payment is made according to the points collected multiplied by the calculated national monetary value of one point. The value of the points therefore changes over time.

Some special outpatient units are paid by global budget, such as dispensaries for oncology, venereal diseases, pulmonology, psychiatric, and alcohol and drug abuse patients. 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 are sometimes paid for separately while other costs of the intervention are covered by DRGs.

Inpatient services are reimbursed according to the type of patient case. A DRG-based prospective payment system is used to reimburse acute care and rehabilitation cases, except for certain tertiary care services paid by central government. 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 bed days adjusted for the complexity of the case.

The previous historical budgets did not link the size of the budget to performance, but the problem with the current system is that it encourages over-treatment, DRG-creep and point inflation. In practice, the points payment system has resulted in an increase in the number of “service-points” (over-servicing) and thus a reduction in the money value of a single point (61). Hospitals currently have no financial incentive to treat people as outpatients rather than inpatients. The payment system for outpatient specialist services contains financial incentives to increase the number of procedures performed per patient.

Payment of physicians

The majority of physicians are salaried public employees. The exceptions are the entrepreneur family doctors who contract with both the Health Insurance Fund Administration and the local governments and are paid on a patient capitation basis. Some medical doctors run a private practice, usually as a second job, and are paid a fee-for-service by their patients. The official salary of public sector medical doctors is very low compared with other sectors of the economy, although informal payments substantially increase the income of some.

Patient capitation was introduced in 1992 in paying family doctors. People were free to choose their family doctors and the number of registered patients became the basis of general practice financing. The income of the practice is made up mainly of a patient capitation component, plus a fixed amount depending on the size and location of the practice, plus a fee-for-service for certain preventive activities, and a case payment for attending non-registered patients. Capitation payments are adjusted to the age structure of registered patients, the qualifications and experience of the family doctor, and are limited to an upper practice size. The capitation payment does not increase above a certain number of patients (the optimal practice size). Most family doctors contract with the Health Insurance Fund and the local government to supply services for the local population.

Most specialists are salaried public employees. This guarantees a minimum level of salary according to a pay scale.¹⁰⁹ The salary is determined by qualifications and years of experience. The average salary in the health sector is lower than most other sectors of the economy (Table 15). In 1997, official monthly average gross earning of general physicians and specialists were 72 091 HUF and 82 528 HUF respectively, while that of qualified nurses was 49 453 HUF. The corresponding figures for a mechanical engineer was 105 750 HUF, while a secretary earned 65 602 HUF and a bus driver 60 724 HUF.

Most clinical specialists also receive informal payments (including gratitude payments) from patients, which provide some material incentive for the doctors to stay in the profession. Nevertheless, informal payment is too unequally

Table 15. Average monthly gross earnings of selected employees (in HUF) 1992–1997

Industries	1992	1994	1997
Industry average	22 294	33 309	57 270
Mining	28 155	43 123	76 952
Manufacturing	21 107	31 997	57 597
Construction	19 945	28 652	46 884
Hotel services & catering	19 156	26 218	41 012
Financial services	42 383	62 249	114 083
Public administration & social insurance	29 323	40 047	65 329
Education	21 928	31 896	49 460
Health & social services	20 193	29 411	45 376
Health services	–	–	48 176

Source: Hungarian Central Statistical Office, 1992, 1994, 1997b, 1998a.

distributed to be an adequate complement to official salaries (apart from its undesirable impact upon low-income patients).

The new Government intends to extend privatization in primary and out-patient specialist care, to raise the salaries of medical doctors, and to solve the problem of depreciation by including capital costs in the reimbursement fees (6).

Health care reforms

Aims and objectives

Health care reforms began in the mid 1980s in Hungary, earlier than in other central European countries. Reforms have been incremental in nature, shaped mainly by financial pressures and by shifting policy priorities. Health sector reform was regarded as necessary by the governments of the 1990s for the following reasons.

First, Hungary had the worst health indicators in central Europe. From the mid-1960s, life expectancy of Hungarian males, especially middle-aged men, had decreased. For example, in 1995, male life expectancy at birth was 65.2, which was 8.6 years less than in neighbouring Austria. (24). Politicians and the population were largely unaware of these disturbing health trends until the 1980s.

Second, Hungary had a hospital-centred health care system with a high population proportion of hospital beds, which took the largest share of the health budget. The aim was to reorganize the system to offer more appropriate and less expensive forms of health care. Attempts to improve the cost-effectiveness of hospitals began in the late 1980s.

Third, government wished to secure other sources of funds for the health sector. The increasing imbalance of foreign trade and the growing budget deficit led to a fiscal crisis in the Hungarian economy by the early 1990s. The health sector was not the most urgent priority of government given other problems in the economy. The drop in GDP and the high inflation rate meant a 30% loss in real value for the health sector between 1990–1996 (39).

