

Health Care Systems in Transition

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Foreword

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

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

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

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

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. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to observatory@who.dk. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at www.observatory.dk.

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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is led by Susanne Grosse-Tebbe.

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The HiT reflects the state of health reforms in early 2004.

Introduction and historical background

Introductory overview

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

Hungary had 10.2 million inhabitants in January 2003 with about 99% holding Hungarian citizenship (1,53). Approximately 5 million Hungarians live outside the current borders of the country. A small share of them left the country during several waves of emigration, such as after the world wars, and after the 1956 revolution against communist rule.

In 2001, 3.1% of the population considered themselves members of a national minority in Hungary. The largest ethnic minority group, the Roma or Gypsy community, numbered 190 000 (1), but estimates of other sources are two to three times higher than of the population census (7). In 2001, 89% of the population revealed its religious affiliation, of which 58.2% considered themselves Roman Catholic, 17.8% Calvinist, 3.4% Lutheran, 3.0% Greek Catholic and 17.7% had another or no religious denomination (1). The official language, Magyar (Hungarian) is part of the Finno-Ugric language group.

With respect to demographic trends, the population in Hungary has been decreasing since the 1980s, mainly because the birth rate has been below the mortality rate since 1981 (1). The population is ageing as the share of the elderly, aged 65 or over, has been increasing steadily, accompanied by a decrease in the share of 14-year olds and under (Table 1).

Fig. 1. Map of Hungary¹

Source: World Factbook 2003.

Budapest, the capital, has 1.8 million inhabitants, while almost half the country's population live in communities of less than 20 000 inhabitants. In 2003, Hungary had 23 large cities ("county rank" cities and the capital), 229 other towns and 2893 villages. Public administration has three levels comprising the national government and two tiers of local government: the counties and the municipalities. The 19 counties each cover a population between 200 000 and 1 000 000 (1).

Since 1996 the territory of the country is also divided into seven larger units, the so-called regions, each of which comprises three counties, except for the region of Central Hungary (Budapest and Pest county). The regions currently serve mere planning and statistical functions for regional development (1999/8),² but they may become a new level of government in an EU-motivated future reorganization of public administration.

¹ The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Systems and Policies or its partners 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 The laws and regulations in this document are referred to by the year of enactment and by an Arabic number, which is not the official number of the law, but corresponds to the numbers used in the section *Laws and regulations in chronological order*. In that section laws and regulations are grouped according to years, and under each year they are listed in chronological order and numbered consecutively. Important acts are mentioned in the text in italics by their name, the year of enactment and by their official (Roman) number. Other references in this document are referred to by a single Arabic number in italics in parenthesis.

Table 1. Population indicators, 1949–2002

Indicators	1949	1970	1980	1990	1992	1994	1996	1998	2000	2001	2002
Population ^a (millions)	9.2	10.3	10.7	10.4	10.4	10.4	10.3	10.3	10.2	10.2	10.2
Live births per 1000 inhabitants	20.6	14.7	13.9	12.1	11.7	11.2	10.2	9.5	9.6	9.5	9.5
Deaths per 1000 inhabitants	11.4	11.6	13.6	14.0	14.3	14.2	13.9	13.7	13.3	13.0	13.1
Natural change per 1000 inhabitants ^a	9.2	3.1	0.3	-1.9	-2.6	-3.0	-3.7	-4.2	-3.7	-3.4	-3.5
% of under 15 years (A)	24.9	21.1	21.9	20.5	19.5	18.6	18.0	17.4	16.9	16.6	16.3
% of 65-year old and over (B)	7.5	11.5	13.5	13.2	13.6	13.9	14.3	14.7	15.0	15.1	15.3
Ageing index (B/Ax100)	30.3	54.4	61.9	64.5	70.1	74.7	79.5	84.1	88.5	91.3	93.5

Source: Hungarian Central Statistical Office (1,2,3,4,5,6,8,53).

Note: ^a residents in Hungary.

After more than 40 years of communist rule in the sphere of influence of the Soviet Union, Hungary regained its full sovereignty and declared itself an independent republic on 23 October 1989. Since then, the country has experienced a stable political system with organized political parties and coalition governments. The unicameral parliament has 386 seats and a 4-year election cycle. The electoral system combines majority and proportional systems. People choose candidates (in 176 single-candidate constituencies) and also cast their votes for a political party under a proportional voting system. Local government elections are held in the same year, but a few months 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 adopting a more settled way of life and converting to Christianity. Hungary's first king and patron saint, *I. István* (Stephen the First), was crowned in the year 1000. He established the Hungarian Kingdom, welcoming all 'foreigners'. Hungary was a large and powerful state throughout the medieval 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 as a

result of passive resistance led by Ferenc Deák. The so-called agreement with the Habsburgs opened the way for the continuous development of the country. 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 it was taken over by German troops and then liberated by the Soviet army. It lost its full sovereignty again and its opportunity to develop a civil democracy in 1948, when the communist party (then Hungarian Workers 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 (then Hungarian Socialist Labour 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 in coalition with the Independent Smallholders' Party and the Christian Democratic People's Party. In May 1994 the Hungarian Socialist Party formed a coalition government with the Alliance of Free Democrats. In May 1998, the Fidesz-Hungarian Civic Party formed a coalition government with the Hungarian Democratic Forum and the Independent Smallholders' Party. The Hungarian Socialist Party and the Alliance of Free Democrats were voted back into power in May 2002.³

Hungary became a full member of the Council of Europe in 1990, the Organisation for Economic Cooperation and Development (OECD) in 1996 and the North Atlantic Treaty Organization (NATO) in 1999. It was in the first wave of "pre-accession" countries that started negotiations with the European Commission in 1998. In December 2002, Hungary was accepted to become a full member of the European Union in May 2004.

The transition has proved challenging, although Hungary had already started liberalization during the 1980s, which allowed for a more gradual approach to economic and public sector reform. GDP dropped by nearly 12% (at constant prices) in 1991 and did not regain growth until 1994 (Table 2). Inflation peaked

³ In September 2004, Ferenc Gyurcsány of the Hungarian Socialist Party was elected Prime Minister by the National Assembly following the resignation of his predecessor Péter Medgyessy. Subsequently, Jeno Rácz was named Minister of Health, succeeding the Ministers of Health, Social and Family Affairs, Mihály Kókény (September 2003–September 2004) and Judit Csehák (May 2002–September 2003).

at 35% in 1991 and 29% in 1995. Unemployment rose to 14% in 1994, while real wages fell continuously until 1997, when they reached only 76% of the 1989 level. A stabilization package was introduced in 1995, accompanied by further privatization of state enterprises and an increase in foreign investment.

The country began to experience stable economic growth in 1997, achieving a GDP growth rate of 5.2% in 2000 and 3.7% in 2001 (1) and 3.3% in 2002 (53). Unemployment and inflation fell below 10% in 1998 and 2000, and reached 5.8% and 9.2% in 2001, respectively (1). Real wages have been rising since 1997 (Table 2).

Evolution of the health care system

Hungary has a long-standing tradition of health services dating back to infirmaries attached to monasteries in the eleventh century. After the early period of private medicine and church-dominated charities, the state gradually assumed an increasing role in the health sector in three areas: the provision of

Table 2. Macro-economic indicators, 1990–2001 (selected years)

Indicator	1990	1991	1994	1995	1997	1998	2000	2001
GDP at current prices (billion Ft) ^a	2 091	2 477	4 365	5 614	8 541	10 087	13 172	14 850
GDP per capita								
– in 1000 Ft	202	239	422	543	829	983	1 290	1 458
– in US \$	3 189	3 192	4 011	4 321	4 440	4 582	4 570	5 087
– in ECU/€	2 505	2 576	3 380	3 339	3 931	4 077	4 961	5 679
GDP growth rate (%) (applying GDP deflator)	-3.5	-11.9	2.9	1.5	4.6	4.9	5.2	3.8
Annual inflation (CPI) (%)	28.9	35.0	18.8	28.2	18.3	14.3	9.8	9.2
CPI deflator (1990=100)	100	135	242	310	453	518	625	683
Health care deflator (1990=100)	100	144	330	433	641	746	910	991
GDP deflator (1990=100)	100	134	239	303	435	490	583	634
Annual changes of real wages (%)	-3.7	-7.0	7.2	-12.2	4.9	3.6	1.5	6.4
Rate of registered unemployment (%)	2.0	8.2	12.0	11.7	11.0	9.6	8.7	7.9
Public expenditure as % of GDP ^b	61.3	66.3	74.0	63.8	56.8	49.9	46.3	45.3

Source: Hungarian Central Statistical Office (1, 4, 5, 6, 8, 9).

Note: ^a Billion means 1000 million throughout this document; ^b Including transfer payments

GDP: gross domestic product; Ft: Hungarian Forint; US \$ = US dollar; ECU: European Currency Unit; € = Euro; CPI = consumer price index.

health services for the poor, public health and health insurance. In the fifteenth century town physicians were employed to make services available for the poor, which was required of every county in 1752. Hospitals were separated from almshouses in 1856 and the eligible poor obtained free health care at special surgeries. The first Hungarian act on public health, which was passed in 1876 (*Act XIV of 1876*), was the second of this kind in Europe. Village and district doctors as well as chief medical officers provided health services free of charge for residents with very low income.

As far as health insurance is concerned, *Act XVI of 1840* legitimized voluntary self-help funds for industrial workers. In 1870 the General Fund of Sick and Disabled Workers was established. *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, and the National Fund of Patient Care was established in 1898 to reimburse health care costs for the poor. 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 communist regime, established in 1948, nationalized the economy, including the funding and delivery institutions of the Hungarian health care system. Private health enterprises, such as insurance companies and private general practices, were dismantled. Instead, 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 and improvement in socioeconomic conditions. Indeed, measures to ameliorate 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 was held responsible (1949/1). 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 (1952/1). Private practice of medical doctors was not forbidden, but allowed only on a part-time basis (1972/2).

The improvements made in the 1950s in the health status of the population slowed in the 1960s. Central planning allowed little flexibility in response to changing circumstances and weighted the health sector heavily towards

achieving quantitative development. Moreover, resource allocation was subject to political influence, which resulted in inequalities in service provision in terms of geographical locations and specialties. Although Act II on Health of 1972 confirmed that access to health services was a right linked to citizenship and promised comprehensive coverage free-of-charge at the point of use (1972/1), an increasing gap developed between rhetoric and reality. The system was suffering from excess capacities, deteriorating service quality and widespread informal payments at the same time.

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. In the course of the so-called reform communist era the Social Insurance Fund was separated from the government budget (1988/2). The financing of recurrent costs of health services were transferred to the Social Insurance Fund (1989/5). In addition, restrictions on the private provision of health care were abolished (1988/2, 1989/4). The head of the Reform Secretariat stayed in the office under the present government elected in 1990. This allowed a degree of continuity in health sector reform during the period of profound economic and political transition.

Health status of the population

Since the end of the Second World War the health status of the Hungarian population has passed through four main phases (11). The first period, until the middle of the 1960s, saw a major improvement that brought life expectancy to a level comparable with the more developed western European countries. The early efforts in public health, including widespread immunization programmes, undertaken by the communist regime, coupled with improvements in the socioeconomic situation successfully brought communicable diseases under control, with a substantial increase in life expectancy for both sexes. These changes took the health of the Hungarian people through the first phase of the health transition, with noncommunicable diseases achieving greater prominence during the 1970s. Yet while life expectancy continuously improved in western European countries during the 1980s, it stagnated in Hungary, and rising adult mortality would have actually caused it to decline had it not been counterbalanced by continuing improvements in infant mortality (Table 3). This second period, from the middle of the 1960s till the end of the 1980s, was characterized by an increasing health gap between Hungary and western

Europe. A similar pattern was seen in other central and south-eastern European countries (CSEC), such as the Czech Republic and Poland, although Hungary did rather worse than its neighbours.

The fall of the communist regime brought about a third period, which was characterized by a marked decline in health status, further widening the gap between Hungary and the countries of the European Union (EU). Life expectancy at birth decreased by more than a year between 1988 and 1993, whilst it steadily increased in the EU as a whole. In addition, the gap widened in relation to the Czech Republic and Poland, where the effect of the transition period was less marked, and recovery had begun faster. Nevertheless, a late recovery started in 1994, and since then a steady improvement in life expectancy has occurred, which at least ensured that the gap between Hungary and its neighbours has not increased.

Between 1960 and 2000, the life expectancy at birth increased by only 3.5 years in Hungary compared to 9 years in the average of OECD countries (54). Hungarian women gained 5.6 years throughout this period, while men's life expectancy improved by only 1.3 years altogether (Table 3). Life expectancy at birth in Hungary still remains among the lowest in Europe. In 1999 it was 71.2 years, almost seven years lower than the EU average (latest data), three years lower than the WHO European region average, one year lower than the CSEC average, and 3.7 and 4.5 years lower than in the Czech Republic and Slovenia, respectively (10). In 2002, Hungarian men had a life expectancy of 68.4 years and women of 76.6 years (53).

The high mortality among middle-aged men is the single most important factor explaining this gap. In 1993, 16 out of 1000 men between the age of 40–59 years died, a rate twice as high as in 1970 (3,6). Premature mortality among Hungarian men improved by only 25% since 1960 compared to 50% in the average of other OECD countries. In 2000, Hungary still reported the highest level of premature mortality for males among OECD countries (54).

At the same time, infant – particularly postneonatal – mortality, the probability of dying before age five as well as maternal mortality improved substantially since the 1950s and continue to rank below the CSEC average. Nonetheless, infant mortality, at 8.4 per 1000 live births in 1999, still is about two times higher in Hungary than in the average of EU countries (10). Until 2002, infant mortality decreased further to 7.2 per 1000 live births (53).

Looking at the causes of death, infectious diseases seem to be less of a problem as incidence and mortality from most childhood infectious diseases, viral hepatitis, tuberculosis and AIDS continue to occur less frequently in Hungary than in the average of CSE countries (10). In contrast, cardiovascular diseases and malignant neoplasms, digestive system diseases – including liver

disease – and external causes, including suicide, are prominent in Hungary, also as causes of premature death that account for the gap with the west. Mortality from these causes continues to be higher in Hungary than in the average of EU and CSE countries (10). In 2001, Hungary had the highest mortality from cancer and the second highest mortality from chronic liver diseases/cirrhosis among all countries of the WHO European region. Cancer and liver mortality had been on a constant rise since the 1970s, particularly with respect to lung cancer, but started to improve slowly from the mid of 1990s like most other causes of death. Although suicide rates show a favourable decreasing trend since the middle of the 1980s, mortality was still almost three times higher than the EU average and twice as high as the CSEC average in 1999 (10).

The reasons for the relatively high mortality in Hungary are complex and not fully understood. For example, there has long been concern about lifestyle, especially smoking, alcohol consumption, and the traditional unhealthy Hungarian diet. In 2000, the obesity rate among adults (19%) and alcohol consumption was higher than in most OECD countries, while the share of smokers among adults (30%) was in the mid range of OECD countries (54). In 1999 the death rate from causes related to alcohol was almost twice as high as the CSEC average, and three times higher than the EU average, whilst the difference in smoking related causes were less marked, but still substantial (10). Current consumption of cigarettes is still above CSEC and EU average, while alcohol intake has come down to EU average but is still above documented CSEC average. Also, inequalities in income have risen substantially, partly as a result of the liberalization policy that characterized the “goulash” communism, where reform began earlier in Hungary than in other CSE countries. At the same time, traditional channels of social support have gradually been disappearing (12). The interaction of socioeconomic factors, behaviour and health in Hungary is being studied (12).

Concerns about health in Hungary are not limited to its lagging behind the EU and CSE countries of similar level of economic development, but also focus on persisting geographical and social inequalities in health. For instance, the gap between countries with the highest and lowest life expectancy at birth was 6.7 years for men and 4.3 years for women in 2000 (13). The difference is partly attributable to the presence of disadvantaged population groups, especially the Roma minority, whose concentration is greatest in the two north-eastern counties of Borsod-Abaúj-Zemplén and Szabolcs-Szatmár-Bereg. Unemployment is much higher in the Roma population than among ethnic Hungarians, and many live in slum conditions without running water and sewerage. Infant mortality rates are high among them, and life expectancy is ten years less than for the rest of the population (14).

Table 3. Trends in mortality based indicators, 1949–2001 (selected years)

	1949	1970	1980	1991	1993	1995	1997	1999	2001
Male life expectancy at birth (years)	59.3	66.3	65.5	65.0	64.5	65.3	66.4	66.3	68.2
Female life expectancy at birth (years)	63.4	72.1	72.7	73.8	73.8	74.5	75.1	75.1	76.5
Maternal deaths per 1000 live births	1.57	0.42	0.20	0.13	0.19	0.15	0.21	0.04	0.05
Infant deaths per 1000 live births	91.0	35.9	23.2	15.6	12.5	10.7	9.9	8.4	8.1
Induced abortions per 100 live births	0.9	126.7	54.4	70.7	64.3	68.7	74.3	69.7	58.1
SDR, all ages per 100 000 ^a									
– all causes	–	1 252	1 302	125	128	121	114	115	104
– external cause, poison and injury	–	97	114	117	111	101	90	90	81
– suicide and self-inflicted injury	–	35	44	37	34	30	29	30	27
– cardiovascular diseases	–	690	689	636	640	592	562	564	504
– ischaemic heart disease	–	248	229	244	258	249	244	244	225
– cerebrovascular diseases	–	185	218	174	168	159	147	147	139
– malignant neoplasms	–	215	240	270	275	276	277	275	266
– cancer of lung, bronchi, trachea	–	32	45	62	65	65	66	66	65
– digestive system diseases	–	45	63	83	108	106	88	90	82
– chronic liver diseases and cirrhosis	–	13	27	55	78	79	62	65	57

Source: Hungarian Central Statistical Office (1, 2, 3, 4, 5, 6), ^a WHO Regional Office for Europe, health for all database (10).

Note: SDR: age-standardized death rate.

Organizational structure and management

The organizational base of the current Hungarian health care system was created at the end of the 1980s as a result of the political, social and economic changes brought about by the collapse of the communist regime. The 1989 amendment to the Hungarian Constitution defined the principles and basic democratic structure of the new republic, the framework in which the health care system operates.

The Constitution guarantees the right to private property and declares Hungary to have a social market economy in which public and private property are to receive equal consideration and protection. The Constitution guarantees the fundamental rights of peaceful assembly and association, of voting and eligibility for public office. On this basis the core governing institutions of the state, the National Assembly, the President of the Republic, the Constitutional Court and both national and local governments are brought into operation (1989/3).

The Hungarian Constitution recognizes the right to a healthy environment, to an optimal level of physical and mental health and to income maintenance through social security. The right to health should be implemented through labour safety, health care, regular physical activity and the protection of the environment. The Constitution assigns overall responsibility for state social welfare and health care provisions to the national government (1989/3), but other actors such as the National Assembly and the Constitutional Court also take part in decision-making concerning the organization and functioning of the health care system.

Organizational structure of the health care system

The current structure of the Hungarian health care system represents a considerable departure from the former, highly centralized, state-socialist model. Since 1989 the system has become more pluralist with responsibilities divided between various players. The previous hierarchical relationships have partly been replaced by contractual relationships and quasi-public arrangements.

Health services in Hungary are funded primarily by social health insurance from the Health Insurance Fund (HIF) for recurrent costs (Table 4 and Table 6), administered by the National Health Insurance Fund Administration (NHIFA). Capital costs are mainly financed from taxation (Table 7). Services are delivered predominantly by local government-owned public providers, who contract with the NHIFA. The national government is the dominant regulator of health services, exercising statutory supervision over the HIF and controls the NHIFA. In addition, it provides capital grants and delivers public health and some tertiary care services.

Fig. 2 presents the current organizational structure of the Hungarian health care system at the national, county, municipal and individual/private sector (dashed box) levels. The main actors are grouped in four columns according to four main functions: ownership/system management, service delivery, financing and public health. It characterizes the relations among these main actors as hierarchical or contractual in its broader sense. The chart illustrates only the typical organizational arrangements both in financing and service delivery. For instance voluntary health insurance exists in Hungary, but it is a negligible source of health care financing. Or the “functional privatization” model according to which a private provider delivers services using the publicly owned facility and infrastructure is open to providers at all levels of care, but the dominant form of service provision only in primary care (see the section on *Health care delivery system*).

Act CLIV of 1997 on Health (1997/16) assigns responsibility for health services to the National Assembly, the national government, the Ministry of Health (now Ministry of Health, Social and Family Affairs, but later referred to henceforth as Ministry of Health), the National Public Health and Medical Officer Service (NPHMOS), and in general the owners of health facilities, who are mainly local governments since 1990 (1990/3).

Fig. 2. Organizational chart of the health care system, 2003

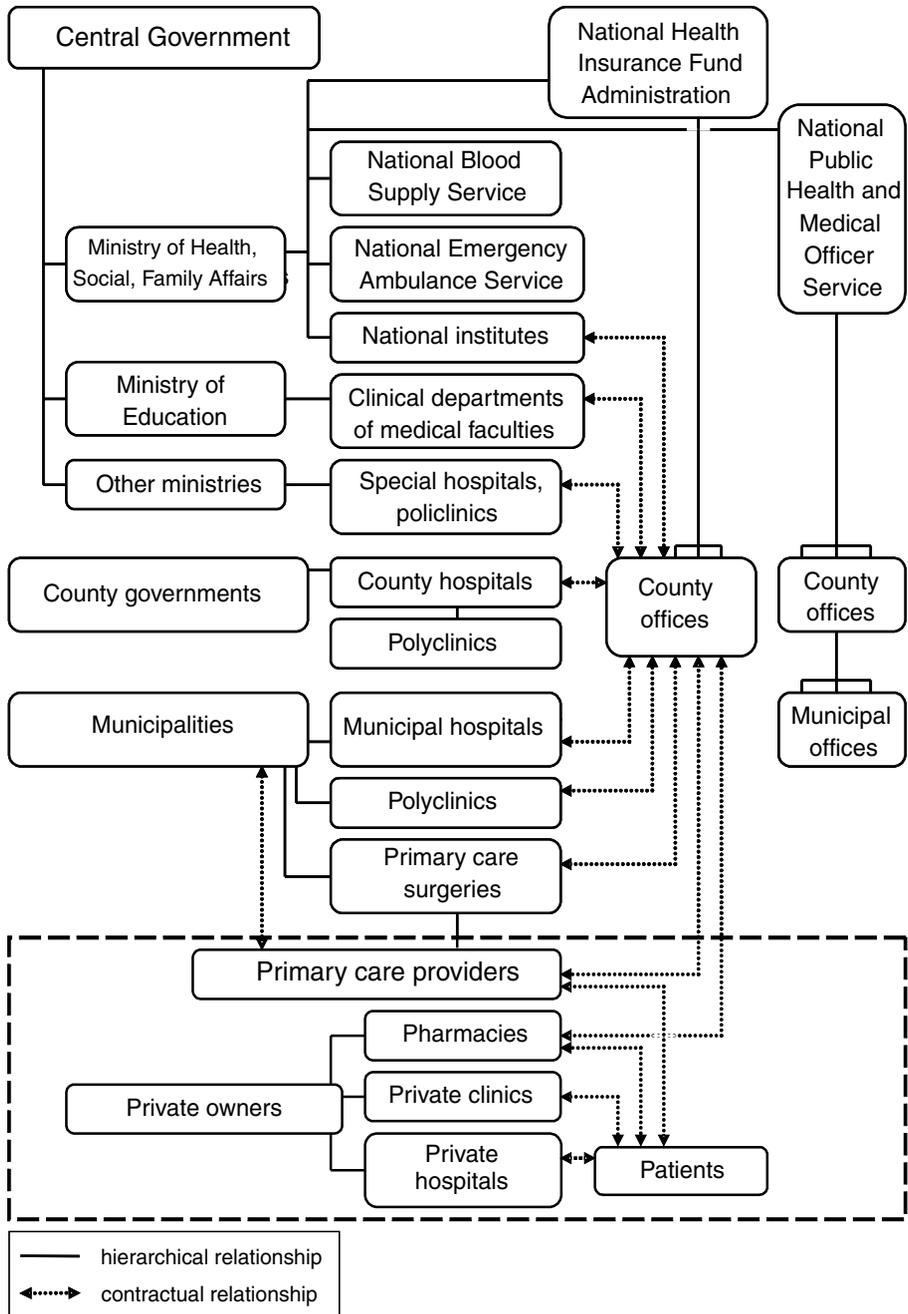
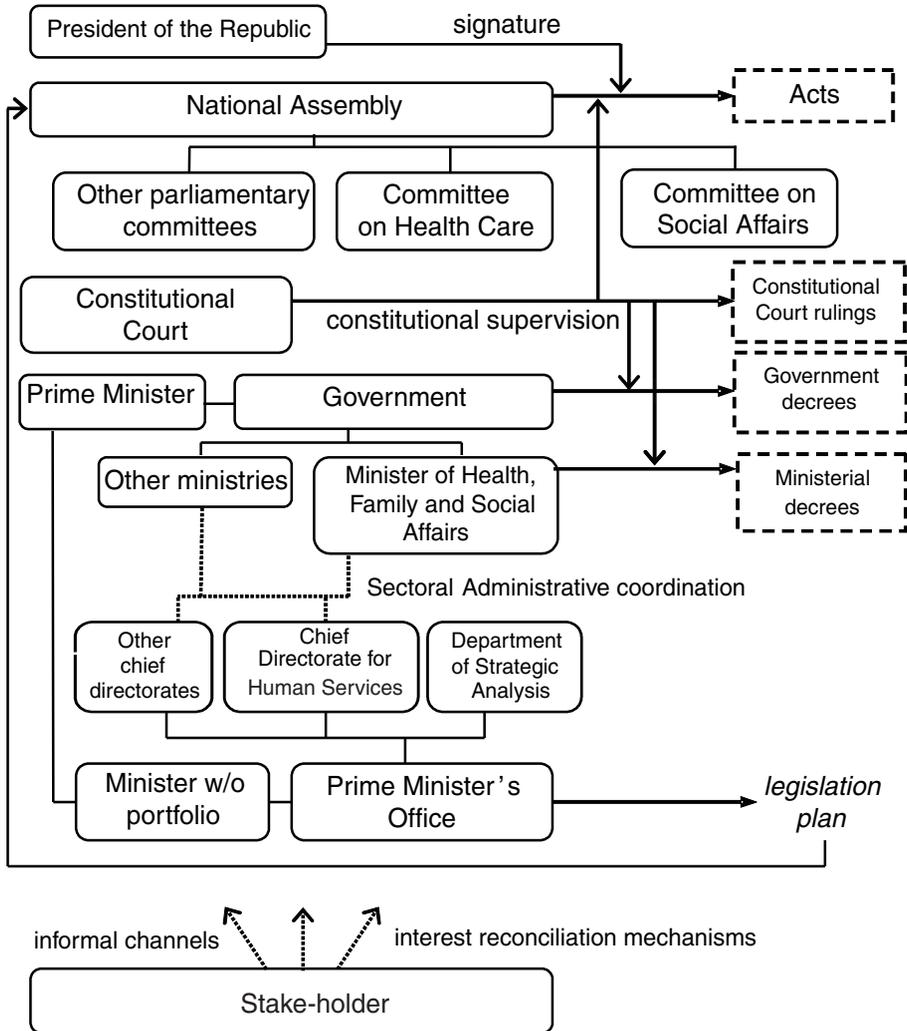


Fig. 3. National-level decision-making process on health care reforms, 2003



The National Assembly

The National Assembly is a key actor in national level decision-making of all areas of public policy, including health. By passing laws, the parliament decides for instance the final size and sub-budget divisions of the HIF, or provider payment methods. In each year the National Assembly votes on the HIF's

planned budget, and has to approve the final expenditures in the following year. The National Assembly also decides annually on the contribution rate to the HIF. While most decisions of the parliament require a simple majority, those pertaining to fundamental democratic institutions, such as local governments, require a two-thirds majority. This provision of the Constitution limits the discretion of the government on health care reform, if the planned changes would require the amendment of any of the fundamental laws.

The parliament debates, proposes amendments and votes on bills, which are prepared and submitted for approval by the government on the basis of the policy framework set by the overall governmental policy. First, the relevant parliamentary committees discuss the submitted bill, before it can go on to the plenary sessions of the National Assembly. Passed bills are promulgated as acts, on the basis of which governmental and ministerial decrees are issued, which regulate the implementation of the provisions of acts in detail. The President of the Republic must sign acts before they are promulgated and has the right to send them back to the National Assembly 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 (1989/3). Constitutional rights are also protected through the institution of the parliamentary commissioners or ombudsmen, who can investigate any abuse of these rights (1989/3).

Fig. 3 summarizes the current national-level decision-making process through which any major reform of the health care system must pass.

National government

The national government (or central government) formulates health policy and is also the most important regulator of the health sector. On the basis of the provisions of *Act CLIV of 1997* a new body, the National Health Council, was established in 1999 to advise the government on health policy, promote consensus on health priorities, thereby facilitating implementation. The members, with a four-year mandate, are representatives of the relevant stakeholders such as professional and patient organizations, unions and local government representatives (1997/16, 1998/25).

Since the separation of the Social Insurance Fund from the government budget (1988/2) and the “fund exchange” in 1990 (1989/5), the national government is no longer the dominant financier or supplier of health services. But it keeps control over health financing, resource allocation and payment together with the parliament and through direct control of the purchasing organization, the NHIFA. However, this does not mean that the government

has no significant direct financing roles in the health sector, since the national government has the responsibility for:

- financing high cost, high-tech interventions, public health, emergency ambulance and blood supply services, health sciences education and research (1997/16, 1998/3);
- partially covering capital costs by providing local governments with conditional and matching grants for renovating health care facilities, replacement of equipment and new investment, via the so-called “earmarked and target subsidies” (1992/8);
- transferring the so-called hypothecated health care tax to the HIF to compensate the social health insurance scheme for non-contributing groups (1998/17, 1997/8);
- covering the HIF deficit (1997/8);
- covering the co-payment for certain medicines, medical aids and prostheses for inhabitants with low incomes, defined by means testing (1993/1);
- giving tax rebates on the purchase of voluntary, non-profit health insurance (1995/9).

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

- directly providing public health services through the National Public Health and Medical Officer Service, emergency services through the National Emergency Ambulance Service and blood products through the National Blood Supply Service;
- supplying mainly tertiary health care through medical universities and national institutes of health;
- providing undergraduate and postgraduate health sciences education, partially continuing education and research by medical faculties of universities and the Institute for Basic and Continuing Education of Health Workers of the Ministry of Health.

Responsibilities for this wide variety of tasks are divided among ministries according to various governmental decrees and recently redefined by *Act XI of 2002 on the Enumeration of the Ministries of the Republic of Hungary* (2002/11). The primary responsibility for health services remains with the Ministry of Health (2002/13), but other ministries are also involved in service delivery and health care financing. The latter includes control over the NHIFA, which has been circulating among the Prime Minister’s Office, the Ministry of Finance and the Ministry of Health since 1998, when the government restored

its supervision over both the HIF and its pension counterpart (1998/13, 1998/14, 1999/4, 2000/10).

Prime Minister's Office

The Prime Minister's Office coordinates government legislation (Fig. 3). After the 1998 general elections, it was strengthened and restructured with the establishment of "reference centres" according to a chancellery model (1998/15). Reference centres, including the Reference Centre for Health and Social Policy, were responsible for sectoral administrative coordination. The reference centre structure has been somewhat modified under the present government, and reference centres were renamed to "chief directorates", headed by "chief officers" (Fig. 3). Chief officers are responsible for the coordination of a number of areas of government policy, one of them is human services, which includes health care and social services.

After its reorganization in 1998, the Prime Minister's Office had assumed an active role in health policy-making for a year. It became responsible for the control of the NHIFA and the administration of the Pension Insurance Fund (1998/14). The secretariat, headed by a political secretary of state, was established in 1998 and produced a proposal for the introduction of competing health insurance funds, parallel to a counter-proposal by the Department of Strategic Analysis of the Prime Minister's Office and one by the Ministry of Health. Eventually, the proposal of health insurance competition was dropped and the control of social insurance administration was transferred to the Ministry of Finance in 1999 (1999/4). In 2001 the minister of health managed to retrieve the control of the NHIFA (2000/10), and the Prime Minister's Office lost its prominent role in health policy making for a while. Nonetheless, the new prime minister, has appointed a governmental commissioner, responsible for the strategy and coordination of health sector reform (2003/15). Currently, several reform committees work on reform proposals aimed at determining the necessary changes in the organization and financing of health services, with special emphasis on the so-called "Care Coordination Pilot" (see section on *Financial resource allocation*).

Ministry of Health, Social and Family Affairs

In 2002, the present government made the Ministry of Health, Social and Family Affairs responsible for the health and the social sectors (2002/11). The new ministry was established by merging the former Ministry of Health and Ministry of Social and Family Affairs, which had been acting separately from 1998 until 2002 (1998/12). Thus, the government has returned to the earlier division of

tasks, as the Ministry of Welfare had the same joint responsibility between 1990 and 1998. The ministry responsible for the health care sector (called Ministry of Health in the following text) has all along shared responsibility with the Ministry of Education concerning health education and training and with the Ministry of Finance and the Ministry of the Interior concerning financing of health care.