Fourth, the government wished to decentralize and partially privatize health services, in the hope of producing a more efficient and effective health care

system. Ownership of most health facilities was transferred from central to local government. The Health Insurance Fund was established as a single compulsory insurance scheme. The introduction of contracting between the insurance fund and health service providers also facilitated decentralization.

Fifth, health care workers welcomed any reform proposal likely to improve their income, working conditions and social status. Wages had not kept pace with inflation and were falling further behind other white-collar workers. Health care workers favoured the establishment of the Health Insurance Fund in the expectation that service contracts would improve their incomes.

Sixth, health care consumers were unhappy with a system that offered little choice and a poor standard of care but still required high social insurance premiums.

Another challenge, the subject of more recent health care reforms, is to create a system which encourages health promotion and facilitates healthier lifestyles for individuals and for society as a whole.

The overall goal is to create a system that makes cost-effective use of scarce resources and that results in improvements in the health status of the nation.

Reforms and reform implementation

This section discusses the reforms of the past decade within election cycles, including the period before the first free elections in 1990 (66). During the communist reform era, the Ministry of Health established a health reform secretariat (1988), and in 1989 switched from tax-based financing to compulsory social insurance. In 1990, the recurrent costs of health care institutions were transferred to this fund. (The investment cost of health care institutions remained a central budget responsibility.)

From 1989, private health care entrepreneurship was legalized. Limited regulation, however, has allowed free riders on the public sector, since medical specialists who work in the public sector can also engage in private practice out of official working hours. Due to limited private capital, limited purchasing power by patients, and limited contract opportunities with the Health Insurance Fund, private health care remains a small component in Hungarian health care. Also, gratitude payments (under-the-table payments by patients) hinder the development of a formal price structure and the growth of private health care provision.

The National Health Promotion Programme and the National Institute for Health Promotion were set up in 1987, but have met with relatively little success in achieving greater awareness on the public policy agenda.

Projects to change from input to output based financing were initiated. Hospital experiments focused upon the American DRG (diagnosis-related groups) method of financing. Various options for primary care were considered including the Scandinavian, British and German models. There were intentions to merge the outpatient specialist network with inpatient facilities as a hospital–outpatient clinic system, and to amalgamate paediatricians and adult physicians to provide a family service. The Health Reform Secretariat was considering the following international options by the end of 1980s:

- from the USA: the diagnosis related group (DRG) as a financing and controlling model; the Health Maintenance Organization as a way of combining financing and provision;
- from Germany: autonomous quasi public sectors owners, strengthening primary care, performance based financing, new management structure;
- from Scandinavia: health centres;
- from England: patient capitation payments for family physicians.

The Antall government (1990–1994) implemented major structural reforms. The 1990 Local Government Act changed the division of responsibilities between central government and local government. The ownership of the primary care surgeries, outpatient clinics and hospitals was devolved from the central government to local government. The local authorities are responsible for maintenance and investment, but since local tax revenues are insufficient, they remain financially dependent on central government. Health investment funds from the central budget are negotiated between the Ministry of Internal Affairs, the Ministry of Health and local governments.

Central government retained ownership of specialist services such as University hospitals, National Institutes, Blood Provision Services, Public Health and Infection Control.

The National Public Health and Medical Officer Service, established as a state agency in 1991, has a broad network of services at national, county and municipal level. In addition to disease control and traditional public health functions, it was assigned other functions including health promotion, professional supervision, quality control and coordination of the delivery of health care. Since the structure and professional profile of the service still emphasizes traditional public hygiene tasks, its role in the modernization of the health system is limited.

Strengthening primary care services was an early goal. From 1992, post-graduate training for general practitioners was made compulsory, and undergraduate training for family physicians was introduced with new departments in medical universities.

The financing system was also changed after a debate on whether to move towards a single- or multi-insurance model. A single-insurance model was developed but leaving open a longer run plan of competition between insurance schemes. Funding was separated with investment costs coming from central and local government tax revenue, and recurrent costs of clinical health services from health insurance. In 1992, the Social Insurance Fund was divided into a Health Insurance Fund and a Pension Insurance Fund, which were made self-governing in 1993.

The view of health care as a citizenship right shifted to a concept of a health insurance customer. Despite a contraction in people's rights, there was no reduction however in service accessibility. (The insurance information system was in any case unable to check individual premium payments.) Other citizenship rights were broadened, however, as people were free from 1992 to choose their family doctor.

Output-based remuneration was introduced for direct medical services. Primary care was financed through patient capitation, outpatient services, by fee-for-service funding and inpatient services by DRG-type remuneration. To ensure financial stability of the Health Insurance Fund, ceiling caps were introduced but could not be imposed on cash benefits, despite the growing deficit of the Fund. Despite these improvements, a perverse incentive to over-service was introduced, together with continuing incentives to refer to inpatient and to specialist care, rather than treat people in outpatient and primary care settings.