The Ministry of Health's dominant role of managing the health care system was confirmed by the *1997 Health Act* (1997/16). The main functions of health policy formulation, coordination and regulation are carried out by a number of institutions under the direct control of the minister of health, social and family affairs (later referred to as minister of health). Beside these administrative functions, some of these institutions provide health services themselves including public health, emergency ambulance service, blood supply, tertiary care services and rehabilitation (Fig. 2). Since January 2001, the minister also controls the NHIFA directly.

The National Public Health and Medical Officer Service (NPHMOS) is one of the most important agencies of the Ministry of Health. The NPHMOS provides public health services, including the traditional public hygiene and infectious disease control, disease prevention and health promotion. It is also the central authority of the implementation, control and enforcement of regulations, including the registration and licensing of health care providers. The NPHMOS is responsible for monitoring the quality of health services. In addition, it used to participate in formal capacity-planning until this was abolished in 2001, although chief medical officers still have a say in capacity changing initiatives of local governments (2001/5). The NPHMOS was formed in 1991 on the basis of the State Supervision of Public Hygiene and Infectious Diseases (1991/1). It is headed by the national chief medical officer, who is appointed by the minister of health. The NPHMOS has a national office, and offices at county and municipal levels. It has national institutes as well.

Blood and blood products and emergency ambulance services are provided by national organizations. The National Emergency Ambulance Service has a long history in the Hungarian health services, providing emergency ambulance services and patient transfers over the whole country, financed by the HIF (1996/13). The National Blood Supply Service was established in 1998 through the reorganization of blood supply units of hospitals (1998/9). The cost of blood and blood products are covered from the HIF.

Institutes and various advisory bodies assist the Minister of Health. Some of them provide expert input in a particular medical specialty, like the national institutes of health and the professional colleges (1989/1, 1999/9), while others deal with a particular area of all specialties, like science and policy issues, or

education, such as the Health Care Scientific Council (1989/2, 2003/2), or the recently established Health Care Professional Training and Continuing Education Council (1998/19). Professional colleges are advisory boards, whose members are elected from the leading consultants of particular medical specializations, by and from the members of a so-called election body, which comprises the delegates of the Hungarian Medical Chamber, the relevant scientific associations and the medical schools. Currently there are 37 professional colleges, from internal medicine to neurosurgery (1999/9).

The national institutes of health are the methodological centres of their particular medical specializations (1997/16). They supervise and support clinical work across the country, undertake continuing education, scientific research and in certain cases prevention activities and patient care, usually highly specialized, tertiary care services for the whole population of the country. National institutes issue clinical guidelines, setting 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 Neurosurgery. Their clinical work is financed from the HIF, while other activities are covered by the central government. The Ministry of Health also runs six state hospitals, mainly sanatoria for medical rehabilitation. They accept patients from the whole country and are partly financed from the HIF.

There are certain national institutes that carry out special administrative duties. The Information Centre for Health Care of the Ministry of Health has piloted and still runs the system of provider performance measurement, on the basis of which service providers are paid (1987/1). The National Institute of Pharmacy operates registration and licensing of pharmaceuticals (1982/1). The newly established Authority for Medical Devices of the Ministry of Health runs a similar system for medical equipment, including medical aids and prostheses (2000/4). The Authority has replaced the Institute of Hospital and Medical Engineering, which was renamed and continues as one organization of quality control and audit in this area (1990/2). Both registration and licensing systems have recently been harmonized with the practice of the European Union (1998/2, 1999/7).

The Ministry of Health has a limited role in education and training via two further training institutes, which provide courses for non-medical health professionals, e.g. the Institute for Basic and Continuing Education of Health Workers. The Ministry of Health is primarily responsible for the coordination and supervision of professional training, while secondary and higher education in health sciences rests with the Ministry of Education.

Ministry of Finance and the Tax Office

The Ministry of Finance is responsible for fiscal policy and the state budget including the national government budget, the local government budget and the HIF. It is mainly concerned with the macroeconomic implications of health care financing, particularly the impact of any deficit of the HIF on fiscal balance, because the government is obliged to cover this. Since the separation of the social health insurance from government budget in 1989, the government is not allowed to use the resources of the HIF for non-health-care related purposes. It also had less discretion over budget allocation and spending decisions until the self-government of the NHIFA was abolished in 1998 and central government supervision was fully restored (1998/13). However, the control of the NHIFA has been unsettled inside the government. The Ministry of Finance took over responsibility from the Prime Minister's Office in 1999, but passed it to the Ministry of Health in 2001 (1999/4, 2000/10). The Tax Office has taken on the function of collecting social insurance contribution since January 1999 from the NHIFA and has been performing this function ever since.

Ministry of Education

The Ministry of Education and the Ministry of Health jointly supervise higher education institutions in health. Before the *1993 Act on Higher Education*, the Ministry of Health was responsible for medical universities and their health services (1993/8). Then the minister of education took over this 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 financier, coordinator and supervisor of health research and development. Notably, neither of the ministries can interfere or restrict the autonomy Hungarian higher educational institutions enjoy in education and research.

Hungary used to have five independent academic medical schools, two in Budapest, and one each in Debrecen, Pécs and Szeged. In line with the government policy, they have been integrated as medical faculties into large multi-faculty universities, except for the institutions in Budapest. In 2001, the two Budapest medical universities merged with the University of Physical Education, establishing the Semmelweis University (15).

Other ministries

Three large ministries have retained their health care facilities, hence they are involved in the provision of care (Fig. 2). 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 Economic Affairs and Transport (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 delivery of health services with the provision of giving priority to railway workers and their dependants (1994/2). The Ministry of the Interior and the Ministry of Defense have their own health care services for inpatients and outpatients, but special rules restrict utilization by the general population. According to the general principles applied in health care financing, the ministries cover capital costs of services, while recurrent costs are financed from the HIF. Ministry of Justice health services for prisoners are totally separate from the main system of provision.

The Ministry of the Interior deals with issues for local governments, which are the owners of most primary and secondary care facilities. Among others, the ministry administers the allocation of capital grants for health care equipment and buildings to local governments (1992/8).

National Health Insurance Fund Administration

The Health Insurance Fund (HIF) is the most important source of financing of the recurrent costs of health services, and provides cash benefits such as sickness allowances. The HIF is separate from the government budget. The government cannot use any surplus of the HIF for other purposes, but is obliged to cover any deficit (1997/8). The NHIFA was responsible for the collection of health insurance contributions until the end of 1998, when the revenue collection function was moved to the tax authority (1998/24). Since the beginning of 2001 the Ministry of Health has been controlling the NHIFA, which has branches at the county level to administer contracting and payments to local health care providers, but budgets are not decentralized to the county level.

The present structure has evolved gradually. Some elements of social insurance had persisted during the communist era: payroll-related social insurance contributions were collected, and cash benefits were administered via the National Social Insurance Administration of the National Council of Trade Unions. This structure formed the base upon which the HIF was built. *Act XXI of 1988* on the Social Insurance Fund separated the Social Insurance Fund from the government budget (1988/2). In 1989, before the end of the reform communist era, financing of health services was transferred to the Social Insurance Fund, in the frame of the so-called fund exchange (1989/5). From 1990 until 1992, the Social Insurance Fund comprised both health and pension insurance, jointly operated by one administration. But in 1992, the Social Insurance Fund was divided into two separate funds: the HIF and the Pension

Insurance Fund (1992/2). Changes in fund administration followed somewhat later in the middle of 1993, when the NSIA was divided into the NHIFA and the National Pension Insurance Administration (1993/7).

The changes in the supervision of the funds and the control of their administration reflect the struggle between the original reform intention, motivated by the distrust in government, and the effort of the democratically elected governments to gain full control over health spending. *Act LXXXIV of 1991* defined quasi-public bodies for the supervision of social insurance funds, the so-called self-governments, which consisted of representatives of employers and employees (1991/5). The Health Insurance Self Government and its pension counterpart began to operate in 1993, after the general population, that is, the insured, elected employee representatives from candidates of various trade unions, while employer representatives were delegated by employer associations (1993/3). Until the new bodies were formed, first the minister of welfare (1990/1), and later a ten-member parliamentary committee exercised the supervisory rights (1991/5).

The new quasi-public government bodies were granted extensive rights over budgetary decisions and given a veto on government decisions on social insurance. Between 1994 and 1998, the government tried to curtail these rights and restructured these bodies (1996/2, 8, 1997/4), but the process was found unconstitutional (1998/4). The next government abolished the Health Insurance Self Government and its pension counterpart in 1998 and restored government supervision of the social insurance funds (1998/13). Within national government, control of the NHIFA was first passed to the Prime Minister's Office (1998/14), then to the Ministry of Finance (1999/4), and finally back to the Ministry of Health (2000/10).

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. Although national policy determines the broad framework for local policy, the Constitution guarantees the discretion of local governments on local affairs, which cannot be overruled by national authorities (1989/3).

Act LXV of 1990 on Local Governments defined the basic structure, rights and duties, sources of funds and properties of local governments. The municipal and county governments share responsibilities on the basis of the principle of subsidiarity. This means that county governments only take over public services

that municipal governments cannot undertake and are willing to transfer to the county level (1990/3).

The 1990 *Local Government Act* assigned responsibility for local health services to local governments, implying that they should plan health services for the local needs. Responsibility for primary care rests with municipalities and that for secondary care with counties, but they are allowed to contract out service delivery to private providers. There is a large proportion of primary care contracted out to entrepreneur family doctors (under the scheme of the so-called functional privatization), and a smaller segment of secondary care contracted out mainly to a few church-owned hospitals. These providers have two types of contracts: one with the local government, in which they take over service provision, and the other with the county offices of the NHIFA, to become eligible for HIF funding (Fig. 2).

The same act transferred the ownership of the bulk of primary care facilities, polyclinics and hospitals from national to local government (1990/3). As a result, local governments have become the main health care providers in the Hungarian health care system. Municipalities usually own primary care facilities, and depending on the size of the municipality may own and run outpatient clinics and municipal hospitals. County governments usually own large county hospitals that provide secondary and tertiary care. Local government-provided health services are financed from the HIF, except for capital costs which, as owners of health care facilities, local governments have become responsible for. Since capital costs are usually higher than the revenue capacity of local governments, the national government provides conditional and matching capital grants via the system of “earmarked and target subsidies” (1992/8). It is often argued, however, that even local and central funds together are not sufficient to cover capital costs, thus threatening the long-term sustainability of the system.

Professional organizations, associations and unions

Voluntary association was restricted until the second half of the 1980s, except for trade unions, which were kept under tight control. During the collapse of the communist regime, the health sector trade union of the communist regime lost its monopoly, and several unions were established, the largest being the Health Workers' Democratic Union. A notable feature of the last decade has been the rapid growth in the number of other voluntary organizations as well, some of which are not just simple interest groups, but have been delegated regulatory functions that used to be under direct governmental control before.

The Hungarian Medical Chamber, abolished by the communist regime, began to function again in 1988, initially on a voluntary basis. *Act XXVIII of 1994* on

the Hungarian Medical Chamber made membership compulsory for practicing physicians and dentists and defined the structure, tasks and responsibilities of the medical chamber, including issuing a code of ethics for medical practice (1994/1). The Chamber can discipline those who violate its rules, and has the right to express opinion on a range of medical issues and to veto contract conditions between medical doctors and the NHIFA. The Hungarian Chamber of Pharmacists was also established in 1994 (1994/4).

In 2003, the current government decided to extend professional self-regulation to other qualified health care workers with the establishment of the Chamber of Non-medical Health Professionals (2003/13).

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

Patient associations are growing in number and influence. In 2000, there were over 80 organizations active in various fields of health and health care (16). They represent the interest of patients at pharmaceutical price negotiations, for example. Their participation has been institutionalized in waiting list committees, in the National Health Council and in hospital supervisory councils (1997/16, 1998/22, 1998/23, 1998/25).

Private and voluntary sector

Private medical practice was not forbidden under the previous regime, but employment or enterprise on a completely private basis was not allowed (1972/2). *Decree No. 113/1989 (XI. 15.) MT on Health Care and Social Enterprises* opened the way for private enterprise. Although legal since 1990, the private sector is still limited, especially in inpatient care. For instance, there is only one small private for-profit hospital in the whole country.

The growth of the private sector has several obstacles. First, the NHIFA does not contract with private providers except family practices, pharmacies and in specialties with shortages, such as some diagnostic services and kidney dialysis. Second, the NHIFA does not cover capital costs of services. Third, the current legislation on social health insurance does not allow providers to charge extra for treatment covered by social health insurance, except for above standard hotel services (1997/9). In the absence of NHIFA funding, private providers have to rely on out-of-pocket payments and private health insurance, but these income

sources are restricted by certain legislation and by most citizen's inability to pay for expensive medical care, or risk-adjusted insurance premiums.

Act XCVI of 1993 on 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. However, voluntary health insurance funds have not been allowed so far to offer benefits covered by the HIF (1993/10). Non-profit health insurance is regarded as complementary to social health insurance. Private for-profit health insurance policies so far have offered only cash benefits in case of illness, except for a couple of recent pilot schemes.

Finally, donations and charities are growing in number, but so far constitute a very minor source of funds to the health sector. In 1996, there were 337 non-profit associations and 1536 charities in the area of health, 9% of all charities in Hungary (17). The only exception of significant private sources is occupational health care, which is to be financed by the employer since 1995, but it is a small and special segment of the health sector and large employers usually maintain their own service (1995/5) (Table 4).

Currently, the proportion of private providers exponentially decreases with the level of specialization in health care. In primary care more than 85% of working medical doctors were private entrepreneurs in 1999 (9). Since 1992 primary care doctors can choose to work as private entrepreneurs under contract with local governments and the NHIFA. The building and equipment remain the property of the local government, which is responsible for covering capital costs, while the family physician receives capitation payment from the NHIFA to run the practice (1992/3, 4). This scheme is called "functional privatization". Some primary care is provided entirely privately, with or without contract with NHIFA, and by the end of 1997 all state-owned pharmacies serving the general public were fully privatized (1). In secondary outpatient care many physicians offer part-time private clinics in addition to their public sector employment. In addition, some private polyclinics have been established, where patients pay for services out-of-pocket.

A few hospitals have been returned to their original church owners or are run by a charity. These hospitals are integrated in the public system in so far as they contract with local governments to provide services for the local population and are eligible for capital grants from the government budget. Altogether the Hungarian private inpatient care sector is insignificant, since private beds were less than 1.5% of all beds in 1999 (9).

The role of private provision of specialist services in the Hungarian health care system is unsettled at the moment. The last measure of the government of 1998–2002 was to elaborate regulations encouraging the transformation of

public health care institutions (2001/11) into non-profit corporations. The aim was to release health care institutions from civil and public service regulations without forcing ownership changes. Although the general legal framework of so-called non-profit corporations was enacted in 1993 (1993/9), only few of these corporations have been established so far in the area of health care (17).

Nevertheless, the present government elaborated new, less restrictive regulations (2003/3), which were later on annulled (2003/17). Thereby, the legal situation prior to 2001 came into effect again when ownership changes were governed by the general legal framework only.

Planning, regulation and management

Health care reforms in the 1990s transformed the Hungarian health care system into a split purchaser-provider contract model. Moving away from the integrated state-socialist health services the two crucial steps were (a) the establishment of the HIF, its quasi-public supervision, the Health Insurance Self Government, and its administration, the NHIFA, which acts as the purchaser, and (b) the transfer of the responsibility for service provision and the ownership of the majority of health care facilities to local governments, which act as providers. The decentralization of both the purchasing and service delivery function initially left the government with the regulatory role only. The expectation was that local government would plan for local health needs and would get rid of the legacy of excess capacity without direct intervention from the national government. For a number of reasons this did not happen. The most important among these was not the lack of administrative capacities in health planning, but the political consequences of closing down a hospital, in certain cases the biggest employer in town.

Governments reacted in two waves, both of which were targeted at the purchaser's side. First, between 1994 and 1998, the government regulated the capacities the NHIFA was allowed and obliged to contract for. Initially, the minister of welfare was appointed to make the downsizing decisions (1995/6), but this was later found unconstitutional, because of the ad hoc nature of the decision making process (1995/8). *Act LXIII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms* approached the problem in a more systematic manner, and defined capacities in terms of outpatient specialist consultation hours and hospital beds per county according to a need-based formula (1996/3). These capacities became the definition of local governments' responsibility for health care provision, the so-called territorial supply obligation.

Second, the next government got full control over the purchasing function when they abolished the self governments of the social insurance funds (1998/13). In fact, the government has never lost control of health care financing, since the budget and sub-budgets of the HIF have always been approved by the parliament, and new investments have always been controlled through the system of so-called earmarked and target subsidies. By cutting out negotiations, this just made the government's purchasing decisions, such as controlling pharmaceutical expenditures, easier to implement (1998/24). Currently, revenue collection, budget-setting, financial resource allocation, contracting and payment are all controlled by the government, but these tools have rarely been used beyond cost containment, for instance for selective purchasing.

The responsibility for planning for local health needs has remained with local governments and local planning capacities are increasing. For example, the Health Plan of Pécs initiative, built on the principle of voluntary participation, has been taken up by others. A network of municipalities with health plans has been created. Some of them are also members of the Hungarian Association of Healthy Cities, an initiative of the World Health Organization (WHO). Since January 2002, local governments enjoy somewhat more flexibility to decide on service provision, since the national government has repealed the *1996 Capacity Act* (2001/5). Local governments still have the obligation to provide capacities of the 2001 status quo, but they are allowed to decrease and restructure capacities according to local priorities, if these decisions are approved by the local county chief medical officer of the NPHMOS. They can even expand local health care provision, but any expansion must be approved by the Minister of Health and the Minister of Finance.

Apart from the financial planning cycle and the *1996 Capacity Act*, the national government does not determine the inputs or outputs of the health sector, since the formal central planning system of the previous regime was abolished. The government does plan, however, for public health. The National Health Promotion Programme should be prepared by the government, accepted by the National Assembly and revised every four years (1997/16).

In 1994, the government set targets for health promotion in its long-term strategy, and later set up an intersectoral body to help achieve these targets (1994/3). The government overruled this initiative in 2001, when its ten-year public health action programme – titled “Healthy Nation Public Health Programme 2002–2010” – was accepted and published, aiming to increase life expectancy of men and women to 70 and 78 years respectively (2001/8). The present government decided to expand and update the programme (18), and the National Assembly approved the “Johan Béla National Programme for the Decade on Health” in 2003 (2003/1).

As mentioned, regulation is the prime responsibility of the government and relevant ministries but other actors, such as professional chambers, national institutes, and the NPHMOS are also involved. In Hungary, all aspects of the production process are regulated except for the quantity of most services. Concerning health care inputs, human resources, medical devices and facilities are extensively regulated.

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

- control of the number of health personnel to be trained by determining the number of students financed from the government budget (1998/3);
- control of recognition of foreign diplomas (1993/8, 1972/2);
- compulsory registration and licensing of health workers through the Ministry of Health, the professional chambers and the Institute for Basic and Continuing Education of Health Workers of the Ministry of Health (1998/10, 1999/5);
- regulation of the number of primary care practices with the introduction of the practice right (2000/1, 2000/2);
- determination of the minimum salary of public employee health workers (1992/5);
- regulation of the behaviour of health care workers including rights, duties and ethical considerations (1972/2, 1994/1, 1997/16).

Pharmaceuticals and medical devices, including medical aids and prostheses, fall under a registration and licensing system administered by the National Institute of Pharmacy and the Authority for Medical Devices of the Ministry of Health (1982/1, 1998/2, 2000/4). Prescription and prices are also regulated, including the wholesale and retail price margins, but these regulations do not apply to pharmaceuticals purchased by health care providers (1995/1, 1995/2, 1999/6, 2001/2, 2001/6, 1999/7, 2000/5).

Health care providers must obtain a licence to practice from the NPHMOS, which maintains the registration database (1989/4, 1996/4, 1997/7). Before issuing the licence to any provider, medical officers inspect the facilities and ascertain whether the minimal building, hygienic requirements, personnel and material standards are fulfilled, as set by *Decree No. 21/1998. (VI. 3.) NM* of the Minister of Welfare (1996/5, 1997/3, 1998/7). Separate or special rules apply to a number of services, such as primary care (2000/3), home care (1996/6), patient transfer (1998/5), emergency ambulance services (1998/6), human fertility treatment (1998/11), sterilization procedures (1998/8) and organ transplantation (1998/21). The provision of non-conventional medical treatment is also regulated including the scope of activities, and educational, infrastructure

and administration requirements (1997/1). All health care providers are obliged to be covered by liability insurance to enable them to compensate patients appropriately in justified malpractice claims.

Health services are supervised by the NPHMOS. Regular monitoring of providers includes checking personnel and material minimum standards and the quality of provided services (1993/4). The system consists of supervisory chief medical doctors at the municipal level for primary care, and at the county and in some cases regional level for various medical specialties. The county and municipal chief medical officers appoint supervisor chief medical doctors, in collaboration with the professional colleges and national institutes of health.

In the frame of social health insurance reimbursement prices and utilization, including the scope of benefits, referrals and waiting lists are also regulated. Patient rights are regulated extensively in the *1997 Health Act*, which has established institutions for the safeguarding of these rights and for resolving disputes, namely the patient rights representative and arbitration (1997/16, 1999/10, 2000/9).

Decentralization of the health care system

The organizational structure of the Hungarian health care system has changed considerably since the end of the 1980s. Health sector reform at the beginning of the 1990s sought to move away from central government control. Hence decentralization was the dominant tendency throughout the restructuring process and the health care sector has become more pluralistic, with responsibilities divided among several organizations. But since the mid-1990s, governments have restored some measures of central control, mainly in order to control health spending. At present, health services are still primarily publicly financed and provided, but the role of the national government as the direct funder and provider of services has decreased, which implies more extensive regulation.

Devolution, delegation and deconcentration

Health policy-making and regulation have remained with the national government, while some functions have been delegated to quasi-public organizations, and others have been deconcentrated. For instance, the regulation of the medical profession was partly delegated to the Hungarian Medical Chamber. Supervision of financing of health services and control of the purchasing organization, the NHIFA, was delegated to the Health Insurance Self Government in 1993, but the national government reassumed supervisory powers in 1998. Within the

NHIFA, decision-making powers and budgets were kept at the national level, while the administration of contracting and payment was deconcentrated to the county level (Fig. 2).

In 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, which became the dominant providers in the Hungarian health care system. The early structural reorganization of the health sector, which laid down the basis of the current purchaser-provider split model, was supported by all major political parties, but there is no consensus on the future direction of decentralization either on the financing or the delivery of health services.

Regionalization

The lack of consensus about decentralization in recent Hungarian health care policy is reflected by the pilot status and repeated redrafting of regionalization programmes. Initiatives for regionalization, which was first raised in the last year of the government of 1994–1998, have addressed aspects of planning, financing and/or delivery of health services. A regional health service modernization project was launched in 1998 within the frame of the Health Services and Management World Bank project. All the seven regions of Hungary set up project teams and elaborated health services development plans, the best of which was to receive substantial financial support for implementation. Although the tendering procedure was completed and the winner was announced, the project was abolished when the next government stepped in during the course of 1998. Instead, a regional reorganization project of the NHIFA was launched with the aim of creating the organizational conditions of health insurance competition, but finally abandoned when the government decided to preserve the single payer system. The present government has revitalized the idea of regional planning and development. The Ministry of Health provides financial support for the establishment of regional health councils and for the elaboration of regional health plans on a voluntary basis (2003/9).

Competition on the financing side

While the proposed changes do not include the establishment of multiple health insurance funds, decentralization of the HIF and the NHIFA have long been on the political agenda, and the issue is unsettled. The first proposal of this kind was also elaborated under the government of 1994–1998 by the Ministry of Finance, and aimed at the abolishment of the monopoly position of the NHIFA.

The idea of competing health insurance funds remained on the agenda in the first year of the next government, but it was dropped in 1999.

It is not yet known whether the decision to preserve the single payer system within social health insurance will be reinforced or overturned by the present government. The debate is currently about the expansion of the Care Coordination Pilot, which could potentially be developed in either direction.

Privatization of providers

Although the legal background of the three privatization options – ownership privatization, functional privatization and corporatization – was created in the early 1990s, significant privatization has taken place in primary care only, including the functional privatization of family doctor services and the real ownership privatization of pharmacies. A few hospitals have been given back to their original church owners and are run on a non-profit basis, but the majority of providers of specialist health services remained in local government ownership.

The privatization of specialist health care institutions is another unsettled question. The biggest obstacle to ownership privatization is not at all legal, but financial. The NHIFA is a monopsonistic purchaser that has rarely contracted private providers, but even if it had, it does not reimburse the capital costs of services. It is irrational to expect private investment if depreciation is not covered, not to mention return on capital. Functional privatization is able to handle this problem, but separates investment decisions from utilization, which may result in inefficiencies in service delivery. Corporatization does not imply ownership changes, but removes public health care institutions from public service regulations. Although legal since 1994 (1993/9), it has not been popular so far. The bulk of local and national government owned hospitals and polyclinics are still managed according to public service regulations. For instance, medical doctors and other health workers are mainly public employees, whose remuneration, hiring and firing are strictly regulated (1992/5).

Until 2001 changes in the legal status of health care providers occurred sporadically for local initiation within a general framework of national laws and regulations. At the end of 2001 and in the first half of 2002, the government created health care specific rules for ownership changes, corporatization, contracting out of service provision and freelance medical practice (2001/11, 2002/3, 4, 5, 6, 7, 8, 9, 10). These measures were intended to encourage more autonomous functioning of public health care providers. It was expected that provision of health care services would consequently become more efficient. Nevertheless, these regulations introduced certain constraints of the

transformation process. First, ownership privatization was bound by legal asset specificity, that is, health care institutions could not be sold off for non-health care purposes. Second, the provision of specialist health services could not be contracted out to for-profit providers. Third, subcontracting was allowed, but subcontractors were not allowed to subcontract provision further. Fourth, those who had business interests in the production and trade of medical supplies (including pharmaceuticals, medical aids and prostheses) were excluded from both the contracting and the subcontracting of publicly funded service provision.

The present government has different views on privatization and suspended most of these clauses (2002/15, 2002/16), and later on the National Assembly repealed the act altogether (2003/4). In line with the policy of the present government the parliament debated and accepted a less restrictive new bill in two rounds. The essence of the new act was to create more chance for private investment in health care, and therefore it removed most of the above restrictions concerning the entity of private investors (2003/3).

In addition, the government encouraged for-profit investment by guaranteeing fair return on capital. Although depreciation was not explicitly addressed in the act, its plan was to introduce the depreciation of capital costs into social health insurance financing gradually, along with the appearance of new, private investors. The effect of the new legislation, however, could not unfold, because the constitutional court annulled it for procedural reasons, as there was not enough time available to implement a meaningful second round of discussion (2003/17). Currently there are no health care specific regulations for the corporatization and/or privatization of service providers and the issue has remained unsettled at least for a while.

Health care financing and expenditure

In 2001, Hungary spent 6.8% of its gross domestic product (GDP) on health. Seventy-five per cent (75%) of total expenditures on health were financed from public sources (54,19) (Fig. 5 and Fig 7). Public sources of health care finance consist of revenues from general and local taxation, but more importantly from contributions to the social health insurance scheme, which since its establishment in 1990 has been operating nationwide as one single fund, the Health Insurance Fund (HIF). The social health insurance scheme provides nearly universal coverage and a comprehensive benefit package with few exclusions and little or no co-payment except for pharmaceuticals, medical aids and prostheses and balneotherapy. In 2000, the HIF spent 63% of total expenditure on health (Table 4). The revenue of the HIF is derived mainly from the health insurance contribution, a proportional payroll tax, paid partly by the employers and partly by the employees. The other revenue source of the HIF is the so-called “hypothecated health care tax” (included in data on social health insurance in Table 4), consisting of two components: a lump sum tax and a proportional tax. The latter is levied only on those types of income which are not subject to social insurance contribution (Table 5).

General and local taxes made up 12% of total expenditure on health care in 2000 (Table 7). While the HIF finances recurrent expenditure, national and local government finance nearly all investments in outpatient as well as inpatient care. Nonetheless, the national government still pays for recurrent expenditures of certain special services, such as high cost, high technology and public health services, and covers co-payment for residents with very low income. Private sources of finance accounted for 24% of total expenditures on health in 2000. They consist mainly of out-of-pocket expenditures, which accounted for 21% of total expenditures in 2000 (Table 8). The market for private health insurance

Table 4. Main sources of financing in the Hungarian health care system, 1991–2000

Source	1991	1993	1995	1997	1998 ^a	1999 ^a	2000 ^a
Public expenditure on health at current prices (billion Ft)	160.6	241.0	352.3	482.5	551.7	606.5	664.5
– Social health insurance ^b	131.6	189.7	282.0	399.4	460.2	508.3	557.3
– Taxes	29.0	51.2	70.3	83.1	91.4	98.2	107.2
Private expenditure on health at current prices (billion Ft)	19.6	34.7	67.3	111.1	142.8	170.2	215.4
– out-of-pocket (households)	19.6	34.7	67.3	111.1	121.3	146.9	187.3
– other private sources ^c	–	–	–	–	21.5	23.2	28.1
Total expenditure of health at current prices (billion Ft)	180.2	275.7	419.7	593.6	694.5	776.6	880.0
Public sources as % of total expenditure on health	89.1	87.4	83.9	81.3	79.4	78.1	75.5
– Social health insurance ^b (%)	73.0	68.8	67.1	67.2	66.3	65.4	63.3
– Taxes (%)	16.1	18.6	16.8	14.0	13.1	12.7	12.2
Private sources as % of total expenditure on health	10.9	12.6	16.0	18.7	20.6	21.9	24.5
– out-of-pocket payments (%)	10.9	12.6	16.0	18.7	17.5	18.9	21.3
– other private sources ^c (%)	–	–	–	–	3.1	3.0	3.2

Source: OECD Health Data, 2003 (20); ^aHungarian Central Statistical Office, National Health Accounts, 2002 (19).

Note: ^b includes hypothecated health care tax and the deficit covered by the central government; ^c includes enterprises, non-profit organizations and non-profit complementary health insurance.

is still insignificant, with 1% of private sources in 2000, and is limited to complementary health insurance.

Between 1991 and 2000, the public/private mix of health care financing shifted towards private sources in Hungary (Table 4 and Table 9). Whilst social health insurance financing dropped as a share of GDP from 5.3% to 4.3% (Table 6), and government spending on health decreased from 1.2% to 0.8% of the GDP (Table 7), the share of private out-of-pocket payments increased from 0.9% to 1.4% of the GDP (Table 8). Despite the increasing importance of private sources, the predominance of public over private spending and social health insurance over government financing has been preserved since the new system of health care financing started to operate in 1990.

The National Health Accounts, developed at first for the years 1998 until 2000 (19), is now considered the official source of health care financing and expenditure data in Hungary. It is based on the OECD health indicator system (21), and has basically been applied by the 2003 editions of OECD health data (20) and the WHO database (10) although there are still some discrepancies. The new version of the NHA, which comprises data for 2001, and some minor revisions for the period of 1998–2000, is expected to be published in the near future, but is not yet currently available. However, until the publication of the

National Health Accounts, both national and international sources provided divergent estimates for health spending and sources of finance (22,23,24,25) which, for example, were reported in the 1999 edition of the Health Care in Transition profile on Hungary (Table 9). The disparities of data originated mainly from difficulties to identify private and tax-financed expenditures, some of which have not been resolved entirely:

First, estimates of the magnitude of informal payment have varied considerably with different surveys and expert opinions. Figures ranged between 0.06% and 0.6% of the GDP (22,26,27,28,29,30). For instance, the World Bank estimated informal payment as 0.6% of the GDP between 1989 and 1996, which made up 7-11% of total health expenditures in itself (22). At the same time, estimates from the regular household budget survey of Hungarian Central Statistical Office were between 0.06% and 0.11% of the GDP (26,27,28). Based on this survey, the statistical office provides estimates which are adjusted to compensate for methodological problems and used for calculating the GDP, which still produces substantial differences (Table 8). The estimation of the magnitude of informal payment and other out-of-pocket expenditures still remains a matter of debate. Figures on out-of-pocket payments presented in Table 4 and Table 8 include conservative estimates of the Hungarian Central Statistical Office for informal payments (see the section on *Out-of-pocket payments*).

Second, the identification of government sources (especially local government expenditures) was another reason for conflicting data on health expenditure. For instance, estimates of the World Bank for entirely tax-funded services and capital expenditures range from 0.9% to 1.4% of the GDP between 1991 and 1996 (22), while the corresponding figures for the same period range between 1.1% and 1.8% in an OECD publication (23). The National Health Accounts has clarified the situation by identifying health-related expenditures by different ministries. However, local and national government capital expenditures can not yet be distinguished (see the section on *Taxation*).