Legislation passed in 1992 set a framework for public sector employment (including all health care staff), which left employer organizations with little flexibility and no financial tools to influence individual physician behaviour.

In the pharmaceutical market, the explosion in products and prices quickly led to a sharp increase in public expenditures. No successful mechanisms have been found to control rising pharmaceutical expenditures. The National Health Insurance Fund now aims to limit drug spending. The pharmaceutical sector has seen significant privatization of manufacturing and distribution channels including most pharmacies.

The Horn Government (1994–1998) had to face the contradiction between the principle of health as a public good and economic constraints as a result of severe economic decline. The Horn Government could not produce consistent health care reforms, given frequent changes of ministers. Health care remained a low priority compared to strengthening the economic structure. The stabilization package introduced in 1995–1996 meant reduced funds for the social and health sectors.

Act LXIII of 1996 called for cuts in hospital beds and institutions. Rationalization criteria were based on regional characteristics and health needs as

well as hospital standards. Despite strong opposition from the health sector and from the population (including political demonstrations), 18 000 beds (15% of bed capacity) were removed from the system. Some bad compromises were made including closing beds rather than entire hospitals. No incentives were introduced to reduce referrals so that the hospitalization trend has continued.

Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on the Minimum Standards of Certain Institutions Providing Health Services set standards that institutes must meet in order to obtain a licence to operate. This decree provides a means to regulate minimum standards, and is expected to further reduce the supply of health care services.

The 1997 *Health Act* represents a modern public health view that emphasizes the prevention of disease, the promotion of health, and the strengthening of primary health care. The legislation also addresses fundamental questions of equity and solidarity. The legislation protect patients' rights and the confidentiality of medical information. A liberal interpretation of patient rights, however, may meet with opposition from the conservative wing of the Medical Chamber. The 1997 *Health Insurance Act* restates the commitment to comprehensive and statutory health insurance based on the principles of solidarity and access to basic health services, although entitlement theoretically depends upon being a contributor or having a contribution paid on one's behalf.

The Orbán Government (1998–) abolished the autonomy of the Health and Pension Insurance Funds and shifted control to the Prime Minister's Office, and then from June 1999 to the Ministry of Finance. The National Health Insurance Fund is now administered directly by government in order to increase accountability and establish direct control.

The future direction of financing reform is not yet fully known. The Government of the Republic of Hungary (1998) has defined the following main health objectives:

- to maintain the principles of solidarity and universal coverage in health insurance
- to further decentralize both funding and delivery
- to decrease the total social insurance contribution to 25% over four years
- to reform the insurance collection system.

The previous government intended to decrease the employers' insurance premium in order to encourage better conditions for investment and increased employment. Further independence of local governments is also intended.

Further privatization of family doctor practices is also on the policy agenda. After a two-year debate on health promotion, accompanied by promises to compensate for changes to the advertising law, and despite the strong marketing

power of the tobacco industry, the *Act XLII of 1999 on the Protection of Non-Smokers* was recently approved by Parliament.

Health for all policy

WHO 'health for all' principles were first incorporated in the 1987 National Health Promotion Programme. The 1994 National Health Promotion Programme set population health targets and established an intersectoral advisory group to coordinate government health promotion activity. The 1997 Health Act contains some of these principles and reaffirms the principles of equitable access to health services and the dignity of individuals. Hungary is also undertaking several projects in cooperation with the WHO Regional Office for Europe in the following areas:

- Middle-term cooperation programmes, for two-year budget periods, to mobilize human and financial resources.
- Working together on Hungarian priorities in the EUROHEALTH programme. The WHO Regional Office for Europe monitors implementation and cooperates in fund raising and human resource capacity building activities. Hungarian regional differences and local priorities will be more precisely addressed.
- Creating and professionally supporting WHO collaborating centres. Hungary has eleven centres in the areas of population policy, occupational health, gerontology, pharmaceutical policy, medical rehabilitation, oncology, protection of water quality, genetic advice, nutritional health, health promotion, and nursing.
- Collaboration between the different donor agencies. The Liaison Office has continuous contacts with the representatives of the World Bank and PHARE, and cooperates in the bilateral, international activities of the Ministry of Health.
- Facilitating action-networks on the national and international level. Thirteen Hungarian cities are participating in the "Healthy Cities" programme, 100 schools in "Healthy Schools", 11 hospitals in "Health Promoting Hospitals", and a programme for "Healthy Workplaces" is being implemented. Three Hungarian counties are participating in the "regions for health" international programme.
- Home care is supported for community-based rehabilitation and special attention is being paid to programmes for the support of the elderly.
- Professional advisory groups are helping the Hungarian health reform process mainly in the area of health policy and public health. One professional

group has been invited by the Hungarian Parliament to put forward health promotion recommendations to improve the health status of the population.