Third, the sharp separation of social health insurance and national government sources has been debated. Some experts and health politicians have argued that it is not clear whether the financial resources that the national government transfers to cover the deficit incurred by the HIF and the hypothecated health care tax are a tax or social health insurance source. Following the approach of the National Health Accounts, Table 4 works with the assumption that all expenditures of the NHIFA are a social health insurance source, although since the fund's inception its expenditures have exceeded its revenues, and its deficit is covered from the central government budget (Table 6) (see the section on the *Main system of financing and coverage*). Nonetheless, the fact that a sizeable part of the HIF budget comes from the national government budget is still used

as an argument by those who would like to see Hungary return to the general tax financing of health services.

Fourth, it is worth noting that reform measures could change the share of sources of finance and the structure of health expenditures without any real spending increase or decrease (see the section on *Health care expenditure*). For instance, emergency ambulance and high cost high tech services were transferred from HIF to national government financing in 1998 (1997/9, 1997/16), and it is expected that depreciation of investments will be integrated into HIF financing during the present governmental period (18).

Main system of financing and coverage

Hungarian health care reforms of the past 15 years have transformed a primarily tax-based system to a social health insurance system. As one of the first countries in the central and eastern European region, the country reverted to the earlier Bismarckian model, which prevailed in Hungary before the Second World War. Since 1990 social health insurance has been the predominant source of health care financing (1989/5), providing coverage on the basic insurance relationship since 1992 (1992/1), yet local and general taxes have remained important as the main source of capital costs (31).

Currently *Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and on the Funding of these Services* sets out the rules of participation in the social health insurance scheme, and the entitlement for in-kind and cash benefits. Membership is compulsory for all citizens living in Hungary (that is, people with the personal identification card); opting out is not permitted. As a general rule, Hungarian minorities living in neighbouring countries are not entitled to health services in Hungary, but this does not mean that they were denied access to care in the past. For instance, charities organized and funded health services targeting these minorities. As of 1 January 2002 however, those who work in Hungary must participate in the social health insurance scheme. Members of Hungarian minorities who do not work in Hungary but utilize its health services can apply for reimbursement of actual expenses (2001/7).

The population is divided into three groups: (1) employees, (2) groups who are covered without contributing (1997/8) – including the dependants of the other groups and special groups such as pensioners, women on maternity leave, conscripts, people with very low incomes, and their dependants – and (3) all other inhabitants with personal identification card. Foreigners who work in Hungary for a longer period are not obliged to participate, but may do so

if they wish. Homeless people are also covered if they register with the local government as people very low income. As a result, population coverage is virtually universal with less than 1% of the population not covered. Health services are provided on the basis of a unique health insurance personal identification number (*TAJ*). However, there is currently no system allowing providers to check whether contributions have in fact been paid.

Table 5. Social insurance contributions and hypothecated health care tax, 1980–2002 (selected years)

	1980	1990	1996	1998	1999	2000	2001	2002
Social insurance contributions ^a								
Total (% of gross salary)	27–34	53	52.5	49	44	44	42	40
– employer	24	43	42.5	39	33	33	31	29
– employee	3–10	10	10	10	11	11	11	11
Of which:								
health insurance contribution								
Total (% of gross salary)	–	^b	22	18	14	14	14	14
– employer	–	^b	18	15	11	11	11	11
– employee	–	^b	4	3	3	3	3	3
Ceiling on monthly employee contribution (Ft)	–	^b	3000	4068	4632	4968	–	–
Hypothecated health care tax								
Lump sum (Ft/month)	–	–	–	2100	3600	3900	4200	4500

Source: Act (1975/1); Act (1997/8).

Notes: ^a Includes pension and health insurance contributions except for 1980; ^b Health insurance and pension contribution were not separated and the ceiling for the employee contribution was determined for the social insurance contribution as a whole; ^c Percentage of gross income not subject to social insurance contribution.

The health insurance contribution is proportional. It is determined by the National Assembly and for group 1 it is split between employer and employee. In 2002 the health insurance contribution was 14% of the gross salary: employers paid 11% and employees had to pay 3%, deducted directly from the gross salary (Table 5). There used to be an upper ceiling for the employee contribution. In 2000, the maximum monthly employee contribution was nearly Ft 5000. Since January 2001 the health insurance contribution no longer has a ceiling (2000/8). Special rules apply to the self-employed, who must pay contributions according to the official minimum wage. In addition, members of the third group, such as small farmers, can choose to pay only 11% of the current minimum wage, but they are not entitled to cash benefits unless they pay the total contribution (14% of the minimum wage) (1997/8). Provisions for non-contributing groups are shared between the HIF 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 “hypothecated health care tax” to the Fund in order to compensate for the rest of group 2 (1997/8).

The chronic problem of the HIF is that it has been in deficit since its inception. In 1998, the deficit peaked at 11.3% of the total HIF expenditure, 0.7% of the GDP (Table 6). The chronic deficit of the HIF is a complex problem with causes on both the revenue and expenditure sides. The shortfall of revenues is particularly striking as revenues of the HIF decreased from 8.0% of the GDP in 1992 to 5.6% of the GDP in 2000 (Table 6). Rising unemployment and decreasing real wages certainly contributed to the problem, at least in the early phase of economic transition (Table 2), but the evasion of health insurance contributions is thought to be a more fundamental weakness of the social health insurance scheme. Unpaid health and pension insurance contributions together peaked at 4.3% of the GDP in 1994, but still amounted to 2.5% of the GDP in 2000. The high rate of social insurance contributions has certainly been an incentive for avoidance and evasion, including payment-arrears, non-payment and under-reporting of salary income. Governments have tried to solve this problem by decreasing contribution rates, shifting the function of contribution collection from the HIF to the more authoritative Tax Office, and by introducing new sources of revenue which would be less likely to be subject of tax avoidance.

The first package of measures was enacted in 1996. The government of 1994–1998 decreased the employer contribution rate by 3 percentage points and introduced an additional tax, the “hypothecated health care tax”, to be paid by employees and to be collected by the national Tax Office as an “unavoidable” lump sum tax (Table 5). It was also intended to compensate the HIF for cutbacks of transfers from the Pension Insurance Fund following the pension reform and from the national government for covering certain non-contributing population groups (1996/7,8,10).

The second step was taken by the government of 1998–2002, which charged the national Tax Office also with collecting the health insurance contributions. It introduced a law which widened the contribution base by abolishing the ceiling for the employee health insurance contribution (2000/8). In addition, a proportional component was added to the hypothecated health care tax from 1 January 1999. The 11% proportional tax was levied on those types of income previously exempt from social insurance contribution, such as dividends and in-kind allowances. Furthermore, the lump sum component of the hypothecated health care tax was increased by more than two thirds (1998/17,18). At the same time, the health insurance contribution of employers was decreased by another 4 percentage points to 11% in 1999 (Table 5).

Table 6. Revenues, expenditures and deficit of the Health Insurance Fund, 1993–2000

Expenditure category	1993	1994	1995	1996	1997	1998	1999	2000
Total HIF revenues (current prices, billion Ft)	277.9	341.8	382.9	420.1	493.1	558.6	650.3	730.8
– as % of GDP	7.8	7.8	6.8	6.1	5.8	5.5	5.7	5.6
Total HIF expenditures ^a (current prices, billion Ft)	303.6	359.9	405.2	463.6	549.2	629.4	698.0	794.4
– as % of GDP	8.5	8.2	7.2	6.7	6.4	6.2	6.1	6.1
HIF expenditures on health care (current prices, billion Ft)	189.7	246.6	282.0	333.9	399.4	460.2	508.6	557.2
– as % of GDP	5.3	5.7	5.0	4.8	4.7	4.6	4.5	4.3
HIF deficit (current prices, billion Ft)	25.7	18.1	22.3	43.5	56.1	70.8	47.7	63.6
– as % of total HIF expenditure ^a	8.5	5.0	5.5	9.4	10.2	11.3	6.8	8.0
– as % of public expenditure on health	10.7	5.7	6.3	10.7	11.6	12.7	7.8	9.5
– as % of total expenditure on health	9.3	5.0	5.3	8.8	9.5	10.1	6.1	7.2
– as % of GDP	0.72	0.41	0.40	0.63	0.66	0.70	0.42	0.48

Source: National Health Insurance Fund Administration (1,32,33,34).

Note: ^a Includes cash (transfer) payments and payments on health care for in-kind benefits and administration; HIF: Health Insurance Fund.

Health care benefits and rationing

The provision of universal and comprehensive coverage was the founding principle of the previous, state-socialist health care system. 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 admitted and dealt with. Rationing probably occurred through queuing, implicit waiting lists, the dilution of services and informal payments.

In the early 1990s government reforms put more emphasis on structural transformations than on setting priorities in terms of health care benefits. Parallel to the establishment of the social health insurance, a list of free services to be covered by the social health insurance scheme was defined in amendments to *Act II of 1975 on Social Insurance* (1992/1). These were broad enough to cover virtually everything, but co-payments for prescribed medicines, medical aids and spa treatments (balneotherapy) were upheld and raised significantly (Table 8). In addition, certain exclusions from the benefit package of social health insurance were also stipulated, such as treatments for aesthetic and recreational purposes (1992/6).

The first steps towards a less generous benefit package were taken during the economic crisis of 1995, when the HIF deficit called for urgent action (Table 6). *Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization* curtailed in-kind and cash benefits. The main exclusion was tooth-preserving dental services. Subsidies for balneotherapy were removed, a co-payment for patient transfer (ambulance) services was introduced, and the sickness benefit was decreased (1995/4). In addition, the financing of occupational health services became the responsibility of employers (1995/5). The adverse effects of these measures – for example, a sharp drop in the use of dental services – forced the government of 1994–1998 to retreat, so that dental services were reintroduced with some co-payments (1996/1). The next government abolished co-payments for tooth preserving dental treatments in 2001, eventually restoring the original situation (2001/10).

In 1997, the new legislation on health and health insurance 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, and ordered priority setting 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 prohibited giving priority to those prepared to pay extra (1997/9). Thus far, national waiting lists have been set up for organ and tissue transplantation, but according to this act, waiting lists have to be set up for all other services that cannot be provided within two months, either on a national basis or per provider. The relevant professional college has to define detailed patient selection criteria to be based exclusively on the need for the service and the expected outcome. Waiting lists of individual institutions have to be supervised by a committee comprising representatives of patient organizations, the financing organization, the professional director and the head of department of the specialty concerned in the provider organization (1998/22, 2003/11). *Act LXXXIII of 1997* and related decrees define health services, which are free of charge, covered but require some co-payments, or

excluded from social health insurance coverage. The Act defines a negative list, since the starting point is that all health services are fully covered and exclusions are stipulated (1997/9). Co-payments are required for medicines (1995/1), medical aids and prostheses (2000/5), balneotherapy (1997/5), dental prostheses, treatment in sanatoria, long-term chronic care and some 'hotel' services in hospitals. Co-payments are also applied if:

- non-emergency specialist services are obtained without a referral from an authorized medical doctor, normally the family doctor;
- patients choose to go to a provider other than the one they were referred to;
- patients want to receive more services than the doctor prescribed (1997/9, 1997/14).

Special rules apply to a few services, such as infertility treatments, where the number of attempts is limited (1997/13). The costs of medical examinations for certificates required for driving and owning firearms are not covered (1997/14). Treatments for aesthetic or recreational purposes and those not proved effective in improving health are explicitly excluded (1997/8). These include services which are not classified in the International Classification of Procedures in Medicine, introduced in 1976 by the World Health Organization. In addition, cosmetic surgery, massage, abortion or sterilization without medical indication, and the prostate-specific antigen test for screening purposes are not covered (1997/11). Some other health services, like high-cost, high-technology interventions and emergency ambulance services are also excluded, but are financed from the national government budget (1997/9, 1997/16).

Complementary sources of financing

National and local taxes as well as private sources complement social health insurance in health care financing. Private sources are almost exclusively out-of-pocket payments to cover co-payment, or to utilize private health care services, since private health insurance has not yet taken root in the system. External sources are also insignificant, but private donations might increase in the future parallel to the growing number of charities in the area of health care.

Taxation

While the HIF covers recurrent expenditures only, capital costs are financed by the owners of health care facilities, which concerns mainly local governments

of municipalities or counties and to a very small degree also private owners (Table 7). This “dual system” of separate sources for recurrent and capital financing applies to the inpatient sector as well as to the outpatient sector. Owners of health care facilities finance the investment and maintenance of infrastructure and equipment according to *Act CLIV of 1997 on Health* (1997/16).

Local government revenue for capital costs can come from four sources:

1. transfers of national tax revenues, such as part of the personal income tax;
2. local taxes;
3. “earmarked and target subsidies”;
4. other conditional capital grants, mainly from the Ministry of Health.

In principle, local governments can use sources 1 and 2 to cover capital costs of health care facilities, but in practice, few local governments can afford to pay for expensive medical equipment or refurbishment of hospital wings or entire buildings. Thus, the national government offers conditional and matching grants under *Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments* (option 3), which also determines the three components of the system, and the process of application (1992/8).

The first component is a conditional capital grant, called “earmarked subsidy”, for large-scale projects, usually for the renovation or extension of existing buildings, exceeding Ft 200 million, but the upper limit and local contribution are not specified. Local governments submit project proposals to the Ministry of the Interior, which makes a priority list, taking into account recommendations from the relevant ministry, then the National Assembly decides on the submitted proposals. The second component is a matching grant, called “target subsidy”, which allows local government less discretion, since both the purposes and conditions are predetermined by the parliament. Local governments can usually apply for target subsidies to purchase medical equipment, that require a 30% to 40% local share. The third component of the system is a budget devolved to the “county regional development councils”, which decide on the allocation of funds among various applications.

Finally, the Ministry of Health also runs various capital grant programmes for the replacement of medical equipment, such as X-ray machines, or specific aid to providers to meet minimum requirements set by *Decree No. 21/1998. (VI. 3.) EÜM* of the Minister of Health (1998/7, 2003/10). It is worth noting that private providers can also apply for “earmarked and target subsidies” and Ministry of Health grants, if they supply services to the population of a local government under the “territorial supply obligation”. Thus, in contrast to other social health insurance systems, Hungary has a dual system of financing (different funders

for capital and for recurrent costs) that not only applies to inpatient services, but also to most primary and secondary outpatient care, except for certain special services, such as public health and emergency ambulance service, which are financed entirely from the government budget.

Thus taxation is the most important source of investments, but tax revenues are also used to finance recurrent expenditures primarily in those cases, where financing and service provision is integrated. In 2000, from the total tax financing of health care, which amounted to 12% of total expenditures and 0.8% of the GDP, roughly one third went to investments, and two thirds to cover recurrent expenditure (Table 7). In 1994, the corresponding figures were 19.5% of total expenditures on health and 1.6% of the GDP, a substantial decrease, a trend within which both recurrent and capital expenditures declined. In 2000, tax financing of recurrent health expenditure made up 8.5% of all recurrent expenditures on health, while the share of social health insurance financing and private sources were 66% and 25% respectively (19).

Table 7. Recurrent and capital expenditures of government on health care, 1991–2000

	1991	1992	1993	1994	1995	1996	1997	1998 ^a	1999 ^a	2000 ^a
Recurrent government expenditure (current prices, billion Ft)	13.9	24.5	30.5	42.5	43.2	48.0	46.4	54.8	62.6	71.7
– national government ^a	–	–	–	–	–	–	–	38.3	44.3	53.4
– local government ^a	–	–	–	–	–	–	–	12.6	15.9	16.6
Government investments (current prices, billion Ft) ^b	15.1	18.5	20.7	28.3	27.1	23.2	36.7	36.5	35.7	35.5
Total government expenditure on health (current prices, billion Ft)	29.0	42.5	51.2	70.8	70.3	71.2	83.1	91.4	98.2	107.2
– as % of total expenditure on health	16.1	18.6	18.6	19.5	19.5	14.3	14.0	13.2	12.6	12.2
– as % of GDP	1.2	1.5	1.4	1.6	1.3	1.0	1.0	0.9	0.9	0.8
Government investments on health ^a at constant prices (1991=100) ^c	100	102	91	105	80	56	75	66	60	55
– as % of total investment on health ^a	–	–	–	–	–	–	–	89.8	96.9	97.9
– as % of total expenditure on health	8.3	8.1	7.5	7.8	6.5	4.7	6.2	5.3	4.6	4.0
– as % of GDP	0.6	0.6	0.6	0.6	0.5	0.3	0.4	0.4	0.3	0.3

Source: OECD Health Data, 2003 (20); ^a Hungarian Central Statistical Office: National Health Account (19).

Note: ^b Equivalent with public investments on health since the HIF does not finance capital costs. Although there is some evidence that health care providers use part of their income from the HIF for financing capital costs, the exact extent of investments from HIF sources is not known. National and local government investments not separable. ^c Applying GDP deflator.

Within tax financing, roughly three-quarters of operational health expenses were funded by national government and one-quarter by all local governments taken together (Table 7). The national government spent about 10% of its current health expenditure on hospitals, 28% on pharmaceuticals, another 28% on prevention and public health services. About 30% was spent on services such as blood supply and emergency services and 6% on administration. Local government sources of current health care expenditures were roughly divided between hospitals (30%), nursing care institutions (30%), outpatient services (15%), prevention and public health services (15%) and administration (10%) (19). Similar break-down of tax financed capital expenditures is not available in the current version of the National Health Accounts (19).

Out-of-pocket payments

Out-of-pocket payments in the Hungarian health care system are discernible in three main forms. First, some products and services are not covered by social health insurance and are financed out-of-pocket. Second, patients make co-payments for services and products which are partly covered by the HIF. Third, some patients pay medical doctors and non-medical health professionals informally for services covered by the HIF. This phenomenon, also referred to as under-the-table, envelope or gratitude payment is a legacy of the state socialist health services, but has continued to play a role in the Hungarian health care system despite 15 years of ongoing health care reforms.

First, patients pay the full price of services excluded from public financing. The same applies to services that are in principle covered, but obtained from a private provider with no contract with the NHIFA. On the other hand providers who do have a contract with the NHIFA are not allowed to charge extra for covered services (1997/9).

Second, co-payments are required for certain medical goods, such as pharmaceuticals (1995/1), medical aids and prostheses (2000/5), dental prostheses, health services, such as balneotherapy (1997/5), treatment in sanatoria (except for rehabilitation after acute illnesses), long-term chronic care, some “hotel” services in hospitals and in general if patients do not observe the rules of service utilization (1997/9,14) (Table 8). The methods applied to determine the extent of co-payment differ for different groups of services or products.

Medicines, medical aids and prostheses have prices annually negotiated between the relevant government actors, including the NHIFA, and the producers. Instead of determining the extent of co-payment, the HIF provides a price subsidy, either a certain percentage of the agreed price or a fixed amount

(1997/9). The extent of subsidy can differ for the same drug, depending on whether it is prescribed by a family doctor or a specialist. Outpatients must have a valid prescription from the medical doctor, and must purchase the medicine at a pharmacy with a NHIA contract to be eligible for the subsidy. It has to be emphasized that the system of co-payments does not apply to inpatient care, which includes the cost of medications (Table 15). Before 1990, drugs were heavily subsidized by the state and consumers paid only a symbolic amount. In contrast, patients paid one fifth of pharmaceutical expenditures of the outpatient sector in 1992 and one third in 2000. There is an exemption system in place (KÖZGYÓGY), which helps inhabitants with very low income get necessary medicines without co-payment, with eligibility based on a means test administered by local governments (1993/1) (Table 8 and Table 15).

The co-payments for dental prosthetic treatments and above-standard hotel services are determined by the providers themselves, within the limits of certain rules set by the *1997 Act on Social Health Insurance* (1997/9). In contrast, the government centrally sets the amount of co-payments for long-term, chronic care, and for services that have been utilized bypassing the regular referral system. These fees equally apply to all providers. For instance, co-payment for long-term chronic care has been Ft 400 per day since 1998 (1997/14), which was equivalent to two litres of milk or one hour parking in the city centre of Budapest. Providers retain the revenue from any of these sources, but HIF reimbursement on these cases is reduced accordingly (1997/9) (Table 8).

Third, the other main out-of-pocket expenditure is informal payment, which took roots and became widespread in the state-socialist health care system. Despite several official campaigns against it, the regime not only tolerated informal payment, but included it in the calculation of salaries of medical doctors, and even required that taxes be paid on it. Since 1989 providers have had to declare informal payments as part of their income tax. The overall magnitude of informal payment is being debated, since various surveys, reports and expert opinions have come to contradictory results. According to the annual representative household surveys of the Hungarian Central Statistical Office, the amount of gratitude payment was Ft 5.9 billion in 1998. Based on these data, the National Health Accounts provided an adjusted figure at Ft 13.4 billion for 1998, which would account for 1.9% of total expenditure on health (Table 8). Based on another survey informal payment were estimated Ft 30 billion for the same year (30, 36, 37) which would account for 4.3% of total expenditure as indicated by National Health Accounts data. The magnitude of informal payments was thought to be even higher according to some expert opinions. For example, one report estimated the amount of gratuities at Ft 41.4 billion for 1996 (22).

There is however conclusive evidence that informal payment is unequally distributed among health workers. Physicians, in particular specialists such as obstetricians and surgeons, receive the bulk of informal payments. Informal payments are more widespread in the inpatient sector than in the outpatient sector, and may differ by type of service, e.g. cardiac surgery, hip replacement or home visit (29,30,35,36).

The practice of informal payment for health services is deeply embedded in the system and will not be easy to remove. The relatively low salary of medical doctors and other health workers compared to other sectors of the economy has been a major contributing factor, but higher salaries alone will not solve the problem. It is true, however, that until 2002 – when one of the first measures of the current government was to increase the salary of public employees, including health workers, by an average of 50% (2002/15) – none of the democratically elected governments was keen to raise the salaries of the health care personnel, not even to explicitly tackle the problem. The elimination of informal payment needs concerted action to restore the lost confidence in public services.

The overall magnitude of out-of-pocket expenditures has also been controversial, not only because of the divergent estimates on informal payment. According to the National Health Accounts, the household budget surveys underestimate not only informal payments, but also total out-of-pocket payments (Table 8). Nevertheless, the difference in the estimates on pharmaceuticals (Table 15) and medical goods is not a problem, since there are direct sales data available to estimate direct household spending on these items (1). The structure of out-of-pocket payments according to the National Health Accounts is similar to the data reported by households: 67% are spent on outpatient medical goods, 21% on health services and 11% on informal payment in 2000.

In any case, the various data sources are consistent in that out-of-pocket spending increased about twofold in real terms and by 50% as share of the GDP between 1992 and 2000, and within that informal payments at least stagnated both in real terms and as a share of total out-of-pocket expenditures (Table 8).

Private health insurance

Voluntary health insurance was non-existent under the communist regime. *Act XCVI of 1993 on Voluntary Mutual Insurance Funds* created the legal framework for complementary insurance schemes on a non-profit basis, according to the model of the French *mutualité*. The government subsidizes the purchase of health insurance from voluntary mutual funds with a 30% tax rebate up to a certain limit (1995/9), yet few voluntary funds have been established in Hungary so

Table 8. Out-of-pocket payments on health care, 1991-2000

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Out-of-pocket expenditure (a) (current prices, billion Ft)	19.0	24.1	32.3	44.9	59.4	68.8	80.1	94.6	137.8
– at constant prices (1991=100) ^b	115	119	135	146	156	153	156	167	222
– % of GDP	0.7	0.7	0.7	0.8	0.9	0.8	0.8	0.8	1.1
Share of out-of-pocket expenditure (a) spent on									
– pharmaceuticals (%)	49	58	64	66	73	71	70	73	
– medical aids and prostheses (%)	17	13	11	9	8	10	10	10	71 ^a
– health services (%)	22	14	13	14	10	11	13	9	22
– informal payment (%)	13	16	13	10	9	9	7	8	7
Informal payment (a) (current prices, billion Ft)	2.4	3.9	4.3	4.7	5.3	5.8	5.9	8.0	9.3
– as % of total expenditure on health	1.1	1.4	1.2	1.2	1.2	1.0	0.8	1.0	1.1
– as % of GDP	0.08	0.11	0.10	0.08	0.08	0.07	0.06	0.07	0.06
Out-of-pocket expenditure (b),(c) (current prices, billion Ft)	27.4	34.7	46.1	67.3	91.3	111.1	121.3	146.9	187.3
– at constant prices (1991=100) ^b	114	117	131	150	164	169	161	178	206
– as % of GDP	0.9	1.0	1.1	1.2	1.3	1.3	1.2	1.3	1.4
Informal payment (billion Ft) (c)	–	–	–	–	–	–	13.4	16.4	20.9
– as % of total expenditure on health	–	–	–	–	–	–	1.9	2.1	2.4
– as % of GDP	–	–	–	–	–	–	0.13	0.14	0.15

Sources: (a) Hungarian Central Statistical Office. Household Budget Surveys (1,26,27,28). (b) For 1992–1997: Hungarian Central Statistical Office data used for the calculations of the GDP including informal payments, cited by Orosz, 2001 (38); (c) for 1998–2000: Hungarian Central Statistical Office: National Health Accounts (19).

Note: ^a Items are not separated in the final publication; ^b Applying consumer price index deflator.

far. In exchange for a membership fee, the existing plans are allowed to offer benefits not covered or not fully covered by the HIF (1993/10). Only the smaller portion of the membership fee is a real health insurance premium, paid in a common fund, or risk pool. The larger part of contributions goes to individual accounts and can be used by the account holder only, which is in fact a medical savings account scheme.

Private for-profit health insurance is even more limited. Some companies offer insurance at the upper end of the market, but these are mainly income-

replacement cash-benefit policies for certain illnesses and not real indemnification insurance. There are new attempts to extend the private health insurance market by offering in-kind benefits in the form of above-standard hotel services, but the outcome of these projects is not yet known.

In 2000, private health insurance accounted for 1% of private and 0.2% of the total health care expenditure (19). The reason for private insurance not having taken root in the Hungarian health care system may be the nearly comprehensive coverage of the social health insurance scheme (31, 36). Voluntary non-profit health insurance funds are still not allowed to offer services that are covered by the HIF. Moreover, informal payment may be considered another obstacle to the growth of the private insurance market (36), in so far as informal payment can “buy” higher quality services less expensively, but this is a matter of debate.

External and other sources of funding

The collapse of the communist regime opened the way for external and other sources to flow into the health sector in the form of governmental aid and loan programmes, voluntary donations and taxpayer donations, since the government granted discretionary power to taxpayers over 2% of their personal income tax.

At the government level, external sources have supported the reform process, especially in its early phase. In the area of health services, these included bilateral aid programmes, the PHARE programme of the EU, partnership programmes of USAID and a World Bank loan – the Health Service and Management Project – supporting the restructuring of the health care system. The largest among them was the seven-year World Bank project supporting the institutional development of public health, health services modernization and the establishment of health services management and public health training, among other things. The government closed down the project in 2000, according to the original plans, but cut short still-running subcomponents, like the regional health services modernization or the hospital management information system. Since then, the most important external projects are financed by EU grants designed to support the country’s preparation for EU accession.

Other private sources include enterprises delivering preventive, curative and rehabilitative occupational services to their employees (2.2% of total health expenditure in 2000). Voluntary donations channelled through charities have also begun to play a role since 1990. The size of the sector is more substantial than that of private health insurance, but it is still a minor source of health care financing (Table 4) (17). In 2000, non-profit organizations accounted for 3% of private and 0.7% of total expenditures on health (19). The government created

a new opportunity for the expansion of the voluntary sector in 1996. Since then taxpayers can decide which non-profit organizations receive 1% of their personal income tax (1996/11). All non-profit organizations that finance or carry out public benefit activities are eligible, except for political parties and organizations representing the interests of employers and employees. Since health care is one of the public benefit activities, non-profit organizations financing and/or providing health care are eligible. The government has extended this scheme by another 1% of income tax to be offered to churches, some of which own and operate institutions for health care provision (1997/10).

Health care expenditure

Total expenditure and public/private mix

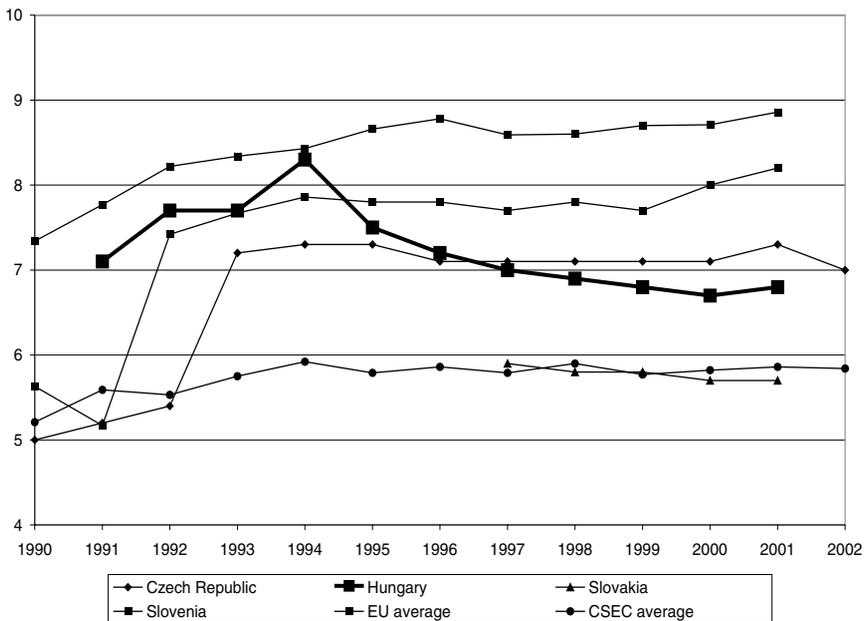
In 2001, Hungary spent an average of US \$911 (at purchasing power parities) per inhabitant on health care (Fig. 6). Total health expenditure accounted for 6.8% of the GDP (Fig. 4 and Fig. 5), which is consistent with OECD data. The National Health Accounts indicated Hungary's total expenditure on health at Ft 880 billion, which amounted to 6.7% of the GDP (19). After a retrospective revision of data sources, present figures deviate from data presented in the Health Care in Transition profile on Hungary 1999 which again differed by source at that time (24,25,40) (Table 9).

Successive Hungarian governments of the transition period implemented a very effective cost containment policy, which did not allow health care spending to upset fiscal balance. In the first phase of the transition, between 1988 and 1994, the health sector enjoyed a relative priority, which meant that health care spending increased at least as a share of GDP (Fig. 4 and Table 9), despite economic depression. In 1994, the year of the second free general elections, health care spending increased about 10% in real terms compared to 1993 (Table 9), but this was the last relatively "happy" year of the health sector, the prelude (and partly the cause) of the cost containment era. Although economic growth started in 1994, its pace slowed down in 1995 and 1996, and the outgoing government had bequeathed a large fiscal deficit to its successor. The government of 1994–1998 anticipated an economic crisis and implemented strict stabilization policies in 1995 and 1996, one target of which was public expenditures on health care. However, while a substantial and stable economic growth started in 1997, total and public health care expenditure decreased as a share of GDP (Table 2 and Table 9). The economic stabilization policies

implemented by the government in 1995 and 1996 were in fact continued by the next government, at least as far as the health sector was concerned.

In comparative perspective this means that, since 1995, Hungary has been spending less on health care than neighbouring countries of similar economic development, like Slovenia and the Czech Republic, both as the share of the GDP (Fig. 4) and in terms of purchasing power adjusted per capita expenditures (10) (Fig. 6). In fact, Hungary was one of only three OECD countries where average real annual growth of total health expenditure (2%) was below real annual growth of GDP (2.7%) between 1991 and 2000 (39). Public expenditure decreased in real terms and as a share of total expenditure from 89% in 1991 to 75% in 2001, which is lower than in most CSE countries, Nordic countries and the UK but similar to most western European countries (Fig. 7).

Fig. 4. Total expenditure on health as a share of GDP (%) in Hungary and selected European countries, 1990–2002



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

Note: CSEC: Central and south-eastern European countries; EU: European Union.