- Conferences and professional visits has been organized or supported by WHO, mainly in the areas of pharmaceutical reimbursement, information technology and environmental health.
- WHO facilitates publishing activities and the distribution of health related publications. The library of the National Institute for Medical Information provides free access to all WHO publications.

The Regional Modernization Programme, a pilot project initiated in 1997, with the help of a World Bank loan, was cancelled by the Orbán Government in September 1998. This programme had been intended to strengthen regional-level planning and management.

Conclusions

Hungary can be described as a cautious reformer in relation to its health sector. The country has been engaged for the last decade in the massive task of transition to a political democracy and to a mixed economy. Until recently, comprehensive health sector reform was not high on the policy agenda. Hungary has retained a mainly public sector health system, funded mostly through a public sector health insurance scheme. Health expenditures have declined since 1995, although (by some measures) remain not far below the average share of GDP in European Union countries. Despite this, structural reform of the health care system has lagged, the health infrastructure has deteriorated and the gap between the health status of the Hungarian population and western Europe has widened. Nevertheless, the health sector of the late 1990s is substantially different to that of the late 1980s. Major reforms have been implemented although many issues remain to be addressed. Hungary has found that there are no easy solutions and that health sector reform is an ongoing process.

Between 1994 and 1998, health policy-making was dominated by the state's fiscal difficulties, which prompted the search for sustainable financing, recentralization measures to regain policy control, and the setting of health services priorities. The frequent changes of government, however, have reduced the capacity of the Ministry of Health to develop continuity in health policy formulation and implementation.

The main steps in the structural reorganization of the health sector have included the following:

- the establishment of a national health insurance fund
- decentralized delivery of health services
- some shift away from government as the dominant provider

- the transfer of ownership of most health care facilities to local government
- the functional privatization of primary care services
- the strengthening of primary health care
- greater emphasis on health promotion
- new methods of paying health providers
- the adoption of modern concepts of public health.

The main achievements

The health sector is not yet assured of adequate funding. In real terms, health care expenditure fell between 1990 and 1997. Over three quarters of known health care revenue comes from health insurance, and an unknown but substantial proportion comes from out-of-pocket payments from health care consumers. A health care tax has been introduced in order to supplement health revenue, given the limitations of insurance funding based in effect upon a payroll tax.

The establishment of a public sector health insurance fund was a substantial achievement. Initially semi-autonomous, the fund has been shifted under the government in order to regain fiscal and policy control. The single payer insurance fund (along with state funding for some tertiary care, public health and capital investment) in theory allows the operation of a split funder/provider model of health care. In addition, local governments can either provide or contract out the provision of health care services.

Most clinical health services have been devolved to local government authorities, in place of the previous centralized and hierarchical system of state management. One problem is that health care is not necessarily a priority for local government, and the over 3000 municipalities do not have the funds and the expertise necessary to run an effective and efficient health care service.

A family physician model of primary care has been introduced, along with functional privatization. People can choose their family doctor, and doctors are paid according to the number of registered patients. Retraining district physicians will take time and these physicians do not yet have the skills nor the financial incentives to become effective gatekeepers in directing patient flows to higher levels of health care.

New payment methods, via service contracts with the Health Insurance Fund, have introduced incentives for more efficient management. Most family physicians are paid through patient capitation funds, specialist ambulatory care is paid according to procedure (fee-for-service) points, and inpatient care is

paid through diagnosis-related groups. However, perverse incentives must be addressed that allow over-servicing, and that favour specialist and inpatient care above primary and ambulatory care. The Health Insurance Fund will also have to set up its regulatory procedures.

Hungary has more doctors for its population than most countries in Europe. Salary pressures from physicians and other health professionals have continued to build up, with physicians' wages generally only one third above the workforce average.

Hungary had a high number of hospital beds, which have been reduced along with some restructuring of the hospital system (but by only 20% between 1990 and 1996). These changes have only been partially successful, since strong vested interests and perverse financial incentives continue to encourage a hospital-centred health care system.

Most health facilities are managed by their public sector owners (mainly local governments). Health facility managers still have little autonomy and few incentives to deliver more efficient services, especially since their debts are generally covered by the Health Insurance Fund.

The private sector, so far, plays only a small role in the funding and delivery of health care services since the necessary conditions for expansion do not exist.

Future directions

The Government elected in 1998 has indicated its commitment to continuing health care reform. Universal access to comprehensive health care is to be preserved but the package of basic benefits is likely to be more tightly defined. The national health insurance fund may remain as the main single purchaser but greater provider competition may be encouraged. The intention also is to continue to strengthen primary care and to provide incentives for people to be treated at lower and more appropriate levels of the health care system.

The precise future direction of Hungarian health care reform have yet to be decided but the cautious approach of governments thus far has succeeded in keeping open several options.