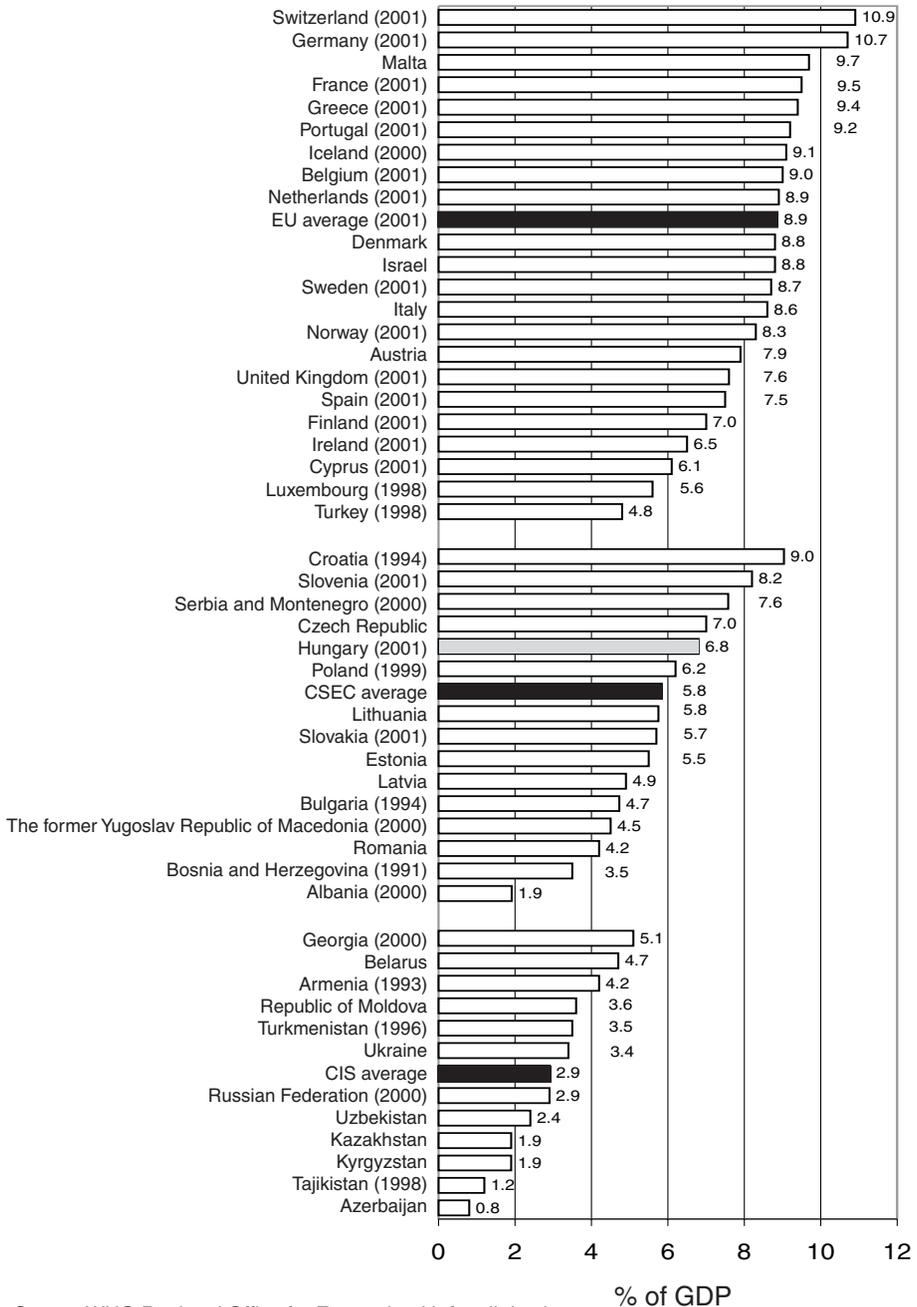
Table 9. Trends in total expenditure on health and public/private mix, 1991–2000 (selected years)

	1991	1994	1995	1996	1997	1998	1999	2000
Total expenditure on health (current prices, billion Ft)	180	364	420	496	594	695	777	880
Per capita (current prices, US\$ PPP)	534	692	677	671	693	751	787	841
As share of GDP (%)	7.1	8.3	7.5	7.2	7.0	6.9	6.8	6.7
– WHO (1999) (a)	7.3	8.2	7.6	7.2	6.9	6.8	–	–
– OECD (1998) (b)	6.6	7.3	7.1	6.7	6.5	–	–	–
– Orosz et al. (1997) (c)	7.3	8.3	7.8	7.5	–	–	–	–
Public expenditure on health (current prices, billion Ft)	161	317	352	405	483	552	607	665
As share of GDP (%)	6.4	7.2	6.3	5.9	5.6	5.5	5.3	5.1
As share of total expenditure on health care (%)	89.1	87.3	83.9	81.6	81.3	79.4	78.1	75.5
– WHO 1999 (a)	80.8	80.0	76.2	76.5	75.3	–	–	–
– OECD 1998 (b)	–	71.1	69.8	69.3	69.1	–	–	–
– Orosz et al. (1997) (c)	87.7	86.7	83.3	82.7	–	–	–	–
Total expenditure on health at constant prices (1991=100)	100	113	101	97	98	101	103	106
Annual change (%)	0	11	–11	–4	1	3	2	3
Recurrent private expenditure ^a (d)	100	131	150	164	169	161	177	–
Recurrent public expenditure ^a (d)	100	111	97	92	91	94	95	95
HIF expenditure on curative and preventive services ^a (d)	100	99	87	83	84	81	84	83
HIF expenditure on medical goods ^a (d)	100	114	104	101	103	118	111	111

Source: For 1991–1997: OECD Health Data, 2003 (20); for 1998–2000: Hungarian Central Statistical Office, National Health Accounts (19); (a) WHO Regional Office for Europe Health for all Database, 1999 (25); (b) OECD Health Data, 1999 (24); (c) Orosz, 1997 (40); (d) Orosz, 2001 (38).

Note: ^a applying consumer price index deflator; PPP: purchasing power parities; HIF: Health Insurance Fund.

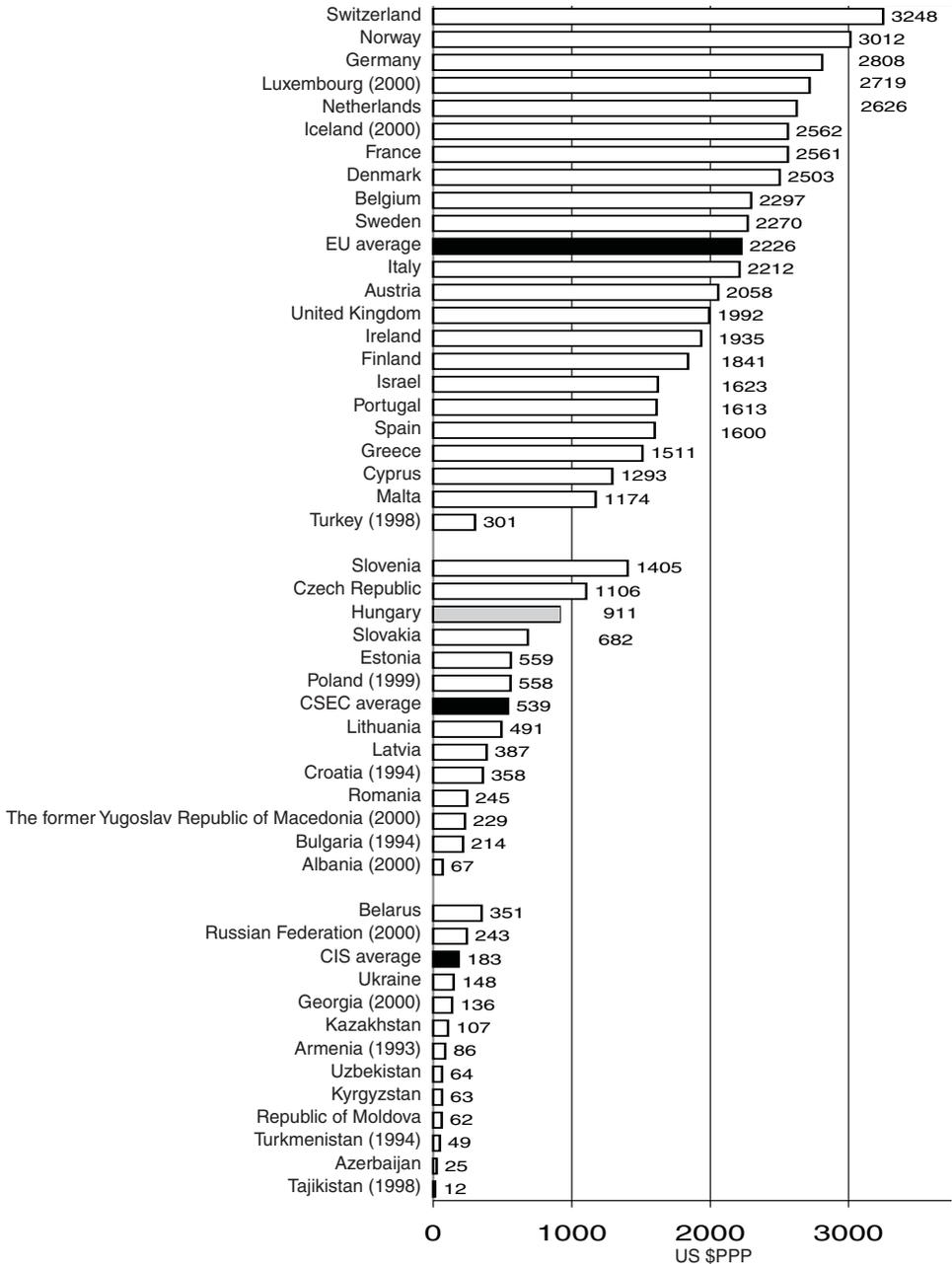
Fig. 5. Total expenditure on health as a % of GDP in the WHO European Region, 2002 or latest available year (in parentheses)



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

Note: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

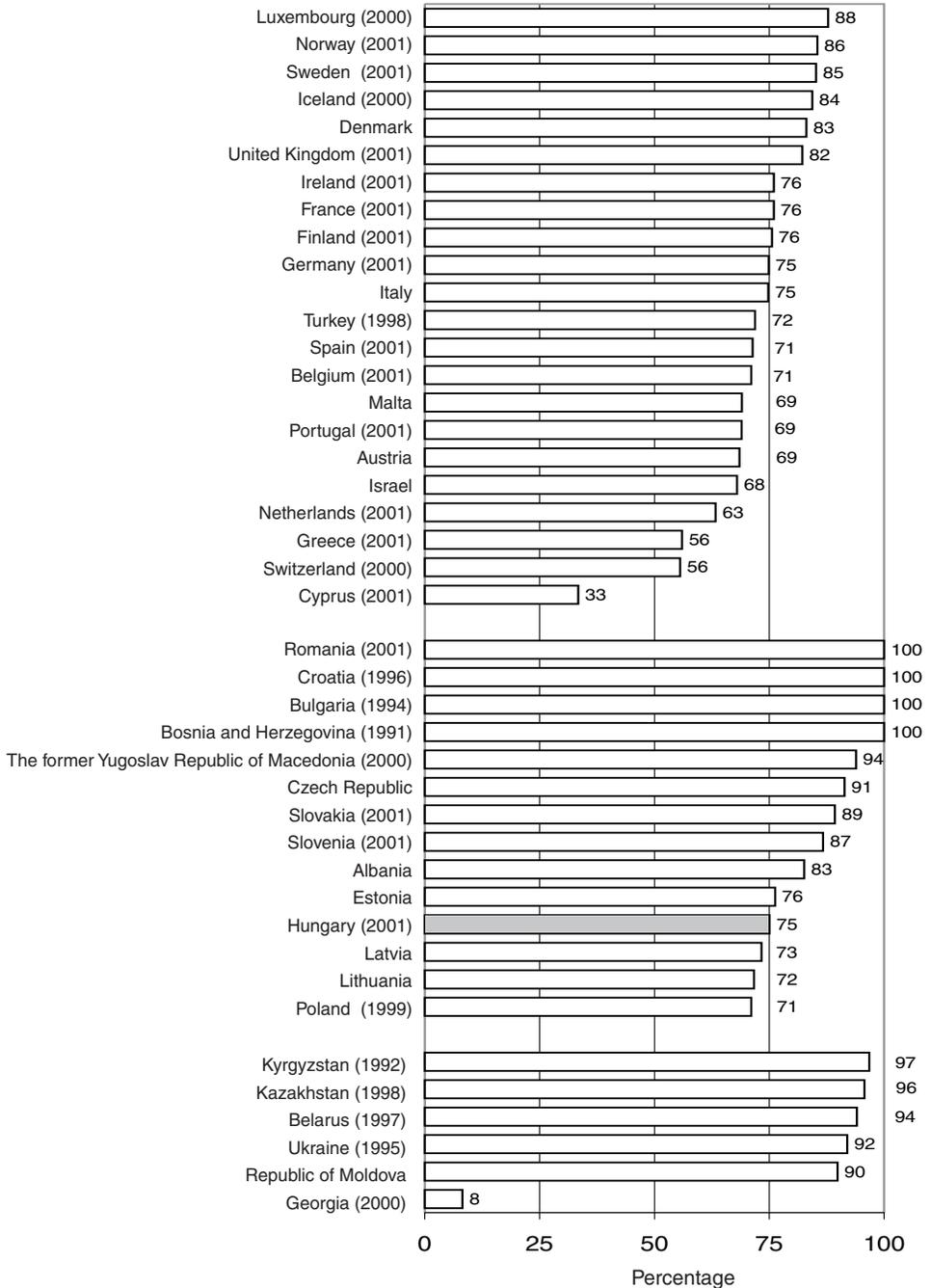
Fig. 6. Health care expenditure in US \$PPP per capita in the WHO European Region, 2001 or latest available year (in parentheses)



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

Note: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

Fig. 7. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 2002 or latest available year (in parentheses)



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

Hungary

Structure of health care expenditures

Of the total expenditures spent on health in 2000, 36% were spent on medical goods, 30% on inpatient care, 16% were dedicated to outpatient care, 6% to ancillary services (including clinical laboratory, diagnostic imaging, patient transportation, emergency ambulance services and blood supply), and 5% to prevention and public health services. Among the medical goods pharmaceuticals dispensed to outpatients accounted for the biggest item with 28% of total expenditure (19). The trends in the structure of total health expenditures and HIF expenditures reflect the tools which Hungarian governments used to achieve their objectives of cost-containment.

The national government has always been in a position to control central government expenditures, and despite the dominance of local government ownership of health care providers, to control investments through conditional and matching capital grants (earmarked and target subsidies). Between 1994 and 1999 public investment in health care almost halved in real terms (Table 7), whilst government current expenditures initially decreased and then stagnated (Table 9).

The government has also been in a position to control expenditures of the HIF, initially by the National Assembly and later by controlling directly the NHIFA, virtually the only (monopsonistic) purchaser of the system. The social health insurance system was designed in a way that allowed national governments to exercise cost-containment for most services. Within the HIF, so-called sub-budgets are assigned to the various services (Table 10). These sub-budgets are capped for curative and preventive services and the corresponding provider payment methods ensure that the predetermined budget ceilings cannot be exceeded (see the section on *Third-party budget-setting and resource allocation*).

As a result, real HIF expenditures for curative and preventive services decreased (Table 9). However, real HIF expenditures for pharmaceuticals (Table 15) and generally for medical goods increased. HIF expenditures for drugs, medical aids and prostheses have been less containable, since a similar method of cost-containment was perceived to be not feasible for these HIF sub-budgets. Prices are set in advance and subject to broader economic trends, and if consumption exceeds the planned level, it cannot be offset with a parallel price decrease, at least during the same year. In addition eventual expenditures derived from purchases of innovative drugs are not predictable. Since the liberalization of the pharmaceutical industry and the privatization of most state drug companies, the rise of pharmaceutical expenditure has always puzzled the government, because overspending in the pharmaceutical sub-budget represented a major factor in the HIF deficit (Table 6).

The first measures directed at containing pharmaceutical expenditures included shifting costs to patients by increasing co-payments, and decreasing the scope of subsidized medicines. These are the most important factors explaining the diminishing public and the increasing private expenditures (Table 4 and Table 15). The second intervention has been the reallocation of financial resources within the health care budget, observable in the diminishing share of curative-preventive services. Third, the government of 1998 introduced strict measures within the system of pharmaceutical subsidies, which seemed to stop public expenditure growth, at least for 2000 (Table 9). These included the introduction of prior authorization for overspending in the pharmaceutical sub-budget of the HIF (1998/24), the extension of fixed amount subsidies (2001/6), the lowering of wholesale and retail price margins for expensive drugs (2001/2), and stricter controls of physician prescribing (2001/3). Finally, the current government has continued the battle against rising pharmaceutical expenditures, and managed to negotiate a price-volume agreement, which made pharmaceutical companies financially responsible for subsidies of drugs that were sold in excess of an agreed volume limit (2003/16) (see the section on *Pharmaceuticals*).

The policies of successive governments to contain public expenditure on health have been implemented effectively, but they do not necessarily imply more efficient resource allocation. Cost containment may be pressed to the point where spending on health care would result in more benefits to society than if resources were committed to any other sectors of the economy. While in general it is difficult to determine the most efficient level of overall health spending, certain benchmarks are used commonly, for example, health expenditure of countries of similar economic development. In this respect, Fig. 4 indicates that Hungary may indeed spend relatively little on health care compared for instance with Slovenia and the Czech Republic.

More importantly, however, cost containment in itself does not ensure efficient resource allocation within the health sector. For instance, if patients are treated in hospitals with a disease that could be treated effectively in an outpatient specialist or primary care setting, the resources are wasted. It is difficult to assess this kind of inefficiency from aggregate spending data, but the structure of HIF expenditures could be used as a crude proxy. Table 10 shows that since 1994 the allocation of financial resources has not changed significantly

Table 10. Health Insurance Fund expenditures by main categories, 1993–2000

Expenditure category	1993	1994	1995	1996	1997	1998	1999	2000
Total expenditure								
(current prices, billion Ft)	303.6	359.9	405.2	463.6	549.2	629.4	698.0	794.4
Cash benefits (%)	36.6	30.0	29.2	26.3	25.8	23.8	25.0	27.8
Health care (%)	63.4	70.0	70.8	73.7	74.2	76.2	75.0	72.2
Expenditure on cash benefits								
(current prices, billion Ft)	111.0	108.0	118.2	122.0	141.8	149.7	174.7	221.1
Expenditure on health care								
(current prices billion Ft)	192.5	251.9	287.0	341.6	407.4	479.8	523.2	573.4
Administration (%) ^a	2.9	4.2	3.9	4.5	4.3	4.4	3.7	3.0
In-kind benefits (%)	97.1	95.8	96.1	95.5	95.7	95.6	96.3	97.0
In-kind benefits								
(current prices, billion Ft)	186.9	214.4	275.7	326.1	389.9	458.5	504.1	556.0
Curative and preventive services (%)	70.4	70.2	69.3	68.9	68.7	65.2	67.2	67.6
Medicines subsidy (%)	26.5	25.8	25.7	26.2	25.9	29.6	27.7	27.1
Medical aids subsidy (%)	2.5	3.0	3.9	3.7	4.3	4.3	4.1	4.1
Balneotherapy (%) ^a	–	0.3	0.4	0.4	0.4	0.4	0.5	0.6
Transport subsidy (%)	0.6	0.6	0.6	0.7	0.7	0.5	0.5	0.6
Other (%) ^a	–	0.2	0.2	0.2	0.2	0.3	0.2	0.2
Curative and preventive services								
(current prices, billion Ft)	131.6	169.4	191.0	224.8	268.0	299.1	338.9	376.1
Primary Care (%)	–	18.5	16.6	15.9	15.7	16.0	15.4	14.7
– family doctor services (%)	–	11.6	10.6	11.1	10.7	11.0	10.4	9.7
– dental care, MCH, other (%)	–	6.8	5.9	4.8	4.9	5.0	5.2	5.0
Outpatient specialist care (%)	–	15.2	17.5	15.8	15.6	16.0	15.9	15.9
Dialysis (%)	–	1.5	2.0	2.4	2.5	2.5	2.6	2.7
CT, MRI (%)	–	–	–	2.1	2.0	2.1	1.9	1.9
Home care (%)	–	–	–	0.0	0.2	0.3	0.3	0.3
Inpatient services (%)	–	57.1	58.6	59.4	58.6	61.5	62.2	59.0
– Acute care (%)	–	49.3	50.7	51.6	50.5	53.3	53.8	50.8
– Specialist care (%)	–	1.5	1.8	1.7	2.1	1.9	2.1	2.1
– Chronic care (%)	–	6.3	6.0	6.1	6.0	6.3	6.3	6.1
Other (%) ^b	–	7.7	5.4	4.3	5.4	1.5	1.5	5.4

Source: National Health Insurance Fund Administration (1,32,33,34).

Note: ^a between 1990 and 1993 included in curative and preventive services; ^b other curative and preventive services comprise patient transfer and ad hoc expenditures, and before 1998 emergency ambulance services and blood supply; MCH: mother and child health services; CT: computer tomography; MRI: magnetic resonance imaging.

Health care delivery system

Health care delivery is based on the constitutional obligation of the state to make health services available for all resident citizens (1989/3). The delivery system is organized on the basis of responsibility for the provision of health services, often referred to as the principle of “territorial supply obligation”, which is divided among local governments according to geographical areas and levels of care: municipalities are responsible for providing primary care for the local population within the border of the municipality, while county governments are responsible for specialist health care services for their entire county (1990/3, 1997/16).

In addition to the general rule of division of tasks, municipalities are allowed to provide outpatient specialist and inpatient care (Fig. 2). According to the principle of “subsidiarity” the county governments cannot refuse to pass the responsibility for service provision to the municipalities if the latter are willing to accept it. Furthermore, the territorial supply obligation determines the size of the catchment area of health care providers that can vary with different levels of care and types of services. For instance, there are municipal hospitals that provide secondary care not only for the inhabitants of the municipality concerned, but also for the neighbouring population. Likewise, large county hospitals provide tertiary care of certain medical specializations for the population of more than one county.

However, to understand fully how the delivery system operates in Hungary, two other distinctions have to be made. First, the principle of territorial supply obligation does not include obligation for local governments to deliver (produce) health services; they are allowed to outsource service delivery to private providers, which is predominantly the case in family doctor services. Second, the owners of health care facilities (whether private or public) providing services under territorial supply obligation are responsible for keeping the assets in

working order, that is, for covering the capital costs of services (1997/16). This principle is referred to as maintenance obligation and has special relevance in those cases where a local government contracts out service provision to a private provider who delivers the services in a health care facility, and with equipment owned by the local government. This scheme is referred to as “functional privatization” and it is the most common in primary care.

The types of services local governments have to provide in the frame of primary, secondary and tertiary care are defined by *Act CLIV of 1997 on Health* (1997/16). There are services, however, whose provision (and financing) is the responsibility of the national government, including public health, emergency ambulance services and blood supply.

Primary health care and public health services

Public health services

Public health services are the responsibility of the national government, in particular the Ministry of Health, which provides these services via the National Public Health and Medical Officer Service (NPHMOS). The agency was formed in 1991 on the basis of the State Supervision of Public Hygiene and Infectious Diseases of the previous regime, but had its origins in the late nineteenth and early twentieth centuries, when the state assumed responsibility for public health, social medicine and health administration, to be performed by civil servants, the so-called medical officers. During the period of state-socialist health care system, sanitary stations of the State Supervision implemented successful compulsory immunization and public hygiene programmes, which produced substantial improvement in the health status of the population, but failed to respond adequately to the health transition that made chronic noncommunicable diseases the number one public health problem. The establishment of the NPHMOS in 1991 aimed to address this shortcoming by extending its duties according to the modern concept of public health, but to preserve its successful public hygiene and infectious diseases control structures and mechanisms (1991/1). With the establishment of the NPHMOS, the ministry has also deconcentrated several health administration duties, like compulsory registration, licensing and professional supervision of health care providers.

Decree No. 7/1991. (IV. 26.) NM of the Minister of Welfare defines the organizational structure of the NPHMOS. The Service is headed by the national chief medical officer, appointed by the minister of health. Its central organ is

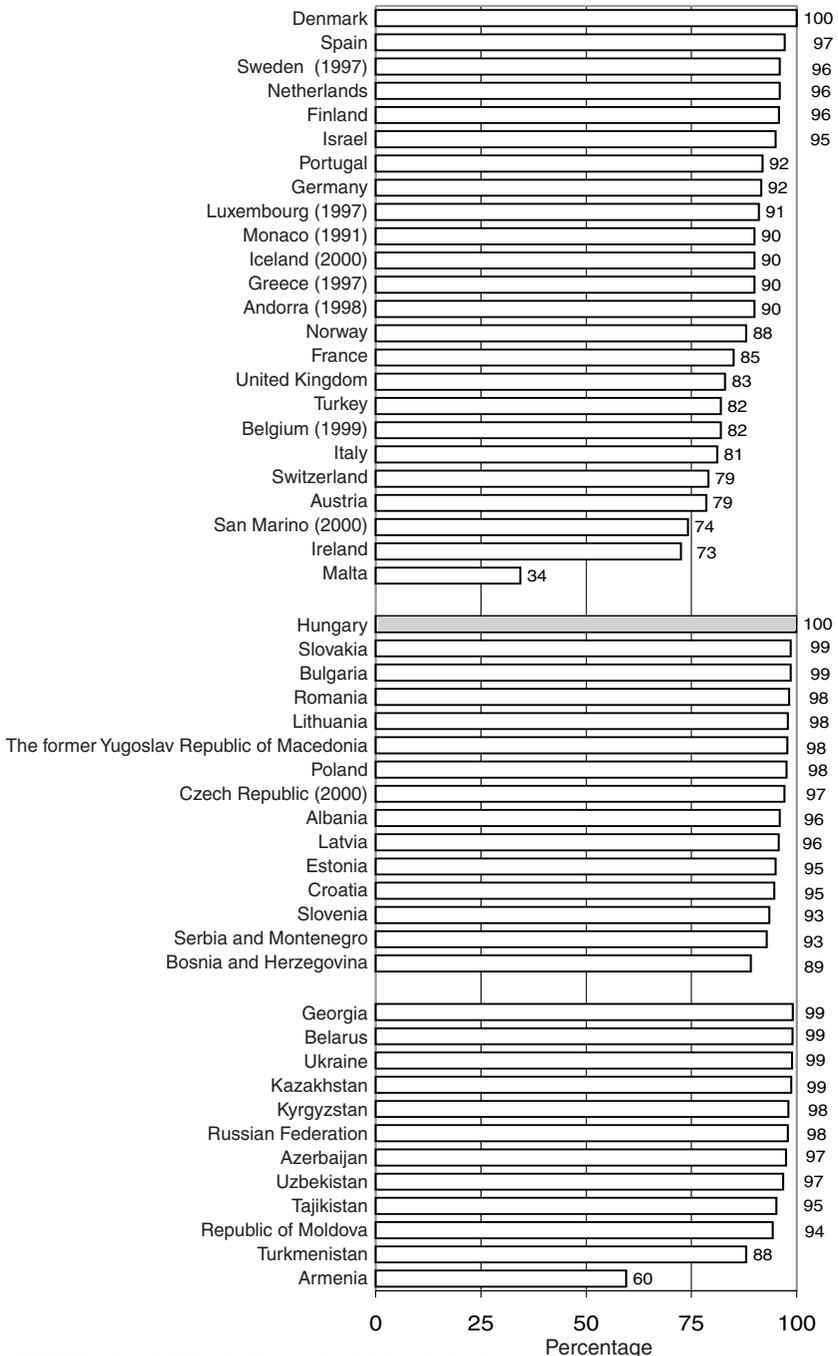
the Office of the National Chief Medical Officer, which has two centres, each responsible for one main area of public health: the Fodor József National Centre of Public Hygiene and the Johan Béla National Centre of Epidemiology. The Fodor József National Centre of Public Hygiene has five national institutes, in the area of occupational health, chemical safety, nutritional health, radiation safety and environmental health. There used to be a third national centre, the Health Promotion Centre, which was established in 2001, when the Minister of Health merged the Health Promotion Research Institute and the National Institute for Health Promotion, and integrated the new organization into the NPHMOS (2001/9).

The present government, however, decided to take out the Centre from the organization of the NPHMOS (2003/7), put it directly under the Ministry of Health, renamed it the National Institute for Health Development, and modified, mainly expanded, its scope of activities. Nevertheless, the task of professional supervision and coordination of child health was transferred to the National Institute of Child Health, which was established in July 2003 (2003/7).

The NPHMOS is organized at three levels on a territorial basis (Fig. 2). The national office supervises and controls 19 county offices and one office in Budapest. This second administrative level controls municipal offices and districts of the capital at the third administrative level. Offices at all three levels are headed by chief medical officers. At the national and county levels the NPHMOS employs chief pharmacist officers for the supervision of drug supply and senior nurses for the supervision of nursing. In addition, specialized senior nurses are responsible for the supervision and coordination of district mother and child health services (1991/1).

The NPHMOS is responsible for the control, coordination, supervision and delivery of public health services. The tasks for delivery of public health services are shared with other actors, especially in primary care. For instance, the NPHMOS coordinates the compulsory immunization programme and supplies the vaccines, while family doctors and the school health services carry out the vaccination of the children. Or, the district mother and child health service provides pre- and postnatal care, prevention and health education at families and schools, while it is coordinated and supervised by senior mother and child health nurses of the NPHMOS. These well-organized programmes are probably a key factor in the country's excellent immunization record (Fig. 8). Effective surveillance of communicable diseases has been kept in place from the previous system. Another example of cooperation is in the area of occupational safety and health. Since 1995 employers have been responsible for financing occupational health services (1995/5). While smaller companies contract with private physicians, larger employers maintain and run their own services. On the

Fig. 8. Levels of immunization for measles in the WHO European Region, 2002 or latest available year (in parentheses)



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

Hungary

other hand, the NHPMOS controls occupational safety, supervises occupational health care at the employer level, and provides advanced occupational care through the National Institute of Occupational Health.

Within the framework of the Johan Béla National Programme, the NPHMOS has been made responsible to initiate, coordinate and supervise primary prevention and national screening programmes. Two programmes have been launched in 2003: the national screening programme for cervical cancer, which offers screening services to women aged 25 to 65 years once in every three years, and the national screening programme for breast cancer, which offers mammography screening to women aged 45 to 65 once in every two years (2003/1). A third national screening programme for colorectal cancer will be launched in the beginning of 2006 for both men and women aged 45 to 65 (2003/5).

Primary health care

According to the primary division of tasks, municipalities are responsible for primary health care (1990/3). They must ensure that family doctor services (through family physicians and family paediatricians), dental care, out-of-surgery hours services, mother and child health nurse services and school health services are available for the local population (1997/16).

The reform of primary care, especially family physician services, has been a top priority since the start of health sector reform. In the state-socialist health services district physicians and – at least in the larger municipalities – district paediatricians served the local population, strictly on a territorial basis. During the 1970s, outpatient care was brought mainly under hospital management, with the aim of integrating health services. The emphasis was put on specialist care, and district doctors had low status among medical doctors. New entrants preferred inpatient care, ranking district physician services among the last options on their priority list. Patients preferred to bypass primary care, hence district physicians did little definitive care.

The early reform measures aimed at strengthening primary care by raising its standard, extending its capacities and capabilities, and establishing a “gatekeeper” function. *Government Decree No. 55/1992. (III. 21.) Korm. and Decree No. 6/1992 (III.31.) NM* of the Minister of Welfare removed primary health care from hospital administration, renamed district physician services to “family physician services”, introduced family medicine as a new specialization (which replaced the specialty in general practice, introduced in 1976) to be obtained by all medical doctors working in primary care and made family physician referral mandatory for specialist care (gate-keeping) (1992/3). On

the other hand the “familization” of district physician services did not abolish the separation of adult and child care in large municipalities. The Minister of Welfare established the National Institute of Family Medicine at the end of 1991, to establish, coordinate and supervise the training of family physicians, and the retraining of medical doctors who had already been working in primary care (1991/6). The institute was later renamed as National Institute for Primary Care. Financing measures also backed up the reform. The funding of primary care was raised substantially, and capitation payment was introduced in 1992 (1992/4). While local governments became responsible for the provision of primary care and the owners of facilities in 1990, they were encouraged to privatize service provision, initially in the form of contracting out. All these measures transformed one of the least attractive jobs to one of the most attractive in the Hungarian health care system.

The initial impetus of the reform abated during the period of 1994–1998 and – except for some pilot projects, for instance to introduce group practice – nothing significant happened until 2000, when the government of 1998–2002 established the institution of “practice right” (2000/1, 2000/2). The original plan was to allow family physicians to sell their practice rights to newcomers, thereby making retirement more attractive to elder doctors and creating more opportunity for young ones to start working, thus improving the quality of care. Indeed, the functional privatization of primary care made it difficult for young family doctors to find a job, since many former district physicians decided to keep working after the age of retirement, as family doctors in private practice. According to the original plan the practice itself would have become a marketed commodity, whose value would have been determined by the interaction of supply and demand. Opponents of the proposal argued that in this system the price of a practice would depend on its income potential. While this measure would be good for those to whom the practice was granted, it would force the buyer to demand informal payments from patients if the official income of the practice was not sufficient to pay back the loan. Moreover, practices would be rationed by ability and willingness to pay, which had little to do with the ability to provide good quality care. Supporters, on the other hand, pointed out that excess demand had already created a black market, where practices were in fact bought and sold and the new legislation would just make this process transparent. The original plan could not be implemented, however, since the responsibility for the provision of primary care lies with local governments, not with family physicians. Changing the law would have required a two-thirds majority vote in the National Assembly.

Instead, the government introduced the so-called practice right, which has been granted to all family doctors who worked in primary care districts

with territorial supply obligation in 2000. According to the new system, if a municipality advertises a family doctor post, the applicant needs to have the relevant qualification and a practice right to be eligible. But the practice right can only be bought from family doctors who have such a right and are willing to sell it, that is to give up practising. The law is intended to ensure that practices are bought and sold, while local governments remain responsible for the provision of primary care, and maintain the discretion to decide in what form and by whom it will be provided. Thus, new entrants need not just money, but also the approval of the local government. That is, the current system has created a new barrier for young family doctors wishing to enter the market. It does not necessarily secure the practice itself for the person who bought a practice right either. There are plenty of unresolved technical difficulties with this new system as well, such as the establishment of new districts and merging of existing districts, which again have remained within the discretion of the local government.