Endnotes

- ¹ The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.
- ² <http://www.valasztas.hu>
- ³ *Act XX of 1949 on the Constitution of the Republic of Hungary*
- ⁴ *Act XXI of 1988, Decree No. 113/1989. (XI. 15.) MT of the Ministerial Council, and Decree No. 30/1989. (XI. 15.) SZEM of the Minister of Social Affairs & Health*
- ⁵ *Act XX of 1949 on the Constitution of the Republic of Hungary amended by Act XXXI of 1989 on the Amendment of the Constitution*
- ⁶ *Constitution of the Republic of Hungary, Article 14*
- ⁷ *Constitution of the Republic of Hungary, Article 9*
- ⁸ *Constitution of the Republic of Hungary, Articles 62 & 63*
- ⁹ *Constitution of the Republic of Hungary, Article 18*
- ¹⁰ *Constitution of the Republic of Hungary, Article 70/D (1)*
- ¹¹ *Constitution of the Republic of Hungary, Article 70/E*
- ¹² *Constitution of the Republic of Hungary, Article 70/D (2)*
- ¹³ *Constitution of the Republic of Hungary, Article 35, section (1), point g)*
- ¹⁴ For instance *Government Decree No. 49/1990. (IX. 15.) Korm. on the Scope of Duties and Authority of the Minister of Health.*
- ¹⁵ <http://www.mkogy.hu>

- ¹⁶ *Constitution of the Republic of Hungary, Article 32/A section (3)*
- ¹⁷ <http://www.obh.hu/adatv/indexek/index.htm>
- ¹⁸ *Constitution of the Republic of Hungary, Article 32/B, section (1)*
- ¹⁹ *Constitution of the Republic of Hungary, Article 44/A*
- ²⁰ *Article 143*
- ²¹ *Government Decree No. 154/1998. (IX. 30.) Korm.*
- ²² *Government Decree No. 49/1990. (IX. 15.) Korm on the Scope of Duties and Authority of the Minister of Welfare*
- ²³ *Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments*
- ²⁴ Medical aids and prosthesis are sometimes referred to as therapeutical equipment or medical devices, but include only those devices which are used directly by the patient, and can be bought in retail shops (for instance orthopaedic shoes, hearing aids, etc.).
- ²⁵ *Act LXXXIX of 1996 on the Amendment of Acts Associated with the Changes in the Financing of In-kind Health Services*
- ²⁶ *Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services, Article 3, section (2)*
- ²⁷ *Act CXVII of 1995 on Personal Income Tax, Article 35, section (2)*
- ²⁸ *Government Resolutions No. 1030/1994. (IV.29.) Korm. and 1006/1995. (I. 27.) Korm.*
- ²⁹ *Act LCIV of 1997*
- ³⁰ *Act XI of 1991*
- ³¹ *Decree No. 55/1996. (XII. 27.) NM of the Minister of Welfare, and the Deed of Foundation of the National Ambulance Service in Welfare Gazette 1997/11*
- ³² *Act CLIV of 1997, and Decree No. 26/1998. (VI. 17.) NM of the Minister of Welfare, and the Deed of Foundation of the National Service of Blood Supply in Welfare Gazette 1998/12*
- ³³ *Act CLIV of 1997, Article 150*
- ³⁴ *1006/1995. (I. 27.) Korm. Resolution*
- ³⁵ <http://www.gyogyinfok.hu>
- ³⁶ *See Deed of Foundation in Welfare Gazette 1998/11, and Decree No. 13/1990. (IV. 17.) SZEM of the Minister of Social Affairs & Health, respectively*

- ³⁷ *Decree No. 6/1989. (III. 22.) SZEM of the Minister of Social Affairs & Health on Professional Colleges, Decree No. 53/1996. (XII. 27.) NM of the Minister of Welfare on Medical Professional Colleges, No. 14/1998. (IV. 22.) on Professional College of Pharmacy*
- ³⁸ *Decree No. 10/1997. (V. 23.) NM of the Minister of Welfare*
- ³⁹ *Act CLIV of 1997, Article 117, and Decree No. 10/1998. (XII. 27.) EüM of the Minister of Health*
- ⁴⁰ *Act LXXX of 1993*
- ⁴¹ *Decree No. 16/1994. (IV. 26.) KHVM of the Minister of Transport, Communication and Water Management*
- ⁴² *Government Decree No. 137/1998. (VIII. 18.) Korm. on the Prime Minister's Office, <http://www.meh.hu>*
- ⁴³ *Act LXXX of 1997*
- ⁴⁴ *Act XLVIII of 1989 on the Social Insurance Fund's Budget of 1990*
- ⁴⁵ *Act LXXXIV of 1991 on Self Governance of Social Insurance, and Act X of 1992 on the Social Insurance Fund's Budget of 1992 and the Amendment of Act XXI of 1998 on the Social Insurance Fund*
- ⁴⁶ *Act CXXI of 1996*
- ⁴⁷ *Act XLVIII of 1997*
- ⁴⁸ *Order No. 16/1998. (V. 8.) AB of the Constitutional Court*
- ⁴⁹ *Act XXXIX of 1998 on the State Supervision of Social Insurance Funds and their Administrations*
- ⁵⁰ *Act LXV of 1990, Article 8 and 70*
- ⁵¹ *Act CLIV of 1997*
- ⁵² *Act XXVIII of 1994; <http://www.mok.hu>*
- ⁵³ *Act LI of 1994 on the Hungarian Chamber of Pharmacy*
- ⁵⁴ *Decree No. 23/1998. (XII. 27.) EüM. of the Minister of Health on The Hospital Supervisory Councils*
- ⁵⁵ *Government Decree No. 89/1995. (VII. 14.) Korm.*
- ⁵⁶ *Act XCII of 1993 on the Amendment of Certain Provisions of the Civil Code*
- ⁵⁷ *Act CLIV of 1997, Article 148 and 149*
- ⁵⁸ *Government Decree No. 229/1998. (XII. 30.) Korm on the Scope of Duties, Organisation and Operation of the National Health Council*
- ⁵⁹ *1030/1994. (IV. 29.) Korm. Resolution on the Principles of Long Term Health Development Policy*
- ⁶⁰ *Act CLIV of 1997*

- ⁶¹ http://www.fact.hu/egeszsegterv/index_e.html
- ⁶² Act CLIV of 1997
- ⁶³ Government Decree No. 72/1998. (IV. 10.) Korm. on the Financing of Higher Education on the Basis of Training and Maintenance Capitation
- ⁶⁴ Act LXXX of 1993
- ⁶⁵ Act CLIV of 1997
- ⁶⁶ Act XXXIII of 1992 on the Legal Status of Public Employees
- ⁶⁷ Act CLIV of 1997, Act XXVIII of 1994 and Decree No. 11/1972. (VI.30.) EüM of the Minister of Health on the Regulations of Health Workers
- ⁶⁸ Decree No. 14/1990. (IV. 17.) SZEM of the Minister of Social Affairs & Health
- ⁶⁹ Decree No. 113/1989. (XI. 15.) MT of the Ministerial Council
- ⁷⁰ Government Decree No. 113/1996. (VII. 23.) Korm. on the Licences for Supplying Health Care Services
- ⁷¹ Decree No. 32/1997. (X. 28.) NM of the Ministry of Welfare on the Registration of Health Care Providers and their Licences
- ⁷² Decree No. 8/1993. (III. 31.) NM of the Ministry of Welfare on the Professional Supervision of Health Care Institutions
- ⁷³ Act LXIII of 1996
- ⁷⁴ Act XXXIX of 1998
- ⁷⁵ Act LXXX of 1997, Article 16
- ⁷⁶ Act LXXX of 1997, Article 24
- ⁷⁷ Act LXXX of 1997, Article 39, section (2)
- ⁷⁸ Act LXXX of 1997, Article 34, section (2)
- ⁷⁹ Act LXVII of 1998
- ⁸⁰ Act LXXXVIII of 1996 on Health Care Contribution
- ⁸¹ Act IX of 1992 on the Amendment and Complement of Act II of 1975 on Social Insurance
- ⁸² Act XIV of 1996 on the 1996 Budget of the Social Insurance Funds and Government Decree No. 61/1996 (IV. 26.) Korm.
- ⁸³ 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
- ⁸⁴ Decree No. 48/1997. (XII. 17.) NM of the Minister of Welfare
- ⁸⁵ Decree No. 2/1995. (II. 8.) NM of the Minister of Welfare and No. 30/1995. (IX. 12.) NM of the Minister of Welfare, respectively

- ⁸⁶ *Decree No. 17/1997. (VI. 30.) NM of the Minister of Welfare*
- ⁸⁷ *Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare*
- ⁸⁸ *Act LXXXIII of 1997*
- ⁸⁹ *Government Decree No. 284/1997 (XII. 23.) Korm.*
- ⁹⁰ *Government Decree No. 217/1997. (XII. 1.) Korm.*
- ⁹¹ Unpublished data from the State Supervision of Funds
- ⁹² *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*
- ⁹³ Unpublished data from the Ministry of Health, Pharmaceutical Department, 1998.
- ⁹⁴ *Act LXV of 1990*
- ⁹⁵ *Act CLIV of 1997*
- ⁹⁶ Unpublished data from the Health Insurance Fund Statistical Office
- ⁹⁷ *Decree No. 26/1991 (XII. 28.) NM of the Minister of Welfare*
- ⁹⁸ *Magyar Orvos* official paper of the Hungarian Medical Chamber, October 1998
- ⁹⁹ Health Care Bulletin, April 1999
- ¹⁰⁰ *Act LXII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms*
- ¹⁰¹ *Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on the Minimum Standards of Certain Institutions Providing Health Services*
- ¹⁰² Unpublished data from the Ministry of Social and Family Affairs, Centre for Social Policy Development .
- ¹⁰³ <http://www.sote.hu/~emk>
- ¹⁰⁴ <http://www.worldbank.org/>
- ¹⁰⁵ *Bill on Financing Budget of Social Security in 1999, Ministry of Finance (1998)*
- ¹⁰⁶ *Act LXIII of 1996*
- ¹⁰⁷ *Act CLIV of 1997 and Act LXXXIII of 1997*
- ¹⁰⁸ *Order No. 3/1987. (Eü.K. 3.) EüM of the Minister of Health*
- ¹⁰⁹ *Act XXXIII of 1992 on the Status of Public Employees*
- ¹¹⁰ <http://www.ksh.hu>