In 2002, there were 5125 family physicians (general practitioners) and 1579 family paediatricians practising in Hungary and the average number of inhabitants per practice was 1979 and 947 respectively (9). The number of family physicians remained stable, with 6704 in 2002 (53). Local governments have the right to designate the primary care districts for family doctor services within their territory. Districts are to be designated according to the requirement that family physician services care for at least 1200 residents over the age of 14 while family paediatrician services should care for at least 600 children aged 14 or under to be eligible for Health Insurance Fund (HIF) finances (1990/3, 1997/16, 1999/1). Primary care districts must cover the entire territory of the municipality, and serve as the basis of the territorial supply obligation. This does not mean, however, that residents have to register with the provider of the primary care district where they live. Since 1992 people are allowed to choose a family doctor freely, with the restriction that they may change only once a year. Doctors are not allowed to refuse patients who live in their primary care district, but are offered the choice of not accepting applicants from other districts (1992/3). Municipalities can also decide whether to deliver family doctor services themselves or to contract with private providers.

As a result of the choice of the local government and residents, family doctors have four employment options (Fig. 14, Fig. 15):

- First, the municipality can employ family doctors on the basis of a monthly salary.
- Second, under the functional privatization scheme, family doctors contract with the municipality as private providers for a primary care district, but they work in a local government-owned surgery with local government-owned

equipment. The private family doctor services provider is paid an adjusted capitation fee to cover recurrent expenses directly from the HIF, according to the number of registered inhabitants, while the municipality remains responsible for capital costs according to the principle of “maintenance obligation”.

- Third, family doctors can work as independent private providers with no municipal contract and no territorial supply obligation, if patients choose them, but they are only entitled to capitation payment from the HIF if they have a minimum of 200 registrees. It is worth noting that the system of “practice rights”, established in 2000, does not apply to this group of family doctors.
- Fourth, the government widened the employment options by introducing the so-called freelance medical doctor status (2001/11 and 2003/14), which removes doctors from public employee regulations, but does not make them self-employed private entrepreneurs. Physicians who opt for a freelance status contract with the health care provider and are free to negotiate fees, and are allowed to form group practices as well. The impact of this measure on the performance of the health care system is not yet known.

The analysis of family physicians’ performance shows that they have not been effective gate-keepers. Between 1990 and 2002, non-diagnostic referrals to providers of outpatient specialist care more than doubled, and the number of patients sent to hospital per 1000 cases attended increased by 71% (9). One of the reasons may be that there is no incentive in the current payment system of family doctor services to provide definitive care and to avoid unnecessary referrals.

Beyond family doctor services, municipalities are also obliged to provide district mother and child health nurse services as well as school health services. The District Mother-And-Child Health Service, which was established in the previous regime, is staffed with highly qualified mother-and-child-health nurses, trained at higher education (college) level. They provide preventive care and health education to families with pregnant women, women in childbed and children under the age of 16 in geographic areas determined by the local government. According to *Decree No. 5/1995 (II. 8.) NM* of the Minister of Welfare these districts should cover no more than 400 persons to be cared for (1995/3). Mother-and-child-health nurses are employed by the local government and work autonomously in the surgery provided by it, or visit families and schools. The work of district mother-and-child-health nurses is coordinated and supervised by senior mother-and-child-health nurse officers at the county level and the national chief mother-and-child-health nurse, who are employed by NPHMOS. Mother-and-child-health nurses also provide school health services

together with medical doctors, to prevent disease in children between the age of 3 and 18. According to the number of pupils to be cared for, the district mother-and-child-health nurse and the family physician or paediatrician may provide school health services on a part-time or full-time basis. School mother-and-child-health nurses and doctors have to be employed by the school. The exact numbers and other professional requirements are determined by *Decree No. 26 of 1995 (IX. 3.) NM of the Minister of Welfare on School Health Services*.

Secondary and tertiary care

The provision of secondary and tertiary care is shared among municipalities, counties, the national government and, to a minor extent, private providers (Fig. 2). The various providers exhibit a wide range of activities in terms of the level of care (secondary or tertiary), the number of specialties covered (single- or multi-specialties) and the type of care (chronic or acute, and inpatient or outpatient).

According to the primary division of tasks between counties and municipalities, only the former are responsible for the provision of secondary and tertiary care to the local population. In practice, however, municipalities also provide specialist care on the basis of the principle of subsidiarity. In general, county governments own large multi-speciality *county hospitals*, which provide secondary and tertiary inpatient and outpatient care to the acutely and chronically ill, while municipalities own: *polyclinics*, independent, multi-specialty institutions providing outpatient specialist care; *dispensaries*, single-specialty institutions providing outpatient care to the chronically ill; and multi-speciality *municipal hospitals* providing secondary acute and chronic, inpatient and outpatient care. Outpatient care is provided in the hospital, or in a separate building of a previously independent polyclinic later integrated into the hospital.

The national government also owns hospitals, which provide acute and chronic, inpatient and outpatient care. These are divided among the Ministry of the Interior, the Ministry of Economic Affairs and Transport, the Ministry of Defence, the Ministry of Justice, the Ministry of Education and the Ministry of Health, Social and Family Affairs. The Ministry of Education owns university hospitals. The single-speciality clinical departments of the medical faculties provide both secondary and tertiary care. The Ministry of Health has single-specialty providers, the *national institutes of health*, which mainly deliver highly specialized tertiary care only. The ministry also owns *state hospitals*, which are mainly sanatoria that provide medical rehabilitation.

The territorial supply obligation applies to all public providers, but the size of the catchment area depends on the type of care provided and on the estimated number of people in need. The same health care institution can have different catchment areas for different types of care. In general, secondary outpatient care services have been assigned the smallest catchment area, but still larger than primary care districts. Tertiary care is to be offered at least on a regional basis, which includes the population of more than one county. Highly specialized tertiary care services, which are provided to patients suffering from rare diseases, have the largest catchment area, namely the whole country (1990/3, 1997/16).

A small private sector is also involved in the provision of specialist care, but usually providers have no contract with the National Health Insurance Fund Administration (NHIFA) and users have therefore to pay out-of-pocket. So far, there have been two exceptions: specialist services with a shortage of public capacities, like kidney dialysis or magnetic resonance imaging, and hospitals owned by churches or charities. But these private non-profit providers are integrated into the main system of financing and service delivery (31).

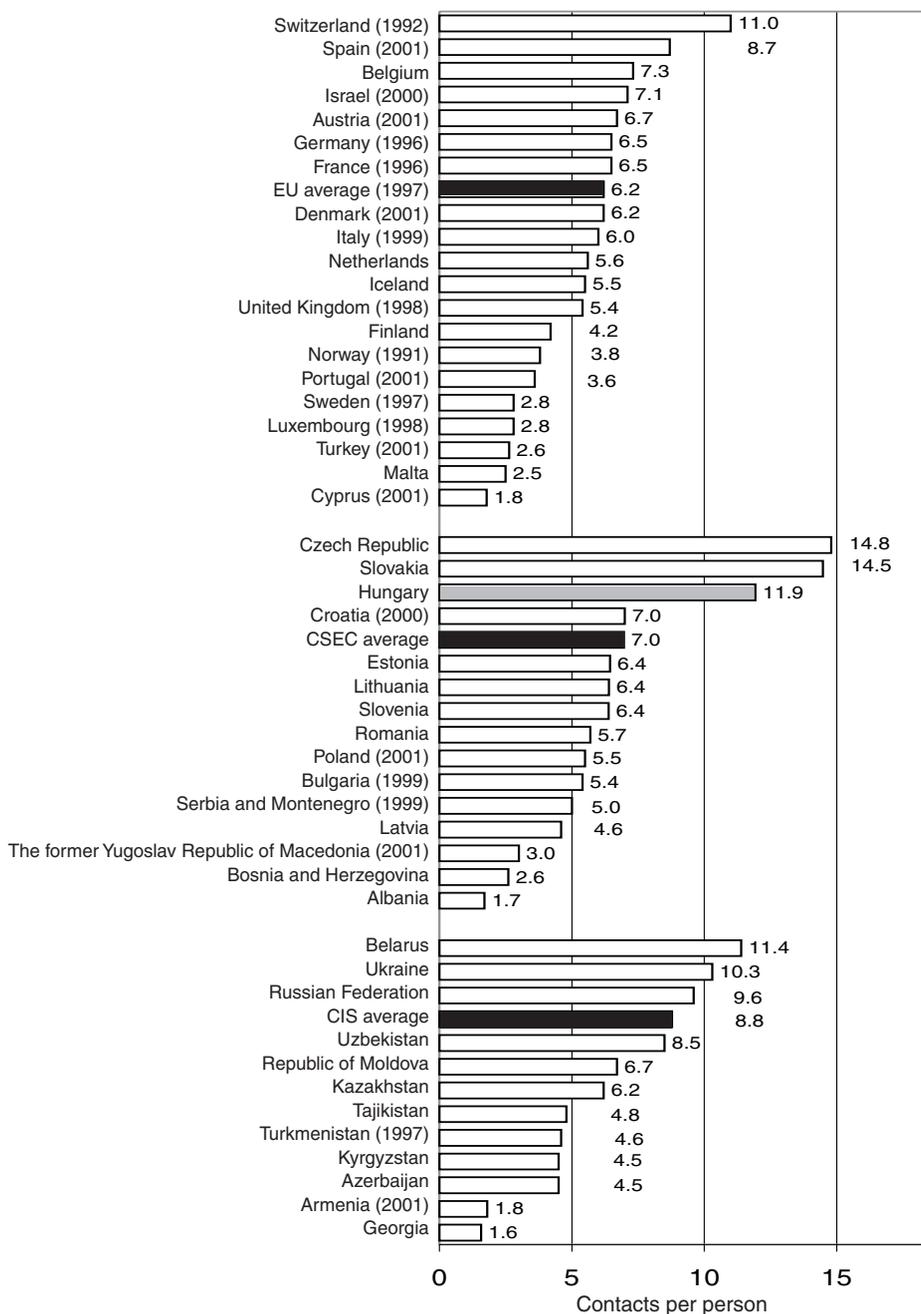
Outpatient specialist services

According to the mentioned provider typology, outpatient specialist services are provided by polyclinics, dispensaries, municipal hospitals, county hospitals, clinical departments of universities, national institutes and health care institutions of other ministries, for example, the Central Hospital of the Ministry of the Interior.

Independent polyclinics employed specialists who worked exclusively in outpatient care. In the early phase of the reform, the objective was to integrate polyclinics partly into hospitals, partly to primary care. Instead of the “three-leg” organization of the state-socialist health care system, integration would have made a “two-leg” system of primary care and specialist care but the integration policy did not work.

Dispensaries were established during the communist regime. They provide outpatient care to chronically ill people with pulmonary diseases, skin and sexually transmittable diseases, alcohol and drug addiction as well as psychiatric disorders. In addition to this chronic outpatient specialist care, dispensaries implement screening programmes in their respective specialties and for hypertension, diabetes, cancer and kidney diseases. In 2002 there were 162 pulmonary, 124 dermato-venereal, 144 psychiatric and 139 addiction dispensaries in Hungary (9).

Fig. 9. Outpatient contacts per person in the WHO European Region, 2002 or latest available year (in parentheses)



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

Note: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

In principle, patients need a referral from the family doctor to utilize outpatient specialist care, if they do not want to pay for it. However, there are numerous exceptions to these gatekeeping regulations. Patients have direct access to specialists for dermatology, ear, nose and throat diseases, obstetrics and gynaecology, general surgery, traumatology, ophthalmology, oncology, urology and psychiatric outpatient care, including dispensaries (1997/9). Moreover, in practice, patients can easily bypass the system, since family doctors have no incentive to deny administering the referral, should patients want to see specialists directly. According to the European health for all database in 2002, Hungary had the third largest number of outpatient specialist contacts per inhabitant among all countries of the WHO European Region. With 11.9 visits per person per year, Hungary ranked third behind the Czech Republic (14.8) and Slovakia (14.5) (Fig. 9).

High utilization rates in the outpatient specialist sector would not be undesirable, if unnecessary hospitalization were avoided by delivering definitive care. However, hospital admission rates in Hungary are comparably high as well (Table 13, Fig. 10, Fig. 11). Utilization of outpatient specialist services was substantially higher than in Finland or Austria, for example, where admissions to acute hospitals are about as high as in Hungary (Table 13).

At the same time, data on the performance of medical specialists question whether current practices in outpatient care allow for the provision of high-quality definitive care and for avoiding hospitalization. Medical specialists spent an average of 5.9 minutes per patient visit in 2001 (1). The relatively short duration of contacts may also encourage patients to seek reappointments or to see another doctor.

Inpatient services

In 2002, Hungary had 182 hospitals and 80 844 approved hospital beds, excluding those of the Ministry of Justice (1). These hospitals, by and large, can provide inpatient care at municipal, county, and regional or national levels, indicating the level of specialization (“progressivity”), which, in general, coincides with the hospital’s catchment area. However, hospitals that provide care in more than one medical specialty can have different specialization levels for different specialties and consequently different catchment areas, as well. Moreover, a hospital can have different catchment areas for the same specialty, as do clinical departments of university medical faculties that have a local catchment area for secondary care and a national catchment area for tertiary care within the same specialty.

The principle of the health care delivery system is that patients must receive care at the lowest level of specialization that can provide adequate treatment, and must be transferred to hospitals with higher levels of specialization only if the problem cannot be solved (1997/9). Where a patient ends up in the hospital system, in principle, depends on the frequency of the disease, the severity or complexity of the case, and the cost and complexity of the available and required therapy.

Municipal hospitals usually offer main specialties, such as internal medicine, obstetrics and gynaecology and surgery. They have the lowest level of specialization and the smallest catchment area. County hospitals usually cover the whole spectrum of secondary care, providing additional specialties, like haematology, immunology, cardiology and psychiatry for the population of an entire county. For the basic specialties county hospitals usually have a local catchment area with the lowest level of specialization and accept more severe or complex cases from municipal hospitals as the second level of specialization with the catchment area of the whole county. They may also provide tertiary care, like open heart surgery, for the population of a region comprising more than one county. Finally, clinical departments of university medical faculties and national institutes provide care of the highest level of specialization for the whole country, but university clinical departments have local catchment areas as well (Fig. 2).

In 2002, local governments owned 76% of all hospital beds in Hungary, of which 14.8% were in the capital (1). University clinical departments had 8.9%, national institutes had 8.2%, the health care institutions of the Hungarian State Railway had 1.9% and the Ministry of the Interior and the Ministry of Defence had 2.5% of the total number of beds. In addition, 2.6% of all hospital beds were owned by churches and charities operating hospitals under territorial supply obligation and were therefore eligible for HIF financing. Private non-profit organizations operate in different fields of inpatient care, the majority of beds being provided in internal medicine, paediatrics, psychiatry and follow-up care.

All hospitals must register and obtain a licence from the NPHMOS, after meeting minimum standards of human and material resources, and must take out liability insurance (1989/4, 1998/7). Hospitals providing care under the territorial supply obligation must have a quality control system in place and set up a hospital supervisory council (1997/16). Hospitals contract with the NHIFA for capacities defined in terms of acute and chronic beds per speciality, and are reimbursed according to various payment methods. Acute inpatient care is paid on the basis of diagnosis related groups (DRGs), while chronic inpatient care is paid by patient days adjusted for the complexity of the case (1999/1). However,

as mentioned before, the HIF payment covers only the recurrent costs of services. Investments are the responsibility of owners, but local governments can apply for capital grants to the national government (dual system of financing).

One of the most serious legacies of the state-socialist health care system faced by the reform governments was the oversized hospital sector, which was regarded inefficient and inequitable for a number of reasons. First, excess capacity sucked up a substantial portion of the health care budget. Second, under line-item budgeting hospital management had no incentive, and not even discretion, to use resources efficiently. Third, budget-setting was subject to political influence, which resulted in inequitable resource allocation. Fourth, hospital managers were medical doctors without adequate training in health administration, working on a part time basis without giving up concurrent medical practice. Fifth, hospital beds were used to provide social care, because of insufficient institutional capacity.

In the first phase of the reform, the government introduced the DRG-based hospital payment for acute, and patient-day payment for chronic inpatient care, and the three-member hospital top management structure, according to which the financial director, the medical director and the nursing director managed the institution together. These measures did not produce significant structural reorganization in the hospital system, but it has to be noted that the incentives of the DRG payment had not been allowed to operate fully until 1998 (1996/12).

The next government attempted to tackle the issue directly. First, as part of the restrictive package of 1995, the Ministry of Welfare became responsible for bed reduction decisions by determining the capacities to be contracted for in the frame of the territorial supply obligation of local governments. Although 8000 beds were removed from the system in 1995, the decision-making process was found unconstitutional (1995/6, 8). The ruling of the Constitutional Court ordered the government to elaborate a more systematic method for the definition of the territorial supply obligation. The *1996 Capacity Act* determined the maximum number of beds and outpatient consultation hours per speciality and per county, according to a formula that aimed to represent the health needs of the local populations (1996/3). It was expected that the law would result in not just a considerable reduction, but more equitable geographical distribution of hospital beds. The implementation of the law was left to the “county consensus committees” convened by the NPHMOS and comprised of representatives of local health care providers, such as hospitals, the local organizations of the Hungarian Medical Chamber and county offices of the NHIFA. In counties where beds had to be reduced according to the formula, the county consensus committees had to agree which provider would give up how many beds. As a

Table 11. Inpatient capacities, 1980–2002 (selected years)

	1980	1990	1994	1996	1997	2000	2001	2002
Approved hospital beds per 1000 population	9.1	10.1	9.8	9.0	9.0	8.2	7.9	7.9
– Acute hospital beds	6.6	7.1	7.1	6.2	5.8	5.6	6.0	6.0
– Chronic hospital beds	2.5	3.0	2.7	2.8	2.5	2.6	1.9	1.9
Hospital beds in operation per 1000 population (a)	8.7	9.8	9.4	8.9	8.2	8.2	7.9	7.9
Hospital beds per 1000 population (b)	9.1 ^a	9.8	9.3	8.8	8.2	8.1	7.9	7.6
– Acute hospital beds	6.6	7.1	–	6.9	5.7	6.3	6.0	6.0
– Psychiatric hospital beds	1.2	1.3	1.0	1.0	0.5	1.0	1.0	1.0
– Nursing & elderly home beds	0.3	0.4	0.5	0.6	0.6	0.6	0.6	0.6

Source: Hungarian Central Statistical Office (9,42,43,44,45,46): excluding hospital beds of the Ministry of Justice, and until 1992 hospital beds of the Ministry of Defence and Ministry of the Interior. (a) Database of the Information Centre for Health Care of the Ministry of Health (47); (b) WHO Regional Office for Europe health for all database (10).

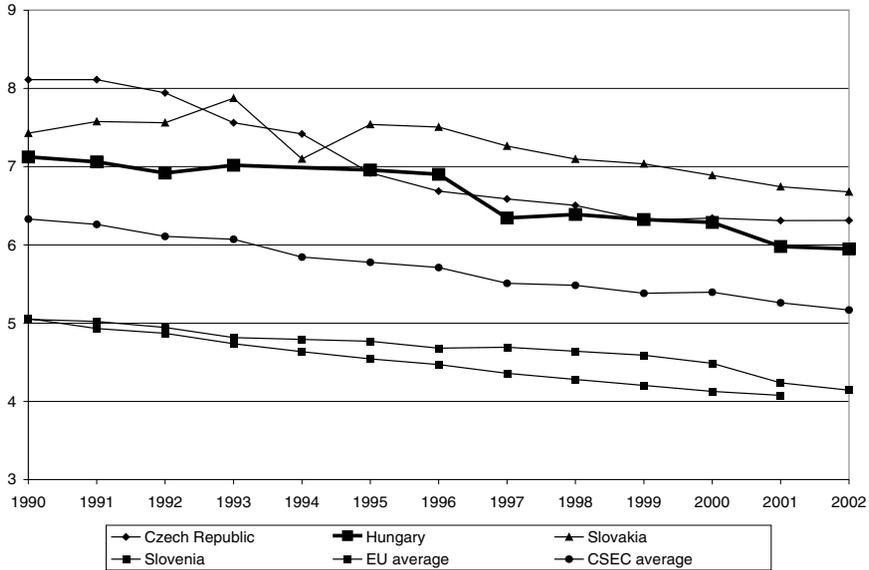
Note: ^a data for 1981.

result, the number of beds dropped by another 9000 for 1997, and has remained stable at around 8 beds per 1000 population (Table 11).

The government of 1994–1998 exercised a few other changes in the hospital sector. It abolished the three-person hospital management structure and phased in the minimum requirements of service provision (1996/5). The establishment of a hospital supervisory council and the introduction of quality control systems in hospitals were made compulsory (1997/16). The government also encouraged the spreading of cost-effective forms of care, including one-day surgery and home care. For instance in 1996, a separate sub-budget was created for home care services in the HIF, for which HIF expenditures increased subsequently (Table 10).

As a result of all these changes, acute hospital beds were reduced by 20% between 1992 and 1997, according to national statistics, and the number of hospital beds for chronically ill patients was also reduced by 17% (Table 11). At the end of 2002, 7.9 hospital beds per 1000 population were still in operation (Table 11). Despite downsizing of inpatient capacities, the number of acute hospital beds in Hungary per 1000 population still rank above the average of EU countries and CSE countries (Fig. 11), but below the rate of neighbouring countries with similar economic development such as the Czech Republic and Slovakia (Fig. 10). The capacities for long-term nursing care in institutions but also in ambulatory care are still considered insufficient to meet the needs of the ageing population (37,48,52) (see the section on *Social care*).

Fig. 10. Hospital beds in acute hospitals per 1000 population in Hungary and selected European countries, 1990–2002

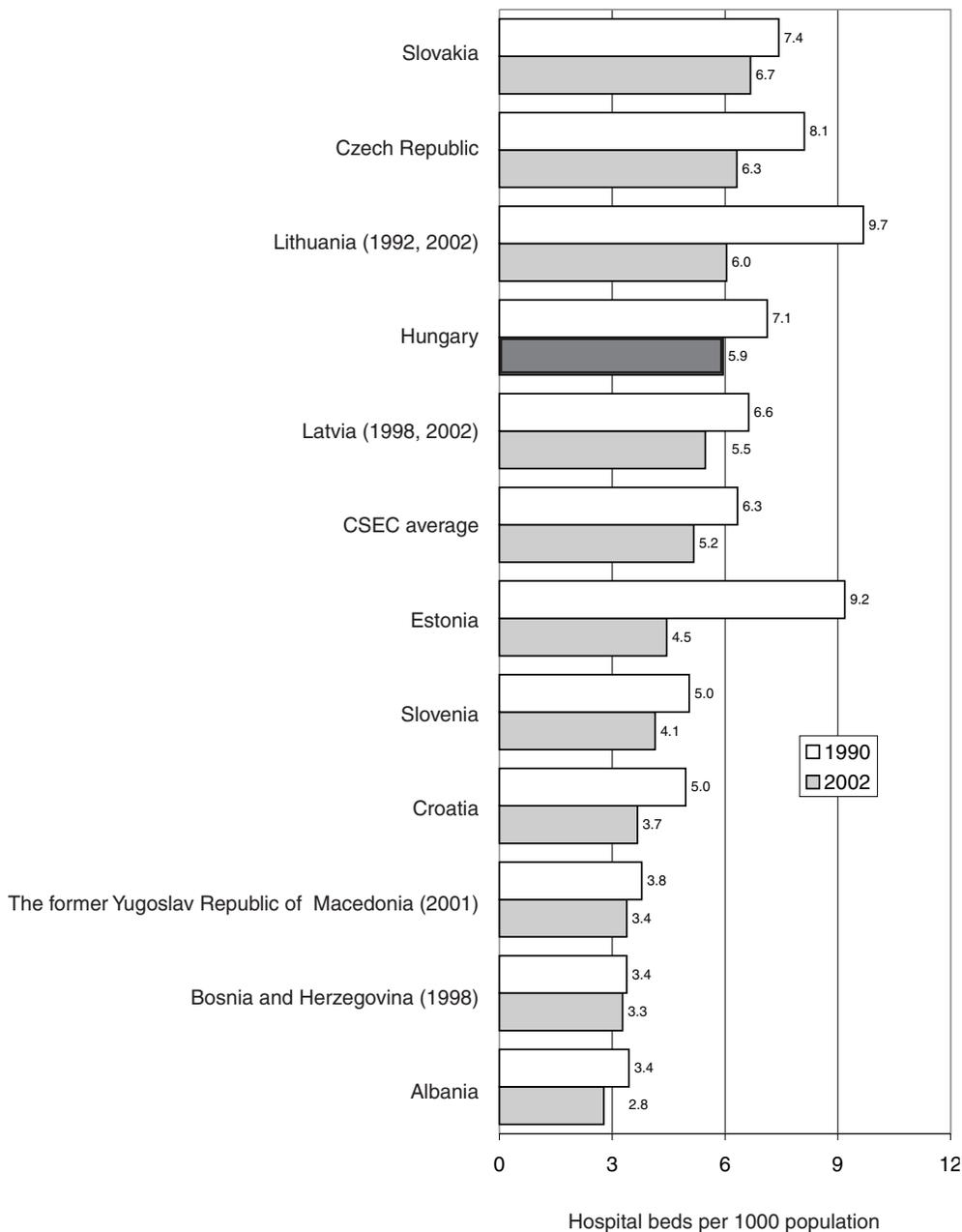


Source: WHO Regional Office for Europe health for all database.

Note: CSEC: Central and south-eastern European countries; EU: European Union.

So, has technical efficiency improved within the hospital sector as a result of these reform measures? Table 12 provides measures of inputs and outputs whose comparison makes efficiency of inpatient care visible. Between 1994 and 2000, hospital discharges increased by more than 10%, while the NHIFA expenditure on acute inpatient care decreased by nearly 20% in real terms (Table 12). Since the introduction of DRGs, however, a better measure of the output of acute inpatient care is the total number of DRG points produced by hospitals. In the DRG system, hospital cases are weighted according to complexity and costs – for instance a bypass surgery is assigned more points than an appendectomy – and these points are added up, not just the number of cases. That is the DRG system considers not just the number, but the complexity of hospital cases (case-mix). Data on the HIF budget of acute inpatient care at constant prices is used as a measure of inputs. Comparing costs and outputs, acute inpatient care produced more output in terms of DRG points from a smaller budget in 2000 than in 1994. These results suggest that efficiency in acute hospitals increased by almost 30% via reduction of cost per unit of output. Other, partial measures, like average length of stay, show a similar tendency (Table 12).

Fig. 11. Hospital beds in acute hospitals per 1000 population in central and south-eastern Europe, 1990 and 2002 or latest available year (in parentheses)



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

Note: CSEC: Central and south-eastern European countries.

The DRG payment system encourages hospitals to treat cases at least cost, which requires transparent cost accounting and increase the cost-consciousness of managers and health professionals alike. Hospitals are interested in short term hospitalization within certain limits, but it has to be noted that the decreasing trend of average length of stay started well before the partial or full introduction of the new payment method. In addition, there are some other factors to be considered, to make a really robust statement about the efficiency of the Hungarian acute inpatient care sector.

Table 12. Trends in utilization and performance of inpatient facilities, 1980–2000

	1980	1990	1994	1995	1996	1997	1998	1999	2000
Discharges per 1000 population (acute and chronic hospitals)	188	218	227	233	242	244	250	253	260
– in acute hospitals	168	191	199	205	211	213	217	218	224
Average length of stay (days)	14.2	12.7	11.3	10.8	10.8	9.8	9.1	9.2	8.9
– in acute hospitals	11.2	9.9	9.0	8.6	8.0	7.6	7.3	7.0	6.7
– in chronic hospitals	38.5	32.2	27.1	26.9	26.0	24.0	23.4	22.3	22.2
Bed occupancy rate									
– acute hospitals (% of approved beds)	83.3	74.9	71.6	71.9	74.4	77.8	75.8	73.5	72.5
– chronic hospitals (% of approved beds)	93.2	84.6	80.9	80.6	81.3	86.2	86.2	84.8	85.0
Sum of DRG points delivered per year (million) (a)	–	–	2.1	2.3	2.5	2.3	2.5	2.3	2.4
Case-Mix-Index (a)	–	–	1.03	1.07	1.11	1.09	1.15	1.06	1.10
HIF expenditure on acute hospital care (current prices, billion Ft)	–	–	83.5	96.9	116	135	160	183	191
– at 1990 constant prices (billion Ft) ^a	–	–	25.3	22.4	21.4	21.1	21.4	22.1	21.0
HIF average payment per DRG point									
– at 1990 constant prices, (1000 Ft) ^a	–	–	12.3	9.8	8.7	9.3	8.6	9.7	8.7
Hospital mortality (% of discharges)	3.4	3.4	3.4	3.3	3.2	3.1	3.1	3.1	2.9
SDR per 100 000 population, age 0–64 years (b)									
– appendicitis	0.8	0.2	0.1	0.2	0.1	0.2	0.2	0.2	0.1
– hernia and intestinal obstruction	1.4	1.2	1.0	0.9	0.9	0.8	0.8	0.9	0.7

Source: Hungarian Central Statistical Office (9,42,43,44,45,46); (a) Database of the Information Centre for Health Care of the Ministry of Health (47); (b) WHO Regional Office for Europe health for all database (10).

Notes: ^a Applying health care price deflator; SDR: age-standardized death rate; HIF: Health Insurance Fund.

First, the increase in the quantity of output and the reduction of costs produce efficiency gains only if the quality of care does not suffer from cost reduction. Some indicators for hospital mortality and certain avoidable causes of death (Table 12) or infant and maternal mortality (Table 3) do not show unfavourable trends (rather some improvement), suggesting that quality has at least not been affected dramatically.

Second, the interpretation of efficiency indicators has to take into account that increase in output may not represent a real increase, but result from manipulated reporting. It is well known that the DRG system stimulates hospitals to describe actual cases as serious as possible to earn more revenue, and thereby the average case severity – the so-called case mix index – increases. There is some evidence of such “DRG creep” in the Hungarian health care system, as the increases in the case mix index were not coupled with an increase in hospital mortality (Table 12). It is possible, however, that the increased case mix index is partly a result of better coding of actual cases by the hospitals and not of over-reporting.

Third, it has to be noted that the efficiency increase of the acute inpatient care sector does not say anything about the efficiency of the whole health care system, for example, whether all admitted patients really needed hospitalization, or might have been treated as outpatients. With acute hospital admission rates of 2.3 per 100 inhabitants, Hungary ranked second among countries of the WHO European Region in 2002 (Table 13). In previous years, acute admissions and all hospital admissions had also been among the highest in the region (10). This certainly cannot be explained on the sole basis of the bad health status of the population. Currently there is no effective system in place to prevent unjustified hospitalization, and providers have a strong incentive to increase hospital throughput.

During the 1990s it also became obvious that inadequate hospital management was a source of inefficiency and a barrier to meeting new challenges. There are two main reasons for this. First, many hospital directors did not have management qualifications. The government tried to address this problem by establishing health service management training, but until recently a degree in management was not a prerequisite for hospital management posts. Second, public hospitals have been operating as budgetary units, while health care workers are public employees subject to civil service laws, allowing little management discretion over human and material resources or financing issues.

The government of 1998–2002 attempted to grant more operating freedom to hospital managers by allowing and encouraging corporatization and freelance medical practice (2001/11). The new legislation has not made the changes compulsory, but those institutions, medical doctors and pharmacists who

Table 13. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Andorra	2.8	10.1	6.7 ^c	70.0 ^c
Austria	6.1	28.6	6.0	76.4
Belgium	5.8 ^a	16.9 ^c	8.0 ^c	79.9 ^d
Cyprus	4.1 ^b	8.1 ^a	5.5 ^a	80.1 ^a
Denmark	3.4 ^a	17.8 ^a	3.8 ^a	83.5 ^b
EU average	4.1 ^a	18.1 ^c	7.1 ^c	77.9 ^d
Finland	2.3	19.9	4.4	74.0 ^g
France	4.0 ^a	20.4 ^c	5.5 ^c	77.4 ^c
Germany	6.3 ^a	20.5 ^a	9.3 ^a	80.1 ^a
Greece	3.9 ^b	15.2 ^d	—	—
Iceland	3.7 ^f	15.3 ^d	5.7 ^d	—
Ireland	3.0	14.1	6.5	84.4
Israel	2.2	17.6	4.1	94.0
Italy	3.9 ^a	15.6 ^a	6.9 ^a	76.0 ^a
Luxembourg	5.6	18.4 ^h	7.7 ^d	74.3 ^h
Malta	3.5	11.0	4.3	83.0
Netherlands	3.1 ^a	8.8 ^a	7.4 ^a	58.4 ^a
Norway	3.1 ^a	16.0 ^a	5.8 ^a	87.2 ^a
Portugal	3.3 ^d	11.9 ^d	7.3 ^d	75.5 ^d
Spain	3.0 ^e	11.5 ^d	7.5 ^d	76.1 ^d
Sweden	2.3	15.1	6.4	77.5 ^f
Switzerland	4.0 ^a	16.3 ^d	9.2 ^a	84.6 ^a
Turkey	2.1	7.7	5.4	53.7
United Kingdom	2.4 ^d	21.4 ^f	5.0 ^f	80.8 ^d
CSEC				
Albania	2.8	—	—	—
Bosnia and Herzegovina	3.3 ^d	7.2 ^d	9.8 ^d	62.6 ^c
Bulgaria	—	14.8 ^f	10.7 ^f	64.1 ^f
Croatia	3.7	13.8	8.7	89.6
CSEC average	5.2	17.6	8.1	72.5
Czech Republic	6.3	19.7	8.5	72.1
Estonia	4.5	17.2	6.9	64.6
Hungary	5.9	22.9	6.9	77.8
Latvia	5.5	18.0	—	—
Lithuania	6.0	21.7	8.2	73.8
Slovakia	6.7	18.0	8.8	66.2
Slovenia	4.1	15.7	6.6	69.0
The former Yugoslav Republic of Macedonia	3.4 ^a	8.2 ^a	8.0 ^a	53.7 ^a
CIS				
Armenia	3.8	5.9	8.9	31.6 ^a
Azerbaijan	7.7	4.7	15.3	25.6
Belarus	—	—	—	88.7 ^h
CIS average	8.2	19.7	12.7	85.4
Georgia	3.6	4.4	7.4	82.0 ^a
Kazakhstan	5.1	15.5	10.9	98.5
Kyrgyzstan	4.3	12.2	10.3	86.8
Republic of Moldova	4.7	13.1	9.7	75.1
Russian Federation	9.5	22.2	13.5	86.1
Tajikistan	5.7	9.1	12.0	55.1
Turkmenistan	6.0 ^e	12.4 ^e	11.1 ^e	72.1 ^e
Ukraine	7.2	19.2	12.3	89.2 ^d
Uzbekistan	—	—	—	84.5

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

Notes: ^a 2001, ^b 2000, ^c 1999, ^d 1998, ^e 1997, ^f 1996, ^g 1995, ^h 1994.