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Appendix 1

Laws and regulations in chronological order

- 1988 *Act XXI of 1988 on the Social Insurance Fund*
the separation of the social insurance fund from the Government budget
- 1989 *Act XXXI of 1989 on the Amendment of the Constitution*
establishment of an independent democratic constitutional state
Hungary is declared to have a market economy
health is reinforced to be a fundamental right
- Act XLVIII of 1989 on the Social Insurance Fund's Budget of 1990*
the “fund exchange”: health services are financed from the Social Insurance Fund
- 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 Activity*
the legal background for “full” private providers in the area of health
- 1990 *Act LXV of 1990 on Local Government*
ownership of most public health facilities is transferred to local governments
local governments are responsible for supplying primary and secondary care to the local population

- 1991 *Act XI of 1991 on National Public Health and Medical Officer Service*
 the Service is established as a state agency on the basis of the former public health stations, but tasks are defined according to the concept of modern public health, and include the professional supervision of health
Resolution No. 60/1991 (X. 29.) of the Parliament on Social Insurance
 the Parliament set out the main direction of the pension and health insurance system
Act LXXXIV of 1991 on Self Governance of Social Insurance
 definition of the structure of self government of social insurance
 division of the social insurance into health and pension funds
 division of the Social Insurance Fund Administration into the National Health Insurance Fund Administration and the National Pension Administration
- 1992 *Act IX of 1992 on the Amendment and Complement of Act II of 1975 on Social Insurance*
 determines entitlement to and defines the services covered under the statutory health insurance
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
 division of the Social Insurance Fund into health insurance and pension funds
Act XXXIII of 1992 on the Legal Status of Public Employees
 regulates employment in the public sector and determines the compulsory minimum salaries of public employees according to a pay scale
Decree No. 6/1992. (III. 31.) NM of the Minister of Welfare on the Family Physician and Paediatric Primary Care Service
 former district doctor system was separated from hospitals and retitled as "family physician service"
 regulation of professional standards including family doctor specialization to be obtained
Government Decree No. 79/1992. (IV. 12.) Korm. on the Social Insurance Financing of Health Services in 1992
 the introduction of contracting and capitation payment in family physician's services

Act LXXXIV of 1992 on the Social Insurance Fund and Its Budget of 1993

the introduction of new financing methods for outpatient specialized care and hospital care from July 1993

Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments

assisting local governments for financing capital costs of their facilities including hospitals, medical equipment, etc.

1993 *Act III of 1993 on Social Services*

determines cash and in-kind assistance

obligations of local governments to provide services for local residents

Decree No. 8/1993. (III. 31.) NM of the Ministry of Welfare on the Professional Supervision of Health Care Institutions

determines the system of professional supervision of health services, in the frame of the National Public Health and Medical Officer Service

Decree No. 9/1993. (IV. 2.) NM of the Ministry of Welfare on the Social Insurance Financing of Specialist Services

detailed list of interventions and their point values, and DRGs

Government Decree No. 91/1993. (VI. 9.) Korm. on the Establishment of the National Pension Administration and the National Health Insurance Fund Administration, and their Administrative Organs and Other Measures in Connection with this

determines the organizational structure of the NHIFA

Act LXXX of 1993 on Higher Education

medical universities are under the supervision of the Ministry of Education

Act XCVI of 1993 on Voluntary Mutual Insurance Funds

legal framework for the establishment of voluntary non-profit insurance in the area of health, pension and self-support

- 1994 *Act XXVIII of 1994 on the Hungarian Medical Chamber*
 compulsory membership for all practising physicians
 the Medical Chamber is given the right to establish ethical norms and procedures; to negotiate on general rules of contracts between health insurance and physicians; and to participate in health policy formulation
- Act LI of 1994 on the Hungarian Chamber of Pharmacy*
 compulsory membership for all practising pharmacists, on the basis of the same principles as in the case of the Hungarian Medical Chamber
- 1030/1994. (IV. 29.) Korm. Resolution on the Principles of Long Term Health Development Policy*
 Sets out health policy goals of the government.
- 1995 *Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilisation* and its executive order of *Government Decree No. 69/1995. (VI. 17.) Korm.*
 health insurance benefits were curtailed (the exclusion of most dental services, removal of subsidies on spa treatment, etc.)
 co-payment for patient transfer was introduced
- 1996 *Act LXIII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms*
 determines health care capacity per county in terms of hospital beds and consultation hours which local governments are to be supplied and the NHIFA is obliged to contract for
- Act LXXXVIII of 1996 on Health Care Contribution*
 introduction of an earmarked lump sum tax for health services
- Act CXXVI of 1996 on the Use of a Specified Amount of Personal Income Tax in Accordance with the Taxpayer's Instruction*
 taxpayer's are allowed to decide on spending 1% of their income tax on public purpose not-for-profit activity, including health services
- Government Decree No. 89/1995. (VII. 14.) Korm. on Occupational Health Services*
 the provision occupational health services is the responsibility of the employer

Government Decree No. 113/1996. (VII. 23.) Korm. on Licences for Supplying Health Care Services

renewal of the licensing system

Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on Minimum Standards of Certain Institutions Providing Health Services

regulates hospital activities and standards

1997 *Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services*

rules of social insurance including compulsory participation, entitlement for services and contribution rates

Act LXXXIII of 1997 on the Services of Compulsory Health Insurance and its executive order of Government Decree No. 217/1997 (XII. 1.) Korm.

determines the in-kind and cash benefits of the statutory health insurance

Government Decree No. 40/1997 (III.5.) Korm. on the Practice of Alternative Medicine

regulation of non-conventional medicine

Act LVIII of 1997 on Commercial Advertising

limits advertising on health damaging products such as smoking

Act XLVII of 1997 on Management and Protection of Health Care and Related Personal Data

protects confidentiality of personal information in health services

Act CLIV of 1997 on Health

set up the general framework for health care including patient rights, the organization of the health care system, major actors and responsibilities for health care.

Decree No. 46/1997 (XII. 17.) NM of the Minister of Welfare on Health Services which are not Covered by the Statutory Health Insurance

list of services which are excluded from public finance

- 1998 *Act XXV of 1998 on the Pharmaceuticals for Human Use*
comprehensively regulates the pharmaceutical industry in accordance with the practice of the European Union
- Act XXXIX of 1998 on the State Supervision of Social Insurance Funds and their Administration*
supervision of the social insurance fund is shifted to the Prime Minister's Office
- Act LXVII of 1998 on Amendment of Act LXXX of 1997*
social insurance contribution is decreased from 1999
- Act LXVI of 1998 on Health Care Contribution*
the original lump sum tax was complemented with a fixed rate component
- Government Decree No. 229/1998. (XII. 30.) Korm on the Scope of Duties, Organisation and Operation of the National Health Council*
the establishment of the National Health Council for assisting the Government in health policy
- Decree No. 10/1998 (XII. 11.) EüM of the Minister of Health on The Organisation and Operation of the Health Care Specialist Training and Continuing Education Council*
the establishment of the Health Care Specialist Training and Continuing Education Council for the coordination and supervision of professional training
- 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*
Waiting lists, and waiting list committees are to be set up in the first half 1999
- Decree No. 23/1998. (XII. 27.) EüM. of the Minister of Health on The Hospital Supervisory Councils*
Hospital Supervisory Councils are to be set up in the first half of 1999
the Councils are to be established for those hospitals which have territorial supply obligation, and should represent the interests of the local population the care of which the hospital is responsible for

Health policy documents

1. Reform communist era (end of the 1980s):
documents of the Reform Secretariat of the Ministry of Social Affairs and Health
2. Antall government (1990-1994):
 - Programme of National Revival, 1990
 - Action Plan for the Renewal of Health Services, 1992
 - *1030/1994. (IV. 29.) Korm. Resolution on the Principles of Long Term Health Development Policy*
3. Horn government (1994-1998):
 - Government Policy, 1994
 - *1006/1995. (I. 27.) Korm. Resolution on the Amendment of 1030/1994. (IV.29.) Korm. Resolution on the Principles of Long Term Health Development Policy*
 - Ministry of Welfare (1995): The Programme of Health Services Modernization
4. Orbán government (1998-):
 - The Policy of the Government of the Republic of Hungary, 1998
[Http://www.meh.hu/](http://www.meh.hu/)

Regular statistical publications

1. Hungarian Central Statistical Office¹¹⁰

- Statistical Yearbook of Hungary
each year
 - Statistical Pocket-book of Hungary
each year
 - Yearbook of Welfare Statistics
1995
for 1996, Yearbook of Health and Social Statistics
 - Household Budget Survey, Annual Reports
till 1993 in odd years, since 1993 each year
 - Not-for-profit Organizations in Hungary
since 1995
2. National Health Insurance Fund Administration
- Statistical Yearbook