CIS: Commonwealth of Independent States; CSEC: Central and south eastern countries.

choose these options will be freed from public service regulations. The law has also made management qualification compulsory for the top management of hospitals. The present government also emphasized managerial competence as a key factor to use resources efficiently within the health sector. A hospital consolidation project is being implemented, which is accompanied by management development programmes (18).

Social care

The boundaries between the health and the social sectors are not sharp, and in certain cases it is difficult to decide which institution should provide care, for instance for the chronically ill elderly, or the mentally handicapped.

Local governments are responsible for the provision of social care (1990/3), and *Act III of 1993 on Social Services* determines the types of care to be provided, the rules of eligibility and the rules of financing. In general, the poor and the disabled are eligible for social assistance. In the case of special institutional care for the disabled, certain groups are stipulated in the act: the elderly, the disabled, the mentally handicapped, drug addicts and the homeless. The scope of services includes cash and in-kind benefits. Cash benefits for the poor may be regular, like income supplements for the elderly, or one-off for people in a transitory crisis situation. In-kind benefits can take two main forms: in-kind benefits for the poor and services of personal social care, that is, in-kind benefits for the disabled.

In-kind benefits for the poor can be either reimbursement of actual expenses or provision of services in-kind. For instance, the poor can be eligible for funeral aid in cash, or a public funeral. The two main health care related in-kind benefits are pharmaceutical co-payment exemptions (KÖZGYÓGY) and eligibility for health care services. For the former, the government covers co-payment of a list of essential drugs and medical aids and prostheses. For the latter, the poor who otherwise would not be covered by the social health insurance scheme become eligible for health care. In both cases the local government determines eligibility by means testing and issue an identity card certifying eligibility to the provider.

In-kind benefits for the disabled include primary social care in the home, including catering and domestic help, and special social care in institutions, including short- and long-term residential care, and rehabilitation. A special form of institutional care takes place in community homes, which provide places for 8 to 14 physically or mentally handicapped people who are at least partially able to care for themselves, with the aim of reintegrating them into the community.

In 2000, 97.7 people per 10 000 received social catering, and 40.1 domestic help. As far as institutional care is concerned, there were 71.9 persons per 10 000 population in short- or long-term residential homes, 55% in residential homes for the elderly, 11% in homes for the mentally handicapped, 21% in homes for the disabled, 2% in homes for drug addicts, 9% in homes for the homeless and 2% in other institutions. The shortage of places in institutions is still a problem. In 2000, 20 people per 10 000 were on waiting lists, half for more than a year. The shortage is most pressing in residential homes for the elderly as applicants for residential elderly care accounted for 70% of people on a waiting list for institutional social care (1). In 1999, Hungary had 58 beds per 100 000 inhabitants in homes for nursing or elderly care (Table 11) which ranked among the lowest in EU and OECD countries. As the share of elderly in need of care is expected to increase, the need for long-term nursing care is expected to rise as well (23,37,48,52).

Just as in the case of health care, the responsibility for provision does not imply that local governments have to deliver the services, and contracting out is even more prevalent in the social than in the health sector. In 2000, the share of nongovernmental social care providers was 24% (1). The services are financed from several sources. The national government provides a capitation payment to support cash benefits, in-kind benefits for the poor and primary social care according to the number of local residents and a capitation payment covering institutional care according to the number of disabled people in residential homes. In addition, the national government fully covers certain cash benefits, and the costs of pharmaceutical co-payment exemptions. There are other conditional grants available from the central government budget, and the local government can supplement these funds from its own revenue of local taxation.

Human resources and training

According to WHO data, Hungary had 3.2 active physicians and 8.5 nurses per 1000 population in 2002 (Fig.13). The country's physician workforce ranked similar to neighbouring countries and lower than the EU15 average (Fig. 12).

Nevertheless, the average number of health personnel hides geographical inequalities, as well as inequalities in terms of specialties. Apart from counties with medical universities, the average number of practicing physicians was the lowest in Szabolcs-Szatmár-Bereg County, with 2.2 per 1000 population in 1999 (9). From the 33 308 medical posts that were available in the public sector, 9% were unfilled, implying not just regional differences, but differences among

specialties. For instance, there was not only a shortage of public health doctors, with 19% of the available posts unfilled, but also in inpatient care, where the corresponding figure was 13%. In contrast, 99% of family physician and family paediatrician primary care districts were filled in 1999 (9).

Throughout the last two decades, the share of general practitioners remained low at around 20% of total active physicians, while specialists accounted for around 80% of the physician workforce (Table 14).

The problems with the overall number of health care professionals in Hungary, their distribution, structure and skill-mix are chiefly inherited from the previous regime. In the course of the state-socialist health services, the salaries of health workers, especially of medical doctors, were kept low compared to other sectors of the economy in Hungary and especially to western European countries. The practice of giving informal payment became widespread, but informal payments were not equally distributed among health professions or medical specialties. The result was that well-paying specialties, like surgery and obstetrics and gynaecology were particularly attractive to new entrants. Other medical specialties, such as diagnostic services, public hygiene and paramedical professions in general began to exhibit shortages. The shortage of nurses and health care support personnel also forced medical doctors, the many specialists as well as family physicians, to carry out nursing and administrative duties (37,48). Moreover, low salaries and informal payment kept medical doctors working well after the age of retirement since the state pension was too low to maintain a decent living standard. In 1999, 6% of working medical doctors were over 65, and more than 3% over 70 (9).

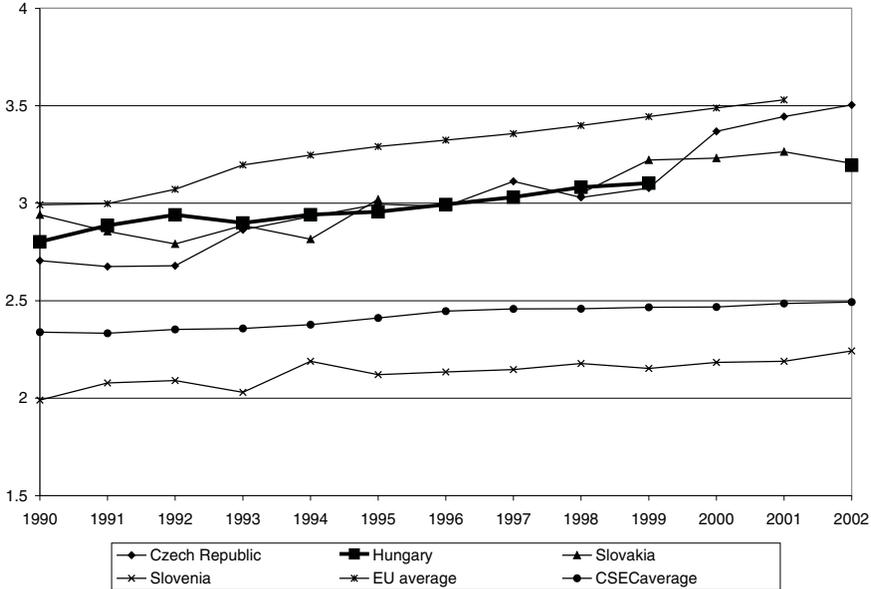
Table 14. Health care personnel per 100 000 population, 1985–2002 (selected years)

Number per 100 000 population	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002
Active physicians	289	280	296	299	303	308	310	–	–	319
Active family doctors ^a	52	57	63	64	65	66	66	66	66	66
Active nurses	–	773	797	801	795	807	793	798	834	855
Active dentists	35	40	40	42	44	45	45	–	–	48
Active pharmacists	32 ^b	33	33	40	43	47	47	48	49	50
Active midwives	24	25	23	23	22	22	22	21	20	20
Physicians graduated	9	9	10	10	9	8	9	9	10	10
Nurses graduated	78	50	53	45	54	53	43	–	48	47

Source: WHO Regional Office for Europe health for all database (10).

Note: ^a includes family physicians and family paediatricians; ^b data for 1987.

Fig. 12. Physicians per 1000 population in Hungary and selected European countries, 1985-2002



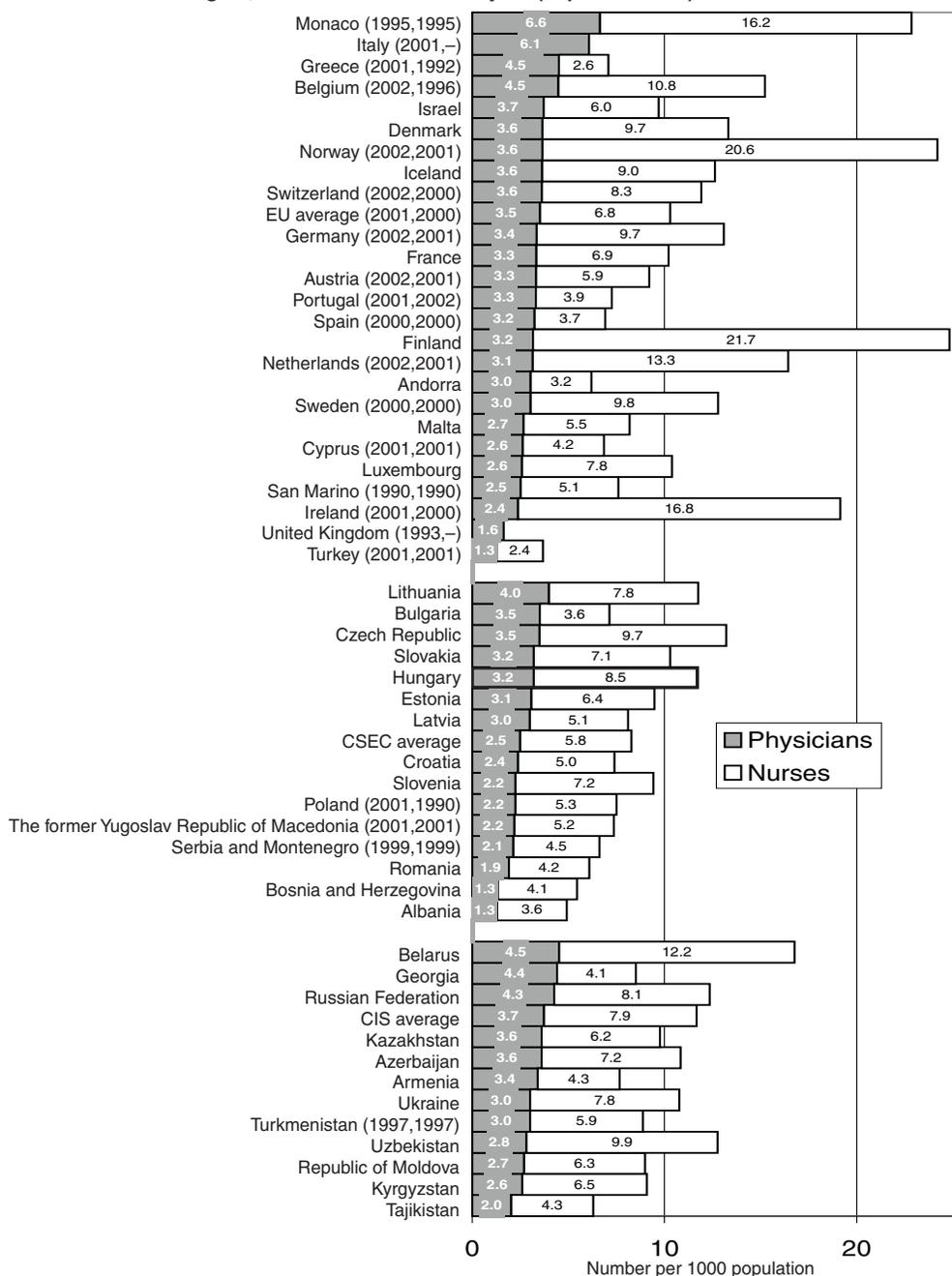
Source: WHO Regional Office for Europe health for all database.

Note: CSEC: Central and south-eastern European countries; EU: European Union.

Until recently, governments did not do much to tackle these problems. Health workers remained public employees with low salaries, which made health, particularly paramedical professions less and less attractive. The only exception was primary care, which became popular as a result of specific reform measures, despite its low status during the communist regime. This is reflected by the 99% occupation rate of family doctor districts (9). One of the first measures of the current government, however, was to increase the salary of health workers and other public employees by an average of 50% (2002/15). This is by far the most substantial pay rise the health sector has seen in the new era. In addition, the government introduced a compulsory minimum wage for employees with higher educational qualifications (twice the minimum wage). It also offered a “loyalty bonus” (equal to one year’s salary) for nurses and other qualified non-medical health professionals who have been working at least for four years in the health sector.

The training of health care professionals is carried out on the secondary, post-secondary and higher education levels, supervised by the Ministry of Education, and in the form of professional training supervised by the Ministry

Fig. 13. Number of physicians and nurses per 1000 population in the WHO European Region, 2002 or latest available year (in parentheses)



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

Note: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

of Health. Medical doctors and pharmacists are trained at four universities, into which the faculties of the five medical universities have been integrated (16). Undergraduate education takes six years for medical doctors, five years for dentists and four and a half years for pharmacists. In addition, universities can offer postgraduate and continuing education courses. Postgraduate professional training of medical doctors is carried out under the central trainee system, a centrally elaborated residency programme supervised and financed by the Ministry of Health.

Non-medical health professionals, like nurses and assistants, are trained on several levels. Practising nurses have been trained at secondary level vocational schools for four years. However, nurse training recently has been harmonized with the EU requirements, and elevated to the post-secondary level. The 3-year training course gives a diploma in nursing. Basic nursing education can be followed by post-basic clinical specialization courses in the form of on-the-job training in various nursing specialties, such as oncology. Nine colleges of nursing offer a four-year baccalaureate diploma in nursing, and graduates can continue in postgraduate programmes (49). There are qualified health workers who enter directly into higher education courses, including highly qualified nurses with diplomas, mother-and-child health nurses, midwives, emergency ambulance officers, dieticians, physiotherapists, sanitary inspectors and optometrists. Further training of qualified health workers is offered by health faculties of universities, and in the two training institutions of the Ministry of Health. One of these, the Institute for Basic and Continuing Education of Health Workers, operates the registration system of non-medical health professionals (1998/10).

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

Pharmaceuticals and health care technology assessment

Pharmaceuticals

In Hungary, the pharmaceutical industry is comprehensively regulated, from production to marketing and distribution (1998/2). Pharmaceutical companies were previously owned by the state and supplied not just most of the domestic market, but exported to countries of the former socialist bloc. In the early period of the economic transition, the market was liberalized, and all but one Hungarian pharmaceutical company were privatized. The majority of the wholesale and retail industries has also been privatized, and by the end of 1997 all of the previously state-owned pharmacies serving the general public were private (1). In 1992, Hungary signed the European Free Trade Area agreement and the Pharmaceutical Inspection Convention, and now follows EU registration conventions and inter-country notification practices, and enforces mandatory standards of good laboratory, manufacturing and clinical practices.

All pharmaceuticals must pass a registration and licensing procedure administered by the National Institute of Pharmacy (1998/2, 1982/1) before they can enter into trade. The price of drugs, including the wholesale and retail margins, are also regulated (2001/2). Price negotiations for the outpatient sector take place between the producers and a governmental committee. Representatives of the Ministry of Health, the Ministry of Finance and the NHIFA take part in the annual negotiations. This has been formalized as the Social Insurance Price and Subsidy Committee (2000/6). During the negotiations, the parties agree on the amount of any subsidies a drug will receive and its consumer price. Previously the Minister of Health promulgated the agreement (1995/1), but as of 1 January 2000, it is done by a governmental decree (2001/6). Although the price set by this regulation is not compulsory, producers, wholesalers and retailers usually adhere to it. Hospitals may buy medicines directly from wholesalers or industry.

The Minister of Health also determines the rules of prescription, which can have an effect on the amount of subsidy the patient is eligible for (1995/2). For instance, certain outpatient medicines receive a smaller subsidy if the family doctor prescribes it, and not the relevant specialist. The subsidy can be 0%, 50%, 70%, 90% or 100% of the agreed consumer price, or a fixed amount. The 90% and 100% subsidy categories are reserved for medicines on specialist prescriptions for special medical indications, such as insulin for diabetic patients. In addition, certain very expensive drugs are purchased centrally by the NHIFA. In 1999, of 3705 listed drugs, 2172 received some subsidy (50). There is a more

restricted list of drugs that can be prescribed within the pharmaceutical co-payment exemption system (KÖZGYÓGY). Patients have to pay co-payments for medicines purchased in outpatient care only, as inpatient care includes the costs of pharmaceuticals, and hospitals purchase medicines on a market free from central regulations.

As has been discussed before, pharmaceutical expenditures take a substantial part of the HIF budget (Table 10). Successive governments have struggled to control overspending in the pharmaceutical sub-budget, which has been a major cause of the ongoing deficit of the HIF. Various measures of cost shifting have been implemented, and the subsidy system is continuously revised (see the section on *Health care expenditure*). A recent measure was the extension of fixed amount subsidies, whereby patients pay the difference between the price of the medicine and a fixed amount, and consequently have an incentive to buy the cheaper drugs (2001/6). Wholesale and retail price margins for expensive drugs were decreased to make pharmacists disinterested in increasing consumption of the most expensive drugs (2001/2), while the rationalization and stricter control of physician prescription has also been on the government agenda (2001/3).

The present government has been in a position to increase the pharmaceutical sub-budget of the HIF substantially in 2002 and 2003. However, this was not enough to offset the rapidly increasing drug expenditures. To tackle the problem, the government successfully negotiated an agreement with the main actors of the pharmaceutical sector to pay back the subsidies of drugs sold in excess of an agreed limit (2003/16).

In 2000, expenditures on pharmaceuticals dispensed to outpatients accounted for 32% of total expenditure (19). One third was financed by private households and two thirds by public sources, mainly in form of social health insurance subsidies (Table 15). While total expenditure on health decreased as a share of GDP, total pharmaceutical expenditure increased from 1.7% to 1.9% as a share of GDP between 1992 and 2000. Private expenditures rose more sharply than public expenditures on medicines. When applying the consumer price index or the GDP deflator, co-payments increased nearly threefold and non-subsidized over-the-counter medicines increased more than twofold. While real total expenditure increased by one third and real public expenditure increased slightly for outpatient pharmaceuticals, hospital expenditures on medicines, even decreased in real terms. Per capita spending on pharmaceuticals at US \$PPP 280 in 2001 was higher than in most CSE countries, for example the Czech Republic, but also some EU countries like the Netherlands or Denmark (54).

Medical aids and prostheses

The trading, distribution, prescription and use of medical aids and prostheses (such as hearing aids and wheelchairs) are regulated similarly to the pharmaceutical system. Registration and licensing has recently been reorganized according to EU regulations (1999/7). The system is run by the Authority for Medical Devices of the Ministry of Health (2000/4). The amount of subsidies provided by the HIF, and the rules for prescribing are determined by governmental and ministerial decrees (2000/5). Since 1990, the share of HIF subsidies for medical aids and prostheses has doubled, from 2% to 4% of all in-kind services of the HIF (Table 10). Compared to pharmaceuticals, medical aids and prostheses have been less subject to cost-containment policies, for example, margins for wholesale and retail prices have not yet been regulated.

Table 15. Pharmaceutical expenditures, 1992–2000

	1992	1995	1996	1997	1998	1999	2000
Expenditures on outpatient pharmaceuticals							
at current prices (billion Ft)	49.5	103.1	121.9	156.6	191.2	229.8	250.1
– as % of total health expenditure	21.8	24.6	24.6	26.4	27.4	29.5	28.2
Public expenditures	40.2	72.8	84.3	110.5	136.7	152.6	161.6
– National government co-payment exemption	–	5.5	6.8	8.8	9.9	10.3	11.0
– Social insurance subsidy	40.2	67.3	77.5	101.7	126.8	142.3	150.6
Private expenditures	9.3	30.4	37.4	46.1	54.4	77.1	88.4
– on non-subsidized medicines	5.3	15.0	19.8	24.8	28.9	41.7	45.9
– co-payments	4.0	15.4	17.6	21.3	25.6	35.4	42.5
Expenditures on outpatient pharmaceuticals at constant 1990 prices (billion Ft)^a							
Public expenditures	24.2	24.7	22.4	24.4	26.4	26.8	25.9
– National government co-payment exemption	–	1.8	1.8	1.9	1.9	1.8	1.8
– Social insurance subsidy	24.2	22.9	20.6	22.5	24.5	25.0	24.1
Private expenditures	5.6	9.8	9.8	10.2	10.5	13.5	14.1
– on non-subsidized medicines	3.2	4.9	5.2	5.5	5.6	7.3	7.3
– co-payments	2.4	5.0	4.6	4.7	4.9	6.2	6.8
Hospital pharmaceutical expenditures							
at current prices (billion Ft)	14.1	22.8	26.2	29.1	30.2	36.3	37.1
at constant 1990 prices ^a	8.5	7.4	6.8	6.4	5.8	6.4	5.9

Source: Hungarian Central Statistical Office (9,42,43,44,45,46); National Health Insurance Fund Administration (32,33,34).

Note: ^a Deflated by consumer price index.

Health care technology assessment

Health care technology assessment has not yet taken roots in the Hungarian health care system. Yet, cost-effectiveness is increasingly recognized as an important criterion in resource allocation decisions (2000/7). In 2002, the Ministry of Health issued a national guideline on preparing economic evaluation of alternative treatment options (2002/12). The guideline provides a detailed description of the structure and content of a correct economic evaluation, including certain country specific parameters. This was a significant step towards a systematic application of economic evaluation to support decision-making on services in social health insurance.

Financial resource allocation

Third-party budget-setting and resource allocation

In the integrated state-socialist health care system, health care budgets were set centrally, and financial resource allocation was based on health care inputs, allowing little flexibility in adapting financing and delivery decisions to health care needs. As a result of health sector reform measures of the 1990s, purchasing and provision were separated, budget-setting was partly decentralized and new payment methods were introduced based on health care outputs instead of inputs. It is worth noting, however, that budget-setting is still almost exclusively done by the national government, which exercises strict control over health spending via the National Health Insurance Fund Administration (NHIFA), the monopsonistic purchaser of the health care sector. Currently, the budget for public health care is made up of three components:

- the budget of the Health Insurance Fund (HIF), derived mainly from health insurance contributions and the hypothecated health care tax (1997/8, 1998/17);
- the central government budget, derived from general taxes;
- and local government budgets from local taxes, and from the national government on a capitation basis and via conditional and matching grants for investment (1990/3, 1992/8).

The budget-setting processes at the central and local levels are virtually independent except for “earmarked and target” subsidies, parts of which have been decentralized to the regional and county levels. Most key budget-setting and financial resource allocation decisions, such as the level of the health insurance contribution, the overall HIF budget, the various sub-budgets of the HIF, and the methods of provider payment are made centrally by the National

Assembly and the national government. A key principle of budget-setting and resource allocation in the Hungarian health care system is the separation of capital and recurrent costs. This “dual system of financing” applies not only to the inpatient sector but also to the outpatient sector. While investment is decided upon and financed by either local or national government (Table 7), the HIF covers recurrent costs of health care only.

The HIF is divided into over twenty sub-budgets (*kassza*) according to service types. For example primary care, outpatient specialist care, acute inpatient care or pharmaceuticals are financed from separate sub-budgets (Table 10). These sub-budgets are nationally unified, that is they are not devolved to the county level. Another key principle of budget-setting and resource allocation is the protection of the HIF from cost explosion. A national budget ceiling is set for each sub-budget prospectively by the National Assembly annually, and the system of provider payment methods ensure that these ceilings are not exceeded. However, not all sub-budgets are capped this way. One notable exception is the pharmaceutical sub-budget. Sub-budgets used to be sealed, that is, transfers between them were not allowed. Since 1999 the Minister of Health can reallocate funds, partly to cover the overspending in the pharmaceutical sub-budget from other sub-budgets of the HIF (1998/24).

Service providers contract with the NHIFA in order to become eligible for reimbursement. The contract defines provider capacities in terms of outpatient specialist consultation hours, and acute and chronic hospital beds, for example. Based on these contracts, individual health care providers are then reimbursed from these sub-budgets by various methods of payments: family physicians are paid by capitation, outpatient specialist services by fee-for-service points, and acute and chronic inpatient services by diagnosis-related groups (DRGs) and patient-days respectively.

Until 2001, contracted capacities were determined per county and speciality by law according to a special formula of local health needs (on the basis of certain socioeconomic indicators of the local population), while the “county consensus committees” agreed on the contracted capacities of an individual health care provider (1996/3). In 2001, the *1996 Capacity Act* was repealed, and the actual contracted capacities became the basis of future contracting (2001/5). The law allows greater flexibility for local governments to downsize and restructure capacities. At the same time, capacity extensions have to be approved by the Minister of Health and the Minister of Finance.

The NHIFA is not allowed to engage in selective purchasing. It has to contract with all providers who have a territorial supply obligation. The quantity and quality of outputs are not stipulated in the contract, except for a few high-cost, high-tech interventions, like liver transplantation, for which the yearly number

of procedures is set in advance. Instead, quality control should be performed by the NPHMOS. The NHIFA does have the right, however, to monitor the contract, mainly to control the validity of providers' performance reports.

The owners of health care facilities are responsible for financing capital costs. Such investment costs are usually beyond the financial capabilities of local governments, who own the majority of health care providers since 1990 (1990/3). The national government provides subsidies via conditional and matching grants. Given that most capital investment comes from these funds, this system allows the national government to control health care investment (Table 7). Local governments are in principle responsible for all debts incurred by their hospitals, but there have been central interventions to bail them out. Since 1995 hospital debts have been tackled more rigorously. Instead of clearing hospital debts, the NHIFA has made loans to indebted hospitals which they have had to repay from next year's revenue, but that, at least, has enabled them to roll over their debts to the next financial year.

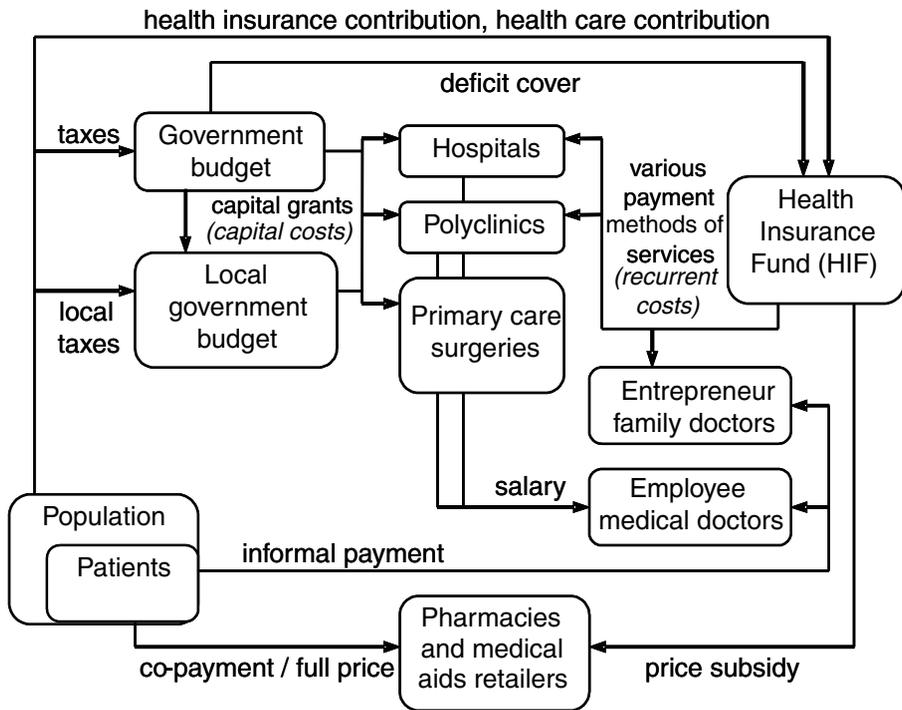
There are certain services, such as public health and emergency ambulance services, which are financed from the central government budget only. In most of these cases, financing and service provision is integrated. The government is also the main funder of higher education and research and development activities.

Fig. 14. presents an overview of the flow of funds in the Hungarian health care system, while Fig. 15. provides a more detailed description, including payment mechanisms.

Payment of hospitals

Under the former state-socialist system, hospitals and other health care institutions received a fixed annual line-item 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 it was subject to political influence. The reforms of the 1990s have brought about significant changes in inpatient as well as outpatient care. The payment system has become performance-based and payment mechanisms are geared to the type of service instead of the type of institution. Patient capitation was introduced for family doctor services in 1992, a fee-for-service point system for outpatient specialist care, a prospective payment system based on diagnosis related groups (DRGs) for acute inpatient services, and payment per patient days for chronic care in 1993 (1992/4, 1992/7). Payment methods for various services are determined in the acts on the yearly budgets of the HIF (1997/9), while detailed regulations are provided in a governmental and a ministerial decree (1999/1, 1993/6).

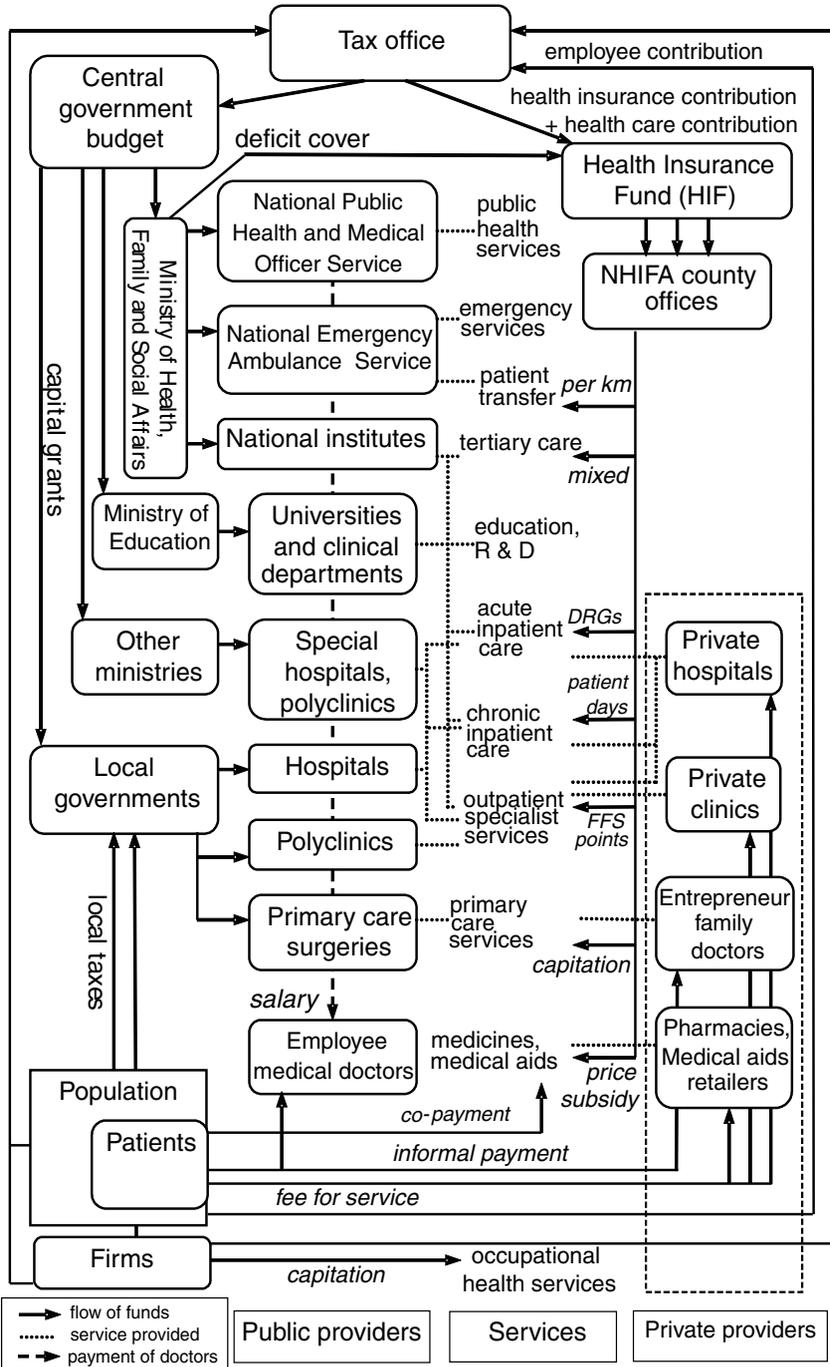
Fig. 14. Flow of funds in the Hungarian health care system, 2003



Most outpatient specialist services are financed by fee-for-service points, the “German point system”. Each procedure is assigned a number of points on the basis of its complexity and requirement of resources. Providers report their monthly sum of points to the county offices of the NHIFA. Before 2000 performance points used to be added up nationally and the monetary value of one point was calculated by dividing the predetermined sub-budget (*kassza*) by the total number of points. Payment was made according to the points collected multiplied by the calculated national monetary value of one point. These procedures allowed effective cost containment. Since the second half of 2000, however, the monetary value of 1 point is fixed in advance and part of the sub-budget is put aside at the beginning of each year to compensate for performance increases and seasonal variations. The money value of 1 point is recalculated only if this reserve is exhausted.

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 the national government. A few high-cost medical interventions, such as bone marrow

Fig. 15. Financial flow chart of the Hungarian health care system including payment methods, 2003



transplantation, are reimbursed on a case basis. Chronic (long-term) care is paid on the basis of patient-days adjusted for the complexity of the case.

The essence of the DRG system is that it classifies inpatient cases into a manageable number of categories on the basis of their complexity and costs. The current version of Hungarian DRGs, the so-called Homogenous Disease Groups (HDGs), has 736 categories. Each category has a weight (or number of points), which is higher for more complex and costly cases. Hospitals have to report their discharged cases monthly, and the reported cases are categorized into DRGs at the Information Centre for Health Care, which operates the system. This procedure determines the hospitals' monthly performance in terms of DRGs, and the NHIFA pays according to the total number of DRG points multiplied by the monetary value of one point, the so-called national base fee. The national base fee is set in advance by the NHIFA for one year and it applies to all hospitals equally. In order to avoid cost explosion, the acute inpatient care sub-budget of the HIF is also capped nationally. In the beginning of the year a certain portion of the sub-budget is reserved, and the preset national base fee is recalculated only if the reserves are exhausted just as in the case of outpatient specialist care.

Since the beginning of 2004 a new mechanism (the system of degression) has been applied both in outpatient specialist and inpatient care to contain performance inflation (2003/19). Providers are eligible for full reimbursement for only 98% of the performance in the preceding year. If a provider in a given month produces more points than that, the excess points up to 5% are reimbursed at 60%, between 5 and 10% at 30%, and above 10% at 10% of the monetary value of one point.

The current system has been developed over a 15-year period, and HDGs are revised continuously to adapt to changes in medical practice and to support purchasing (1998/1, 2001/1). The Information Centre for Health Care was founded in 1987, when it started a pilot project to collect cost data in hospitals for the adaptation of the United States DRG system (1987/1). The first version of HDGs was developed on the basis of cost data of 500 000 cases of 28 participating hospitals, and was introduced countrywide in July 1993 (1993/5). Initially, the base fee was unique to each hospital. It was calculated for each institution on the basis of its previous budget and performance, and the differences were gradually decreased until the national average was reached in 1998 (1995/6, 1996/12). *Government Decree No. 13/1998. (I. 30.) Korm.* introduced the uniform national base fee in March 1998, with the provision that it can be recalculated if performance exceeds budget reserves. For a short period of time, the government introduced a fixed element in hospital financing, unrelated to hospital performance, but it was later abolished by the government of 1998–2002 (1996/10, 1998/24).

A transition period was also allowed for outpatient specialist care providers. Initially they could retain 90% of their previous historical budget and only the rest of their income was calculated according to the collected fee-for-service points. The share of the historical budget was decreased from year to year, until the total income came from fee-for-service points produced. 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 base fees (unique to each hospital), and of retaining parts of the historical budget punished the most efficient hospitals. For instance, in the case of the DRG payment system, individual base fees were calculated on the basis of the previous historical budget of the hospital concerned, which was divided by the DRG points earned by the hospital in a pre-introductory period. This means that those hospitals that produced the most output (in terms of DRG points) from the lowest yearly budget had the lowest individual base fee.

In addition to the main payment methods, special rules apply to certain services, whose running costs are covered from separate sub-budgets of the HIF. Dispensaries are paid by global budget. 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.

The previous line-item 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. Hospitals currently have no financial incentive to treat people as outpatients rather than inpatients, and there are no effective incentive or control mechanisms in place that would prevent unnecessary hospitalization (37,38). The control function of the NHIFA is weak, and mainly focuses on the audit of reporting. For instance, the NHIFA does not have a legal basis to investigate whether the provided diagnostic or therapeutic interventions were really necessary to improve the health status of the patient. This task of quality assurance is legally assigned to the NPHMOS.

The government of 1998–2002 launched a pilot project in 1998 seeking alternative ways to overcome the aforementioned shortcomings of the control function and to eliminate the dysfunctions of the payment systems on the basis of incentives. The essence of the so-called care coordination pilot (Irányított Betegellátási Rendszer) is that health care providers have been offered the opportunity to take responsibility for the whole spectrum of care of a population group, initially up to 200 000 people (1998/24). The health care providers eligible for applying for the status as “care coordinator organization” (Ellátásszervez) can either be a hospital, or a polyclinic or a group of family doctors. If the care coordinator organization is a group of family doctors the

people participating in, and covered by the pilot are those registered with the family doctors in question. If the care coordinator organization is a polyclinic or a hospital, they have to invite and contract with local family doctors, whose registered inhabitants in turn become the population covered.

The NHIFA sets up a so-called “virtual budget” (a budget which is not transferred to the bank account of care coordinator organizations), which equals the number of people covered by the care coordinator organizations multiplied by a capitation fee adjusted for instance the age composition of the population in question. During the year the actual costs incurred by the patients covered by the pilot are summarized. If actual costs are smaller than the “virtual budget” the difference is actually paid to the care coordinator organization and savings can be used for investment or remuneration purposes. The great advantage of this pilot is that it does not change how the system operates. If anything goes wrong, the care-coordination function can be withdrawn, without any risk of people remaining without adequate care.

The first wave of the care coordination pilot project was launched in July 1999 with nine care coordinator organizations. The largest organization, the “Misszió” non-profit corporation (a polyclinic) at Veresegyház, covered a population of 240 000 in 2003. The part of the total population of Hungary that could be drawn into the pilot has been expanded gradually, and the evaluation of the project has begun. The present government has decided to continue the care coordination pilot project, and to further expand it, first up to 1 million in 2003 and then up to 2 million inhabitants in 2004 (2002/17, 2003/18). Currently, the minimum number of inhabitants to be covered by a care coordinator organization is 75 000. There are eleven care coordinator organizations covering 1.3 million inhabitants in total.

Payment of physicians

In the state-socialist health care system all physicians were salaried public employees, and private practice was allowed only on a part-time basis (1972/2). Public employment with salaries has remained the dominant form of medical practice throughout the years of ongoing health care reform, with the sole exception of entrepreneur family doctors, who contract with both the NHIFA and local governments and are paid on a patient capitation basis. Some medical doctors run private practices, usually as second jobs, and are paid a fee-for-service by their patients, free from central regulation.

Patient capitation was introduced in 1992 as method of payment of family doctor services (1992/4). People were allowed to choose their family doctors

freely, and the number of registered inhabitants (the practice list) became the basis of general practice financing. The income of the practice is made up mainly of capitation payments, plus a fixed amount depending on the size and location of the practice and case payments for attending non-registered patients.

Capitation payments are based on the size of the practice list, which must be updated regularly by the family doctor to allow for any changes due to death or migration, but are adjusted to the age structure of registrees, and to the qualification and work experience of the family doctor. The population is divided into 5 groups. For a person aged 0 to 4 years family doctors receive 4.5 points, between 5 and 14 years 2.5 points, between 15 and 34 years 1 point, between 35 and 60 years 1.5 points and over 60 years 2.5 points. Above a certain number of points (2400 for adult or child practice, and 2600 for mixed practice), the family doctor does not receive the full capitation payment, to prevent the quality of care being adversely affected by an unmanageable practice size. Different limits apply, however, if the practice is not single-handed. The total number of points is multiplied by 1.2 if the family doctor has a relevant qualification, either a specialization in family medicine or in internal medicine for adult practices, or in paediatrics for child practices. The factor is 1.1, if the family doctor has no relevant qualification, but has at least 25 years of work experience in primary care (1999/1). The family doctor receives the calculated practice income directly from the NHIFA, if a private entrepreneur with an NHIFA contract. If the family doctor is a salaried employee of the local government, the NHIFA transfers the capitation payment to the latter, from which the salary is paid to the family doctor.

Most specialists are salaried public employees, who are guaranteed a minimum level of salary according to a pay scale (1992/5) based on qualifications and years of experience. Most clinical specialists still receive some informal payment from patients, but it is too unequally distributed to be considered as a complement to official salaries. Nevertheless, for certain specialties, informal payment provides some material incentive for doctors to stay in the profession.

The government extended the available employment options with the so-called freelance medical practice in the end of 2001. The impact of this measure on the income level of medical doctors and other health workers is not yet known. The majority of personnel in the Hungarian health care system continue to be salaried public employees. Until the recent rise in salary for all public employees, the average salary in the health sector was lower than most other sectors of the economy. In 2000, health care workers were the fifth lowest paid among the full-time employees of the 14 main sectors of the Hungarian economy. The situation was even worse, if the average salary of workers with a higher education was considered (1). One of the first measures of the present

Health care reforms

Aims and objectives

Health care reforms in Hungary began in the last years of the communist regime of the mid 1980s, when the continuously deepening recession and increasing pressure from the emerging political opposition allowed a reform-oriented, liberal faction of the communist party to take over government and formulate reform policies for the reorganization of the state-socialist health care system. Reform communists and successive, freely elected governments have sought answers to the legacies of the state-socialist health care system in the context of profound political, economic and social transitions that occurred in all post-communist countries.

Health sector reform was motivated by a number of factors. First, the gap was widening between the health status of the Hungarian population and inhabitants of western European countries. Second, there was a general distrust of the central government, whose budget was seen as a black hole swallowing people's money with little evidence that it was spent wisely. Third, the over-centralized health care delivery system was seen as inefficient, unable to provide services to meet the population's changing needs. The oversized hospital sector sucked up the majority of the health care budget, and the system was providing care at unnecessarily high levels at a cost that was increasingly thought unaffordable. The management of health care institutions was regarded as inefficient because of central control, the incentives embedded in the payment system and inadequate managerial capacity, given that the directors of health care institutions were mostly medical doctors who kept on practising. Fourth, resource allocation was subject to political influence, and as a result geographical

inequalities arose, as well as inequalities among specialties. Fifth, the majority of health care workers were becoming increasingly unsatisfied with the slowly deteriorating working conditions, the decreasing prestige of the profession and the low salaries, as the income from informal payments was shrinking.

The early reform objectives followed from the above-mentioned problems of the inherited system. Policy makers wanted to increase its efficiency by securing funding for health care, the structural reorganization of the system with considerable decentralization, introduction of appropriate incentives and increased competition by wider consumer choice. Policy makers also wanted to decrease inequalities by improving resource allocation, and to increase the quality of care, all at an affordable cost. Policy makers envisaged a substantial role of health promotion to change the health culture of the population, including related lifestyle.

In the first phase of the reform, until 1994, most measures were implemented as originally devised during the reform communist period with considerable decentralization. By the end of the period of the first freely elected government, the integrated state-socialist health care system was transformed to a contract model, in which the purchaser and provider were separated. All this happened in a time of considerable economic recession. Although the GDP regained growth in 1994, the deficit of the state budget prompted restrictive measures. The second phase of the reform was overwhelmed by the economic stabilization efforts of the government of 1994–1998, and the cost-containment objective started to dominate health care policy. The Health Insurance Fund (HIF) was increasingly seen as a potential threat to fiscal balance, and measures were aimed at restoring government control to allow direct intervention into the system. Despite some policy proposals, pilot projects and piecemeal reform measures, cost-containment remained the number one policy objective throughout the period of the succeeding government. The contract model of the health care system has not been changed since it was established.

Overall, the main health policy objectives have not changed since the end of the 1980s. They were declared in the acts on health care and social health insurance: to protect and promote patient rights, to provide equal access to health services for people with equal needs, to provide effective services, to provide services efficiently (1997/16, 1997/9). Policy-makers envisage a more efficient health service, which delivers good quality services according to the health needs of the population at an affordable cost.

Reforms and reform implementation

This section discusses the reforms of the past 15 years according to election cycles, starting with the period before the first free elections in 1990 (51). Each governmental period has its own peculiarities, which distinguish it from the others. However, 1994 can demarcate another division. Before 1994, health sector reform was characterized by decentralization, with the aim of moving away from a failed and distrusted centralized model of integrated health services, and by the end the new contract model of health services was established and operating. It was thought that command and control mechanisms had failed, hence the emphasis was put on incentives to produce the necessary structural changes without direct government intervention. After 1994, however, cost-containment became the first priority of government policy, which inevitably determined the direction of further reforms. This period was characterized not only by fiscal restrictions, but direct government intervention with the intention of regaining as much control as possible over health care spending. It is interesting to note that cost-containment has remained the dominant health policy objective during the 1998–2002 government, despite the favourable economic climate characterized by stable economic growth and early policy proposals for further decentralization.

The blueprint for health care reform: second half of the 1980s

During the second half of the 1980s, the so-called reform communist era, the Ministry of Social Affairs and Health established the Reform Secretariat, which produced policy proposals on the basis of international models and experiences.

The Reform Secretariat considered options from a number of countries, namely:

- from the United States, the DRG payment method and the Health Maintenance Organization, which integrated financing and provision;
- from Germany, autonomous quasi-public ownership, the strong outpatient care system with output-based payment of providers, and the three-member management (consensus management) of health care institutions;
- from the Scandinavian countries, the health centres;
- and from England, the capitation payment of family physicians (51).

The ministry launched a number of pilot projects, including the adaptation of the American DRG- based hospital payment system. In 1987, the Information

Centre for Health Care (GYÓGYINFOK) was set up, which was responsible for the DRG project, and has been the key institution in designing and administering provider payment methods ever since (1987/1).

The proposals of the Reform Secretariat outlined the principles of the new health care system. A key element was that sources of health care financing should be separated from the central government budget, so that revenues could not be used for other purposes. Another key principle was the so-called sector neutrality, that is, health care financing should not discriminate against private providers. There were intentions to merge polyclinics with inpatient facilities to increase the quality of outpatient specialist services, and together with strengthening primary care to make the delivery system “two-pillar”, as opposed to the “three pillar” state-socialist model (primary care, polyclinics, and hospitals). In the area of primary care, a family physician treating the whole family from young to old was envisaged, and so it was planned to amalgamate the district paediatrician and district (adult) physician system into one family service.

The reform communist era saw the first changes implemented. In 1989 the system was switched from tax-based financing to compulsory social insurance (1988/2). In 1990, the budget of the health service was transferred to the newly established Social Insurance Fund, referred to as the “fund exchange” (1989/5). Since the Social Insurance Fund was meant to cover the recurrent costs of services, funds for capital costs remained in the central government budget. In 1989, full private health care entrepreneurship was legalized, and private providers were permitted (1989/4).

Establishment of the contract model: 1990–1994

The government continued the major structural reforms, according to the previous plans. The head of the Reform Secretariat became the permanent Secretary of State under the present government, which allowed a degree of continuity in health sector reform. Some technocrats working on pilot projects remained in office, which also provided some stability in the implementation of the reform.

The *1990 Local Government Act* created the provider side of the new contract model (1990/3). The ownership of primary care surgeries, polyclinics and hospitals was devolved from the national to local government along with the responsibility to ensure the supply of health care services to the local population, the so-called territorial supply obligation. The new owners became responsible for maintenance and investment costs, but the central government established

the system of “earmarked and target subsidies” to support local governments with conditional and matching grants (1992/8).

As part of the reform of public health and the modernization of health system administration, the National Public Health and Medical Officer Service (NPHMOS) was established as a state agency in 1991 (1991/1). The NPHMOS was built on the State Supervision of Public Hygiene and Infectious Diseases of the communist regime and managed to preserve its well organized service of infectious diseases surveillance, immunization and public hygiene. The government envisaged the wider role of public health and health promotion, but the Service had to build on the available human resources. In addition the Service was assigned the task of professional supervision and coordination of the delivery of health care (1993/4).

The financing system was developed further after a debate on whether to move towards a single- or multi-insurance model (1991/3). A single-insurance model was accepted, but leaving open the option of competition between insurance schemes in the future. It was decided that the Social Insurance Fund would be divided into a health and a pension fund, and that both funds would have a quasi-public supervision consisting of the representatives of contributors, that is employers and employees (1991/5). In 1992, the social insurance contribution was split into health insurance and pension insurance contribution (1992/1), the Social Insurance Fund was divided into the HIF and the Pension Insurance Fund (1992/2), and was made self-governing after the election of trade union representatives (as representatives of employees) in 1993 (1993/3). Right after the establishment of the Health Insurance Self Government, the administration of the former Social Insurance Fund was divided into two, as well, and the National Health Insurance Fund Administration (NHIFA) was put under the direct control of the Self Government (1993/7).

The policy for the strengthening of primary care was implemented gradually. In 1991 the National Institute of Family Medicine was established to coordinate raising the professional standard of primary care (1991/6). In 1992 the district physician system was renamed “family physician”, postgraduate training for general practitioners was made compulsory, and undergraduate training for medical students was introduced with new departments in medical universities (1992/3). People were allowed to choose their family physicians (1992/3), and the capitation payment and contracting of family doctor services were introduced (1992/4). Family doctors were encouraged to become private and contract with the local government for the provision of primary care services, with surgeries and equipment still owned by the local government, which became known as the scheme of “functional privatization”. The original plan to abolish the district paediatrician service was not implemented, however.

The new payment systems for all other services were initiated in this period. The introduction of output-based payment methods, fee-for-service points, Homogenous Disease Groups (the Hungarian version of DRGs) and patient-days was coupled with the capping the Health Insurance Fund (HIF) sub-budgets (1992/7, 1993/5, 1993/6). From a cost-containment perspective these measures have been an effective tool throughout the successive government periods. No real change occurred, however, in the remuneration of the health care workforce. Under the act of public employment, a minimum salary was guaranteed according to a pay scale, and although no upper ceiling was determined, the salaries remained low in comparison to other sectors (1992/5).

At the end of 1993, Parliament created the legal framework for the establishment of non-profit health insurance (1993/10), and in 1994 the Hungarian Medical Chamber and the Hungarian Chamber of Pharmacists began to operate on a self-regulatory basis, with compulsory membership for practising doctors and pharmacists (1994/1, 1994/4). The government was less cautious concerning the pharmaceutical sector. National drug companies, the wholesale and the retail industry were mostly privatized along with the liberalization of the pharmaceutical market. It is not surprising that rising drug expenditure became one of the most important sources of the HIF's deficit, which continuously puzzled the successive governments.

By the end of the first governmental period, the foundations of the new model of the Hungarian health care system had been laid down. There was a single monopsonistic purchaser, the NHIFA, who contracted with service providers, mainly in the public but also in a growing private sector of family doctor services and pharmacies. Supervision of the HIF and the control of the purchaser were delegated to the quasi-public Health Insurance Self Government, but many purchasing decisions were made by the national government and the National Assembly, for example, budget-setting, financial resource allocation and the choice of payment methods. The transition of the economy was well under way, and began to show the signs of recovery in 1994. Health workers, however, perhaps with the exception of family doctors, did not feel much improvement in their working conditions, especially not in their salary. In 1994, the parties of the governing coalition lost the elections and the Hungarian Socialist Party formed a coalition government with the Alliance of Free Democrats.

The beginning of cost containment: 1994–1998

The first significant measure of the present government in June 1995 was not favourable for the health sector. The government had anticipated an economic crisis as GDP growth slowed down, and inflation started to rise again coupled

with a substantial deficit of the state budget. In this context the health sector was seen as a potential threat to fiscal balance, and reform measures aimed to achieve the new priority objective of cost-containment. The first economic stabilization package was introduced in the middle of 1995 and targeted the welfare provisions, including health services.

On the financing side, the next year's health care budget was cut, and reached its lowest level in real terms since 1990 (1995/6). Dental services were excluded from HIF coverage, subsidies on spa treatment were removed, and a co-payment for patient transport was introduced (1995/4). However, shifting costs to patients was somewhat counterbalanced insofar as the government offered tax rebates for the purchase of voluntary non-profit health insurance (1995/9). In addition, the responsibility for occupational health services was shifted to employers (1995/5). The government had also decided to directly tackle the problem of the oversized hospital sector, and assigned the minister of welfare to determine the capacities the NHIFA had to contract for, under the territorial supply obligation (1995/6). As a result, approximately 9000 beds were removed from the system, even though the decision-making process was later found unconstitutional (1995/8).

Seeing the sharp drop in the utilization of public dental services, the government decided to reintroduce tooth-preserving dental services into the benefit package, with some co-payment (1996/1), but this was just a short pause before the next restrictive package, which targeted the revenue side of social health insurance and reconsidered capacity-regulation as a means of downsizing the delivery system.

Instead of the direct intervention of the Minister of Welfare, *Act LXIII of 1996* devised a need-based formula to determine health care capacities. It is not surprising that the formula called for cuts in hospital beds in most counties, but decisions regarding the number of beds to be given up by which institutions were left to the so-called county consensus committees (1996/3). It was a wise decision inasmuch as the political unpopularity of hospital closures did not directly fall on the government, but it also cost the government the opportunity to achieve really significant savings. In fact, few institutions were closed, partly because it was easier to get an agreement for everybody reducing a small number of beds than to close down any one institution, especially in light of local political resistance. Finally, approximately 9000 more beds were removed from the system between 1996 and 1997.

Another implicit rationalization measure was the introduction of the so-called minimum standards for health care institutions. By defining the minimum requirements for the provision of health care services in terms of personnel, equipment and building, it was expected that certain substandard health care

facilities could eventually be closed down (1996/5). However, the deadlines by which health care providers had to meet the requirements were postponed twice, because politicians feared that enforcing these regulations would result in mass closures (1997/3, 1998/7).

The revenue-side strategy comprised three components: widening of the social insurance contribution base, decreasing the employer health insurance contribution rate and introducing a lump-sum tax (hypothecated health care) (1996/7, 1997/8). All these measures aimed to increase HIF revenue by mitigating evasion of the social insurance contribution. Since the establishment of the Social Insurance Fund, under-reporting of income and arrearage had been general techniques to avoid paying the contribution. Contribution rates for health and pension insurance were indeed high, 54% of the gross salary, including a 23.5% health insurance contribution. It is interesting to note that the government deliberately introduced a new hypothecated tax rather than determining a fixed minimum level of social insurance contribution. The Constitutional Court ruled many measures of the first economic stabilization package unconstitutional on the grounds that in an insurance relationship the parties could not freely modify the terms of the agreement, while there were no such restrictions for tax-funded services. Moreover, some analysts viewed this measure as the first step towards recentralization of the HIF. And indeed, the other main thrust of measures targeted the Health Insurance Self Government and the output-based payment methods.

During the new cost-containment era, the government considered the extensive rights of the HIF on budgetary decisions as a potential threat to the planned cuts of the HIF budget. Therefore, it curtailed those rights in 1996 (1996/2, 1996/9). In addition, the government weakened the self-governance of both the HIF and the Pension Insurance Fund through restructuring in 1997 (1997/4). The number of self-government representatives was decreased. Members were no longer elected, but delegated. This clause was found unconstitutional in 1998 (1998/4), but this ruling of the Constitutional Court lost its significance since the succeeding government abolished self-governance altogether (1998/13).

The government was not satisfied with the DRG based hospital payment system. After a long debate, it introduced a fixed payment, 20% of the hospitals' budget, regardless of actual performance (1996/10). On the other hand, it ordered an acceleration of the transition period from retrospective payments for individual hospitals to achieve a prospective uniform base fee at national level. By March 1998 the national base fee was not just uniform, but was fixed in advance (1996/12).

The last significant legislative package of this governmental period came in the form of new laws for social insurance (1997/8), social health insurance (1997/9) and health (1997/16). Apart from a couple of new institutions, like the National Health Council, or the hospital supervisory councils, these acts did not create new reform principles, or considerable change in the foundation of the health care system. The significance of *Act CLIV on Health* came from the declaration of patient rights, which had not been previously regulated in a comprehensive manner. The Act also established the institution of patient right representatives for the safeguarding of patient rights and the institution of arbitration for resolving disputes between patients and health care providers (1997/16, 2000/9).

The government of 1994–1998 successfully implemented a strict cost-containment policy, which resulted in a significant cut in the health care budget. By the end of 1997 health care expenditures were almost 30% lower in real terms than in 1990, while in the same year the GDP increased by 4.6%. Preoccupation with economic stabilization had left little time for thinking about the future of the health care system. Nevertheless, within the already running World Bank/Ministry of Welfare project a regional modernization project was launched. In addition, the Ministry of Finance prepared a proposal in 1998 envisaging a reform of the financing side via competing health insurance funds. The government had no time left to debate and put the idea into practice, since the 1998 elections brought the opposition parties into power.

Searching for the way forward: 1998–2002

One of the first measures of the present government was to abolish the self-government of the social insurance funds, thereby taking full control over the health insurance fund (HIF) and its administration (NHIFA) (1998/13). The measure brought the government into a good position in terms of cost control, and also of a planned reform of the HIF. Control of the NHIFA was transferred to the Prime Minister's Office (1998/14), which was itself strengthened by adopting a chancellery model (1998/15). In addition, the present government ceased the World Bank supported regional pilot project.

The Secretariat for the Supervision of the Social Insurance Funds of the Prime Minister's Office proposed a model of competing health insurance funds, which was finally dropped by the prime minister. The control of the NHIFA was shifted to the Ministry of Finance (1999/4), and the Ministry of Health regained its primacy in health policy-making. Instead of reforming the financing side, the policy focus was shifted to the delivery system, but against the background of the persistent efforts to contain overall health expenditure.

Throughout the whole period, the government targeted both the revenue and the expenditure side of the HIF. The key element of the latter was the seemingly uncontainable pharmaceutical sub-budget. In order to overcome the contribution evasion problem, the government extended and increased the hypothecated health care tax (1998/17). At the same time, it decreased the health insurance contribution substantially from 18% to 14% (1998/18). The expenditure side was more problematic, since there was no way to cap the pharmaceutical budget, as had been done to the other sub-budgets. Nevertheless, the government kept a close eye on the pharmaceutical sub-budget by ordering overspending to be approved beforehand, and allowing the Minister of Health to reallocate between sub-budgets so as to cover overspending from other sub-budgets of the HIF or from the Ministry's budget (1998/24). With the same law, the government shifted the collection of contributions to the Tax Office, abolished the partial fixed element in the payment system and initiated the "care coordination pilot", as described earlier (1998/24).

After the rejection of health insurance competition, the first delivery-side reform measure of the Ministry of Health came in the beginning of 2000, when the "practice right" was introduced with the objective of creating a market for family doctor practices (2000/1, /2). The government offered subsidized loans for family doctors to help them buy the surgery and equipment from the local government (2000/2). During the second half of 2000, however, nothing significant happened, as far as the reform of the delivery system was concerned, but the government continued its battle against rising pharmaceutical expenditure. The Social Insurance Price and Subsidy Committee was established (2000/6), and negotiated a long-term agreement with the representatives of the pharmaceutical industry to secure a price increase below inflation level over a three-year period (2000/11). Further measures included the revision of the subsidy system, and the decrease of wholesale and retail price margins of expensive medicines, both of which were implemented in 2001 (2001/6, 2001/2). On the revenue side of the HIF, the ceiling on employee health insurance contributions was abolished (2000/8).

As of 1 January 2001, a new Minister of Health was appointed, who managed to retrieve control of the NHIFA from the Ministry of Finance (2000/10). The *1996 Capacity Act* was repealed (2001/5), and a 10-year public health action programme was elaborated to increase life expectancy of men and women to 70 and 78 years, respectively (2001/8). The programme was coordinated by a project unit in the NPHMOS and continued and later expanded and updated by the current government. The reform of the delivery system continued with the establishment of the freelance medical doctor status, and the encouragement of the corporatization of public providers (2001/11). The 2002 general elections

brought the Hungarian Socialist Party and the Alliance of Free Democrats back to power. The whole period of 1998–2002 was characterized by uncertainty about the desired direction of health care reform and the search for the way forward. On the other hand, uncertainty implied cautious – hence reversible – changes, which left open many of the reform “pathways”.

Health policies of the present government (2002–)

A promising first step of the present government was to introduce a long-awaited substantial pay rise for the health care workforce (2002/15). This increase of about 50% and an extra bonus for nurses seemed sufficient to reduce the exodus of health care professionals. Later, the social status of non-medically qualified health personnel was also raised by establishing the Chamber of Non-Medical Health Professionals (2003/13).

The fall of 2002 saw structural reform enter the phase of policy formulation. The government suspended some of the restrictions on the privatization of delivery organizations (2002/15,16) and replaced the existing law with a new one, which provided a wider scope for the inclusion of private investment into the health care system (2003/3,4). To support the change in the ownership of health care facilities the government even offered subsidized loans for employee groups to privatize public providers (2003/12). Nevertheless, the impact of the new privatization regulation on the delivery system could not unfold, as it was later annulled by the Constitutional Court, as there was not enough time for a second round of discussion (2003/17).

Since 2002, health planning and prevention have been given more emphasis. The National Assembly accepted the Johan Béla National Programme for the Decade of Health, which set targets to improve the health status of the population through public health actions (2003/1). In the frame of this public health programme, Hungary has launched national screening programmes for breast and cervical cancer and will introduce screening for colorectal cancer in 2006 (2003/5). In addition, the government encouraged regional health planning through the formation of the so-called Regional Health Councils, and the elaboration of Regional Health Plans (2003/9).

By the end of 2003, for fiscal and for professional reasons the government focussed its attention again more on cost-containment and financing reforms. An agreement was reached with the pharmaceutical companies that they would cover the subsidies for medicines that were sold in excess of an agreed limit (2003/16).

The government also decided to extend the care coordination pilot project further to cover a maximum of 2 million inhabitants (2003/18). The Prime

Minister appointed a governmental commissioner to evaluate the results of and propose plans how to proceed with the pilot (2003/15). There are interesting issues to be debated, especially the appropriateness of service providers as opposed to insurance companies in fulfilling the care coordination role.

Health for all policy

The WHO health for all principles have been incorporated into the health promotion programmes of successive governments. The first of these was the National Health Promotion Programme in 1987, in the reform-communist era. The first freely elected government elaborated a new programme in 1994, and set population health targets (1994/3). These were accepted by the next government, which established an intersectoral advisory group to coordinate government health promotion activity according to the health promotion programme. *Act CLIV of 1997 on Health* has institutionalized the National Health Promotion Programme, which must be elaborated by the government, reviewed by the National Health Council and accepted by the National Assembly. The Act also incorporates many principles of “Health for all”, including equal access to health services and the dignity of individuals (1997/16). The law on the protection of non-smokers was passed in 1999, after a long debate (1999/2). In 2001, the government launched its own 10-year health promotion programme, which set targets for life expectancy for men and women.

Drawing on the work done, the present government has expanded and updated the public health programme and, as Johan Béla National Programme for the Decade of Health, it was accepted by the National Assembly in the first half of 2003. The programme has ambitious targets, which are envisaged to be achieved in four main areas (health promoting social environment, addressing unhealthy life styles, preventing avoidable mortality, strengthening public health institutions) with the focus on cardiovascular diseases, cancer (e.g. national screening programmes in breast, cervical and colorectal cancer), mental health, locomotor diseases, HIV/AIDS, and risk factors such as smoking, alcohol, drugs, unhealthy diet and lack of exercise (2003/1). Compared to previous plans, the novelty of the new programme is that it focuses on the wider environment, in which diseases might develop. The programme also puts more emphasis on health promotion, primary prevention measures, and equity (disparities in health status) by targeting disadvantaged social groups.

Hungary is also undertaking several projects in cooperation with the WHO Regional Office for Europe including middle-term cooperation programmes, the EUROHEALTH programme, home care, publication and information dissemination activities, conferences and professional visits. Hungary has

11 WHO collaborating centres, 13 cities participating in the Healthy Cities initiative, 100 schools in the Healthy Schools programme, 11 hospitals in the Health Promoting Hospitals initiative. A programme for Healthy Workplaces is being implemented. In addition, three Hungarian counties are participating in the Regions for Health international programme. The WHO Liaison Office has been working successfully for 12 years, representing the World Health Organization in Hungary and coordinating joint projects.

Conclusions

Health sector reform in Hungary dates back to the second half of the 1980s, when the increasing tension between the expectations of the population and the performance of the state-socialist health services called for a profound change. The state-socialist Semashko system was unable to meet the challenges of health transition and rapidly advancing technology, and the command economy could not provide enough resources to back up the necessary modernization. Instead, health policy was focused on quantitative development in the number of hospital beds, consultation hours and medical doctors, which later became part of the difficult legacy of the collapsing regime. The major political, economic and social changes of the 1990s provided the opportunity for the implementation of large-scale health sector reform.

The main achievements

Hungary has achieved a successful transition from an integrated health care system to a contract system in which purchasers and providers are separated (successful in this context means functional, not perfect). A social health insurance scheme has been implemented, funded from employer and employee health insurance contributions and from a two-component hypothecated health care tax. The administration of the Health Insurance Fund (HIF), the National Health Insurance Fund Administration (NHIFA), has become the single most important (monopsonistic) purchaser in the new setting.

The ownership of most health care facilities was transferred from the national to local governments, which became the dominant providers of health services. Local governments have become responsible for the provision of health care for the local population (territorial supply obligation), but they are allowed to contract out the actual service delivery to private providers. In turn, the NHIFA

contracts with health care providers and reimburses them according to various payment methods. These have been changed from input- to output-based techniques, including capitation for family doctors services, fee-for-service points for outpatient specialist care services, DRGs for acute and patient-days for chronic inpatient care, but effective cost-containment mechanisms have also been put in place. Most medical doctors and other health workers remained salaried public employees, among the lowest paid professionals in the Hungarian economy.

So, how does the current system perform, and to what extent have reform measures been able to address the problems of the state-socialist health care system? As far as the underlying principles are concerned the solidarity of financing has been preserved in the new system, notwithstanding that in general, the payroll related health insurance contribution is more regressive than tax revenues for two reasons. First, the contribution base was limited to work incomes. Second, although the contribution was proportional, the employee contribution had a ceiling. This arrangement has been modified several times by successive governments. Widening the contribution base and abolishing the employee contribution ceiling has made the financing system more progressive, but the lump-sum hypothecated health care tax, introduced in 1996, is clearly regressive. However a proper evaluation should take into account the extent of evasion of the health insurance contribution. Unfortunately there is not enough data available to assess the evasion problem and consequently carry out a complete analysis of equity in financing.

One of the most important paradoxes of the previous health care system was that despite its wish to ensure equal access, inequalities in service provision arose both in terms of geographical locations and specialties. Two particular measures have brought improvement in this respect. First, the new payment techniques have ensured better resource allocation, as the money follows the patient, that is, providers receive the same payment for the same service, regardless of the provider's location. Indeed, the introduction of the DRG payment system has shown that historical line-item budgeting created large disparities. For instance, costs per unit of output (DRG point) were found to differ more than twice between the cheapest and the most expensive hospital, when the DRG system was introduced in 1993. This also implied efficiency problems. Second, the *1996 Capacity Act* tried to achieve not just more efficient, but more equitable resource allocation on the basis of health needs. Almost 20% of the hospital beds were removed from the system, along with a slight extension of capacities in undersupplied geographical areas.

One of the most remarkable achievements of the current Hungarian health care system is that most services are still readily available, although the health care budget has shrunk considerably as a result of four years of economic

recession and eight years of effective cost containment policies in the health care sector. Indeed, the Hungarian health care system produces services much more cheaply than the lowest spending countries of western Europe, even if health care spending is adjusted for purchasing power. For instance, in 1995 the average cost per hospital case was US \$1588 in Hungary and US \$2387 in the UK at purchasing power parity (10). However, these comparisons are limited by the lack of proper outcome data. The available crude quality indicators do not imply any dramatic change in the standard of care (Table 12), but this is not enough to draw firm conclusions on the efficiency of the Hungarian health care system, since they do not illuminate modest deterioration in the quality of care. As has been discussed before, output-based payment techniques pushed providers to decrease the average cost per case, but currently there is no effective mechanism in place to ensure that quality of care at least remains the same.

Challenges and future directions of health sector reform

Despite these achievements a number of issues remained unresolved. First, the establishment of the independent HIF did not secure funding for health services, as was expected. Instead it became a very effective tool in the hands of the central government to contain expenditures and even to withdraw funds from the health sector. This tendency has continued even during the years of the economic expansion. The current state of regulation also leaves little scope for the NHIFA to develop its function as purchaser of health care. Second, the separation of decision-making on investments from actual utilization is an important source of inefficiency. Third, there are no effective incentives or control mechanisms in the system to prevent unnecessary service provision – including hospitalization – and to secure definitive care at the lowest possible level. The current incentives probably encourage technical efficiency within levels of care, but there is no incentive to ensure efficiency across levels of care. For instance, the DRG system has probably increased the efficiency of the hospital sector, but in itself cannot prevent unnecessary hospitalization. On the contrary, it encourages short term hospitalization. Or, the capitation payment of primary care might motivate doctors to keep patients healthy, but once they become ill, family doctors have no incentive to provide definitive care and to avoid unnecessary referrals to higher levels. As mentioned, family physician referrals to providers of outpatient and inpatient care show a steady increase over the past 10 years, which implies a weak gate-keeping function. Outpatient specialist contacts and hospital discharges exhibit a similar upward trend (see the section on *Health care delivery system*), the latter with an almost 20% increase between 1990 and 2000 (Table 12). Fourth, there are no effective mechanisms for assuring the quality of health care.

Altogether, it seems that further efficiency gains can be realized in the Hungarian health care system. On the other hand, cost-containment has probably been pressed to the point where further restrictions could threaten the viability of the system. It can be argued that health sector reform in Hungary was too slow and too cautious, and that successive governments have avoided confronting the real performance problems of the system. The other side of the coin, however, is that few irreversible changes have been implemented, implying that a number of reform options have remained open for Hungary. On the financing and purchasing side, most probably there will be three competing options on the agenda: enhancement of the NHIFA's purchasing function, introduction of competition among insurance funds, and extension of the regional care coordinating pilot project.

Current debates on the care coordination pilot project are concerned with a possible extension of the project to the whole population. It is also debated whether providers will be able to retain the privilege of being care coordinator organization or whether the care should be coordinated from the financing side.

One of the key issues on the delivery side is how the necessary structural changes will be achieved and what role privatization will play in the future. The government of 1998–2002 decided to preserve the public hospital system and, instead of privatization, to allow health care providers more discretion concerning the use of resources (corporatization). The present government prefers a more active role of private investors in the health sector. However, the issue of depreciation and a fair return on capital is yet to be resolved. Another important issue is whether the government will be able to maintain the recently increased pay level of health care personnel. Human resources, particularly nurses, will require increased attention, especially in light of the expected rise in workforce mobility after accession to the European Union in 2004.

The task health policy-makers face in Hungary is indeed complex. They have to find answers for the questions posed by the health needs of an aging population that has one of the worst health status in Europe, with the reform of a health care system that is still struggling with the legacies of the state-socialist past of the country, and the adverse effects that 15 years of ongoing health care reform itself created. Furthermore, this delicate mix of performance problems is further complicated by the challenges of the European internal market, which inevitably raise the problems of the new member states to the level of the EU.

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Laws and regulations

In this section laws and regulations are grouped according to years, and under each year, listed in chronological order and numbered consecutively in Arabic numbers which do not indicate the official number. The official number of laws is given in Roman numbers.

The listed laws and regulations have all been published in the Hungarian Gazette (*Magyar Közlöny*), which is available only in Hungarian. All effective laws and regulations are also available in electronic format in Hungarian (CD database published monthly by KJK-Kerszöv, Budapest). Certain health related laws and regulations are available in English on the web-site of the Ministry of Health, Social and Family Affairs.

1949

1. Act XX of 1949 on the Constitution of the People's Republic of Hungary
 - establishment of the communist regime in Hungary

1952

1. Decree No. 95/1952. (X. 13.) MT of the Ministerial Council on the District and Public Health Physician Services
 - establishment of the district physician services, which unifies primary care

1972

1. Act II of 1972 on Health
 - the old law on health care
 - access to health services is a right linked to citizenship (Article 25)
2. Decree No. 11/1972. (VI. 30.) EüM of the Minister of Health on the Code of Order of Health Workers
 - registration and regulation of health workers
 - full time private practice is not allowed (Article 39, section 2, point b)

1975

1. Act II of 1975 on Social Insurance and its executive order No. 17/1975. (VI. 14.) MT of the Ministerial Council
 - the old social insurance law, which the new social insurance structures and institutions have been built on

1982

1. Decree No. 9/1982. (VII. 21.) EüM of the Minister of Health on the National Institute of Pharmacy (see also the Deed of Foundation in Welfare Gazette 1998/11)
 - the National Institute of Pharmacy runs the registration and licensing system of pharmaceuticals

1987

1. Order No. 3/1987. (Eü.K. 3.) EüM of the Minister of Health on the Information Centre for Health Care of Ministry of Health (see also Order No. 3/1991. (NK. 23.) NM of Minister of Welfare and Deed of Foundation in Welfare Gazette 1995/13)
 - the establishment of the Information Centre for Health Care (IHC), which piloted and runs the performance based provider payment methods of FFS points and Hungarian DRGs in specialist outpatient and in patient care

1988

1. Decree No. 22/1988. (XII. 26.) SzEM of the Minister of Social Affairs and Health on the Social Insurance Subsidies of Prices of Pharmaceuticals
 - determines the extent of subsidy provided to registered medicines
2. Act XXI of 1988 on the Social Insurance Fund (promulgated: 31/12/1988)
 - the separation of the Social Insurance Fund from the national government budget

1989

1. Decree No. 6/1989. (III. 22.) SZEM of the Minister of Social Affairs and Health on Professional Colleges (see also Decree No. 16/1995. (IV. 13.) NM and Decree No. 53/1996. (XII. 27.) NM and Decree No. 52/1999. (IX. 12.) EüM on the Medical Professional Colleges)
 - the advisory bodies of the minister of health in the relevant specialties and professional areas
2. Order No. 5/1989. (SZEK 9.) SZEM of the Minister of Social Affairs and Health on the Health Care Scientific Council (see also Decree No. 10/1997. (V. 23.) NM and Decree No. 17/2001. (IV. 28.) EüM)
 - the advisory body of the minister of health on health sciences and policy
3. Act XXXI of 1989 on the Amendment of Act XX of 1949 on the Constitution of the Republic of Hungary (promulgated: 23/10/1989) (see also Act XL 1990 and Act LXIII of 1990)
 - establishment of an independent democratic constitutional state with its core institutions of the president, the National Assembly, the Constitutional Court (Article 32/A, section 3), the ombudsmen (Article 32/B, section 1), and the national and local government, whose discretion is guaranteed over local Affairs (Article 44/A)
 - Hungary is declared to have a market economy (Article 9)
 - right to private property (Article 14), and to peaceful assembly and association (Article 62, 63)

- health is reinforced to be a fundamental right: right to healthy environment (Article 18), right to physical and mental health (Article 70/D, section 1), right to income maintenance (Article 70/E)
 - right to health is implemented through the provision of labour safety, health care, regular physical activity, environmental protection (Article 70/D, section 2) with the overall responsibility of the national government (Article 35, section 1, point g)
4. Decree No. 113/1989. (XI. 15.) MT of the Ministerial Council on Social and Health Enterprises and Decree No. 30/1989. (XI. 15.) SZEM of the Minister of Social Affairs & Health on the Practice of Medicine, Clinical Psychology and Other Health and Social Services
 - “full” private providers are allowed to be established in the area of health and social services
 5. Act XLVIII of 1989 on the Social Insurance Fund’s Budget of 1990 (promulgated: 27/12/1989)
 - the “fund exchange”: health services are financed from the Social Insurance Fund

1990

1. Government Decree No. 49/1990. (IV. 12.) Korm. on the Scope of Duties and Authority of the Minister of Welfare
2. Decree No. 14/1990. (IV. 17.) SZEM of the Minister of Social Affairs & Health on the National Institute of Hospital and Medical Engineering (see also the Deed of Foundation of the Institute for Medical and Hospital Engineering in Health Gazette 2000/7)
 - registration and licensing of medical devices
3. Act LXV of 1990 on Local Government (promulgated: 14/08/1990; see also Act XX of 1991 on the Scope of Duties and Division of Authority between Local Governments and their Organs, the National Government Representatives and Certain Centrally Controlled Organs)
 - ownership of most public health care facilities is transferred to local governments (Article 107, section 1, point c)
 - local governments are responsible for supplying primary and secondary care to the local population (territorial supply obligation) on the basis of the principal division of tasks (Article 8, section 4 and Article 70, point b) and the principle of subsidiarity (Article 69, section 2-6)
 - the scope of territorial supply obligation and the catchment area of service providers is the status quo, which can only be modified by an agreement between local governments concerned (Act XX of 1991, Article 132; for primary care Article 129, section 1 and Article 133, point I)

1991

1. Act XI of 1991 on the National Public Health and Medical Officer Service (promulgated: 09/04/1991) and Decree No. 7/1991. (IV. 26.) NM of the Minister of Welfare on the Organisation and Operation of the National Public Health and Medical Officer Service
 - the Service is established as a state agency on the basis of the former public hygiene stations, but tasks are defined according to the concept of modern public health, and include the professional supervision of health care
 - defines the structure and organs of the NPHMOS
2. Decree No. 9/1991. (IV. 17.) NM of the Minister of Welfare on the Amendment of Decree No. 11/1972. (VI. 30.) EüM of the Minister of Health
 - doctors with foreign diplomas have to pass an exam before they can be registered

3. Resolution No. 60/1991. (X. 29.) OGY of the National Assembly on Social Insurance
 - the parliament sets out the main directions of the pension and health insurance system
4. Decree No. 18/1991. (XI. 5.) NM of the Minister of Welfare on the Prescription and Dispensing of Pharmaceuticals
 - determines which pharmaceuticals can be obtained with or without prescription
5. Act LXXXIV of 1991 on the Self Governance of Social Insurance (promulgated: 28/12/1991)
 - determines the structure of self governments of social insurance
6. Decree No. 26/1991. (XII. 28.) NM of the Minister of Welfare on the National Institute of Family Medicine (see also Deed of Foundation of the National Institute for Primary Care in Welfare Gazette 1998/2)

1992

1. Act IX of 1992 on the Amendment and Complement of Act II of 1975 on Social Insurance (promulgated: 09/03/1992)
 - determines entitlement to and defines the services covered under the social health insurance scheme (Article 4, 5 (15, 16/A))
 - social insurance contribution is separated into health insurance and pension insurance contributions (Article 19 (103))
 - determines ceiling for employee contributions (Article 21 (103/B))
2. Act X of 1992 on the Social Insurance Fund's Budget of 1992 and the Amendment of Act XXI of 1988 on the Social Insurance Fund (promulgated: 09/03/1992)
 - division of the Social Insurance Fund into health insurance and pension funds
3. Government Decree No. 55/1992. (III. 21.) Korm. on the Amendment of Decree No. 16/1972. (IV. 29.) MT on the Executive Order of Act II of 1972 on Health and Decree No. 6/1992. (III. 31.) NM of the Minister of Welfare on the Family Physician and Paediatric Primary Care Services
 - the former district doctor system is separated from hospitals and renamed as "family physician service"
 - free choice of family physician and family paediatrician
 - regulation of professional standards including family doctor specialization to be obtained
4. Government Decree No. 79/1992. (IV. 12.) Korm. on the Social Insurance Financing of Health Services in 1992
 - the introduction of contracting and capitation payment in family physician's services
5. Act XXXIII of 1992 on the Legal Status of Public Employees (promulgated: 02/06/1992)
 - regulates employment in the public sector and determines the compulsory minimum salaries of public employees according to a pay scale
6. Government Decree No. 107/1992. (VI. 26.) Korm. on Health Services which Can Be Utilized with Co-payments Only and on the Method of Payment
7. Act LXXXIV of 1992 on the Social Insurance Fund and Its Budget of 1993 (promulgated: 30/12/1992)
 - the introduction of new financing methods for outpatient specialist care and hospital care from July 1993

- till 1 October 1995 hospitals have individual base fees (the monetary value of 1 DRG point)
8. Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (promulgated: 31/12/1992)
 - assisting local governments for financing capital costs of their facilities including hospitals, medical equipment, etc.

1993

1. Act III of 1993 on Social Services (promulgated: 27/01/1993)
 - determines cash and in-kind social provisions
 - obligations of local governments to provide services for local residents
 - determines the eligibility for and administration of the co-payment exemption system in health care
2. Government Decree No. 28/1993. (II. 27.) Korm. on the Certificate for Co-payment Exemption
3. Act XII of 1993 on the Election Rules of Social Insurance Representatives (promulgated: 12/03/1993) and its executive orders of Decree No. 5/1993. (III. 26.) BM and 6/1993. (III. 26.) BM of the Minister of the Interior
 - elections of trade union representatives of the social insurance self governments on 23 May 1993
4. Decree No. 8/1993. (III. 31.) NM of the Minister of Welfare on the Professional Supervision of Health Care Institutions
 - determines the system of professional supervision of health services, in the frame of the National Public Health and Medical Officer Service
5. Government Decree No. 52/1993. (IV. 2.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - detailed description of the payment systems of various services
6. Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services
 - detailed list of outpatient specialist interventions, DRGs of acute inpatient care and their point values
7. Government Decree No. 91/1993. (VI. 9.) Korm. on the Establishment of the National Pension Insurance Administration and the National Health Insurance Fund Administration, and their Administrative Organs and Other Measures in Connection with this
 - as of July 1993, the Social Insurance Fund Administration is divided into the National Health Insurance Fund Administration and the National Pension Insurance Administration
 - determines the organizational structure of the National Health Insurance Fund Administration (NHIFA)
8. Act LXXX of 1993 on Higher Education (promulgated: 03/08/1993)
 - medical universities are under the supervision of the Ministry of Education
9. Act XCII of 1993 on the Amendment of Certain Provision of the Civil Code (promulgated: 30/10/1993)
 - legal framework for the establishment of non-profit corporations in the areas of public benefit activities, including health care

10. Act XCVI of 1993 on Voluntary Mutual Insurance Funds (promulgated: 06/12/1993)
 - legal framework for the establishment of voluntary non-profit insurance in the area of health, pension and self-support

1994

1. Act XXVIII of 1994 on the Hungarian Medical Chamber (promulgated: 05/04/1994)
 - compulsory membership for all practising physicians
 - the Medical Chamber is given the right to establish ethical norms and procedures; to negotiate the general rules and content of contracts between the NHIFA and physicians; and to participate in health policy formulation
2. Decree No. 16/1994. (IV. 26.) KHVM of the Minister of Transport, Communication and Water Management on the Scope of Insured by the Railway Health Insurance and the Rules of Referral to the Institutions of the Railway Health Service
 - railway health service is integrated into the main system of funding and delivery
 - concerning utilization, priority is given to railway workers and their dependants
3. Resolution No. 1030/1994. (IV. 29.) Korm. on the Principles of Long Term Health Promotion Policy
 - sets out health policy goals and targets of the government
4. Act LI of 1994 on the Hungarian Chamber of Pharmacists (promulgated: 07/05/1994)
 - compulsory membership for all practising pharmacists, on the basis of the same principles as in the case of the Hungarian Medical Chamber

1995

1. Decree No. 2/1995. (II. 8.) NM of the Minister of Welfare on the Pharmaceuticals which can be Prescribed with Social Insurance Subsidies and on the Extent of Subsidies Provided to the Prices Accepted as the Basis of Subsidy
 - determines the consumer price of pharmaceuticals as the basis of social insurance subsidy
 - determines the extent of subsidy provided to the purchase of registered medicines
2. Decree No. 3/1995. (II. 8.) NM of the Minister of Welfare on the Prescription and Dispensing of Pharmaceuticals
 - determines which pharmaceuticals can be obtained with or without prescription
3. Decree No. 5/1995. (II. 8.) NM of the Minister of Welfare on the District Mother and Child Health Nurse Service
4. Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization (promulgated: 05/06/1995), its executive orders of Government Decree No. 69/1995. (VI. 17.) Korm, Government Decree No. 70/1995. (VI. 17.) Korm. and Government Decree No. 71/1995. (VI. 17.) Korm.
 - economic stabilization measures (the so-called Bokros package)
 - health insurance benefits are curtailed (the exclusion of most dental services, certain cases of treatment in sanatorium, removal of subsidies on spa treatment)
 - co-payment for patient transfer is introduced
 - the scope of territorial supply obligation is defined as capacities contracted by the NHIFA

5. Government Decree No. 89/1995. (VII. 14.) Korm. on Occupational Health Services
 - the provision (financing) of occupational health services is the responsibility of the employer
6. Act LXXIII of 1995 on the Social Insurance Funds' Budget of 1995 and the Payment Methods for In-kind Benefits (promulgated: 14/07/1995)
 - budget cuts
 - principles of the payment system remain unchanged
 - hospital payment is modified, performance is weighted according to the level of care and specialty
 - the Minister of Welfare defines the capacities, which the NHIFA is obliged to contract for (Article 10, section 2)
7. Government Decree No. 103/1995. (VIII. 25.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - detailed description of the payment system of various services
8. Ruling No. 77/1995. (XII. 21.) AB of the Constitutional Court
 - the method of the definition of health care capacities in the frame of territorial supply obligation is unconstitutional
9. Act CXVII of 1995 on Personal Income Tax (promulgated: 22/12/1995)
 - tax rebates for the purchase of voluntary, non-profit health insurance (Article 35, section 2)

1996

1. Act XIV of 1996 on the 1996 Budget of the Social Insurance Funds (promulgated: 29/03/1996) and Government Decree No. 61/1996. (IV. 26.) Korm.
 - dental services are reintroduced into the social insurance benefit package with some co-payments
2. Act XLVII of 1996 on the Amendment of Act LXXXIV of 1991 on the Self Governance of Social Insurance (promulgated: 07/06/1996)
 - curtails the rights of the Self Government of Health Insurance concerning budgetary decisions
3. Act LXIII of 1996 on the Obligation of Supply of Health Services and the Regional Supply Norms (promulgated: 23/07/1996)
 - determines health care capacity per county in terms of hospital beds and consultation hours which local governments are to supply and the NHIFA is obliged to contract for (territorial supply obligation)
4. Government Decree No. 113/1996. (VII. 23.) Korm. on Licences for Supplying Health Care Services
 - renewal of the health care provider licensing system
5. Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on Minimum Standards of Certain Institutions Providing Health Services
 - regulates minimum standards of specialist service providers in terms of buildings, equipment, personnel requirements
6. Decree No. 20/1996. (VII. 26.) NM of the Minister of Welfare on Home Care
 - determines the requirements of providing home care

7. Act LXXXVII of 1996 on the Amendment of Act II of 1975 on Social Insurance (promulgated: 16/11/1996)
 - the social insurance contribution base is widened
 - employer health insurance contribution rate is decreased by 3% points (Article 10) national government transfers for non-contributing groups are ceased in their previous form (Article 21 modifies Article 119 of Act II of 1975)
8. Act LXXXVIII of 1996 on the Hypothecated health care tax (promulgated: 16/11/1996) and its executive order Government Decree No. 202/1996. (XII. 23.) Korm.
 - introduction of an earmarked lump sum tax for health services
9. Act CXXI of 1996 on the Amendment of Act XXXVIII of 1992 and Related Laws (promulgated: 21/12/1996)
 - curtails the rights of the self governments of social insurance (Article 55 and 56)
10. Act CXXV of 1996 on the Social Insurance Funds' Budget of 1997 (promulgated: 25/12/1996)
 - modification of the performance principle in the payment system, a new fixed (guaranteed) element is introduced
 - cross-subsidization between the social insurance funds is abolished (Article 30, section 2 repeals Article 3, section 5 of Act LXXXIV of 1992)
11. Act CXXXVI of 1996 on the Use of a Specified Amount of Personal Income Tax for Public Purposes in Accordance with the Taxpayer's Instruction (promulgated: 26/12/1996)
 - taxpayers can offer 1% of their personal income tax to non-profit organizations, including those in the area of health services
12. Government Decree No. 238/1996. (XII. 26.) Korm. on the Amendment of Decree No. 103/1995. (VIII. 25.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - the base fee is made uniform over a 12-month period in acute inpatient care, as of 1 March 1998 the base fee is the same for all hospitals in the country (Article 15, section (3) (24(6)))
 - introduction of a fixed element to the payment of providers (Article 10, section (3) (20(8)))
13. Decree No. 55/1996. (XII. 27.) NM of the Minister of Welfare on the National Emergency Ambulance Service (see also the Deed of Foundation in the Welfare Gazette 1997/11)

1997

1. Government Decree No. 40/1997 (III.5.) Korm. on the Practice of Alternative Medicine and Decree No. 11/1997. (V. 28.) NM of the Minister of Welfare on Certain Aspects of the Practice of Alternative Medicine
 - regulation of complementary and alternative medicine
2. Act XLVII of 1997 on Management and Protection of Health Care and Related Personal Data (promulgated: 05/06/1997)
 - protects confidentiality of personal information in health services
3. Decree No. 12/1997. (VI. 5.) NM of the Minister of Welfare on the Amendment of Decree No. 19/1996. (VII. 26.) NM on the Minimum Standards of Certain Institutions Providing Health Services
 - extends the deadline until which providers have to meet the minimum standards

4. Act XLVIII of 1997 on Amendment of Various Acts in Connection with the Self Governance of Social Insurance (promulgated: 11/06/1997)
 - self governments are not elected and the number of representatives are decreased
5. Decree No. 17/1997. (VI. 30.) NM of the Minister of Welfare on the Prescription of Balneotherapy in the Frame of Medical Rehabilitation, on the Professional Requirements of Providing Balneotherapy which is Subsidized by Social Insurance, and on the Administration of these Social Insurance Subsidies
6. Act LVIII of 1997 on Commercial Advertising (promulgated: 04/07/1997)
 - limits advertising on health damaging products such as tobacco
7. Decree No. 32/1997. (X. 28.) NM of the Minister of Welfare on the Registration and Licensing of Health Care Providers
 - detailed regulation on the administration of registration and licensing
8. Act LXXX of 1997 on those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services (promulgated: 25/07/1997) and its executive order of Government Decree No. 195/1997. (XI. 5.) Korm.
 - rules of social insurance including compulsory participation (Article 2, section 1), entitlement for services and contribution rates
 - the government is obliged to cover any deficit incurred by the HIF (Article 3, section 2)
 - participation is compulsory for every citizens, including small farmers (Article 39, section 2), who can choose to pay higher contribution to be eligible for cash benefits (Article 34, section 3)
 - the government transfers the revenue from the hypothecated health care tax to the HIF to compensate for non-contributing groups, such as pensioners, women on maternity leave, conscripts and the poor (Article 39, section 1 and Article 16, section 1, points b-o)
 - contribution rates are determined annually by the National Assembly (Article 19, contribution ceiling – Article 24)
9. Act LXXXIII of 1997 on the Services of Compulsory Health Insurance (promulgated: 25/07/1997) and its executive order of Government Decree No. 217/1997. (XII. 1.) Korm.
 - determines the in-kind and cash benefits of the social health insurance, and the rules of their utilization
 - declares the responsibility of the state to provide services, regardless of the revenues of the HIF (Article 4)
 - defines services, which are excluded from social health insurance coverage (Article 18, section 4-6; high cost, high-tech interventions
 - Article 18, section 5, point g), which can be utilized with co-payment (Article 23), and whose price is subsidized (Article 21)
 - defines to rules of utilization and the referral system (Article 18, section 1-3; Executive order, Article 2)
 - rules of contracting (Article 30-33, and Executive order Article 13-25), control of implementation of the contracts (Article 36-38)
 - determines methods of payment in general, and that the HIF covers recurrent costs of services only (Article 34-35)

10. Act CXXIX of 1997 on the Amendment of Act CXXVI of 1996 on the Use of a Specified Amount of Personal Income Tax for Public Purposes in Accordance with the Taxpayer's Instruction (promulgated: 10/12/1997)
 - taxpayers can offer 1% of their personal income tax to registered churches
11. Decree No. 46/1997. (XII. 17.) NM of the Minister of Welfare on Health Services, which are not Covered by Social Health Insurance
 - list of services which are excluded from HIF financing, but covered by the central government budget (Annex 1)
 - list of services which are excluded from public finance
12. Decree No. 48/1997. (XII. 17.) NM of the Minister of Welfare on Dental Services which Can Be Utilized in the Frame of the Social Health Insurance
13. Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare on Infertility Treatments which Can Be Utilized in the Frame of the Statutory Health Insurance
14. Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees of Certain Health Services which Can Be Utilized with Co-payments Only
 - determines the amount of co-payment for certain services, and the full fee of services which are not covered by the social health insurance (medical examination for driving and shotgun licences, blood alcohol test, detoxifying, forensic health status description)
15. Act CLIII of 1997 on the Social Insurance Funds' Budget of 1998 (promulgated: 23/12/1997)
 - determines the main methods of provider payment
16. Act CLIV of 1997 on Health (promulgated: 23/12/1997)
 - sets up the general framework for health care including patient rights, the organization of the health care system, major actors and responsibilities for health care (Article 143).
 - establishes the institutions of patient right representatives (Article 30-33), arbitration (Article 34), hospital supervisory councils (Article 156, section 1-5) and hospital ethical committees (Article 156, section 1-2, 6-7)
 - establishes the National Health Council (Article 148, 149)
 - introduces the National Health Promotion Programme, to be approved by the Parliament (Article 146)
 - determines the services which have to be financed from the national government budget (Article 142, section 2, high cost, high tech interventions – point d)
 - establishes the Health Care Professional Training and Continuing Education Council (Article 117)
 - confirms national institutes to assist the Minister of Health (Article 150)
 - defines maintenance obligation (Article 155, section 2)
 - utilization according to the principle of “appropriate level of specialization” or “progressivity” (Article 75, section 3 and Article 76)
 - efficient use of resources (Article 75, section 4)

1998

1. Decree No. 6/1998. (III. 11.) NM of the Minister of Welfare on the Regulation of Updating Professional Classification Systems and Financing Parameters Used in Health Care
 - establishment of the Committee of Updating of Financing Parameters, and the detailed procedures for the modification of existing classification systems including HDGs
2. Act XXV of 1998 on the Pharmaceuticals for Human Use (promulgated: 01/04/1998) and Government Decree No. 37/2000. (III. 23.) Korm. on the Personnel and Material Requirements of Production of Pharmaceuticals for Human Use and Decree No. 60/1999. (XII. 1.) EüM of the Minister of Health on the Wholesale of Pharmaceuticals and Decree No. 12/2001. (IV. 12.) EüM of the Minister of Health on the Registration and Licensing of Pharmaceuticals for Human Use
 - comprehensively regulates the pharmaceutical industry in accordance with the practice of the European Union
3. Government Decree No. 72/1998. (IV. 10.) Korm. on the Financing of Higher Education on the Basis of Training and Maintenance Capitation
 - higher education is financed by capitation according to the number of students
4. Ruling No. 16/1998. (V. 8.) AB of the Constitutional Court
 - the restructuring of self governments of social insurance violates constitutional law
5. Decree No. 19/1998. (VI. 3.) NM of the Minister of Welfare on Patient Transfer
6. Decree No. 20/1998. (VI. 3.) NM of the Minister of Welfare on Emergency Ambulance Services
7. Decree No. 21/1998. (VI. 3.) NM of the Minister of Welfare on Minimum Standards of Certain Institutions Providing Health Services
 - further extends the deadline until providers have to meet the defined minimum personnel and material requirements
8. Decree No. 25/1998. (VI. 17.) NM of the Minister of Welfare on Artificial Sterilization
9. Decree No. 26/1998. (VI. 17.) NM of the Minister of Welfare on the National Blood Supply Service (see also the Deed of Foundation in Welfare Gazette 1998/12.)
 - reorganization of the blood supply units of hospitals into one national organization
10. Decree No. 27/1998. (VI. 17.) NM of the Minister of Welfare on the Registration and Licensing of non-medical health professionals
 - establishment of a registration system for non-medical health professionals
11. Decree No. 30/1998. (VI. 24.) NM of the Minister of Welfare on the Rules of Special Procedures for Human Reproduction and on the Detailed Rules of Use and Freeze Storage of Reproductive Cells and Embryos
12. Act XXXVI of 1998 on the Enumeration of the Ministries of the Republic of Hungary (promulgated: 1/7/2002)
 - the Ministry of Welfare is divided into the Ministry of Health and the Ministry of Social and Family Affairs

13. Act XXXIX of 1998 on the State Supervision of Social Insurance Funds and their Administration (promulgated: 15/07/1998)
 - the government abolishes the self governance of the social insurance funds and reinstates government supervision
14. Government Decree No. 131/1998. (VII. 23.) Korm on the Scope of Duties and Authority Concerning the Control of Social Insurance Administration
 - the control of social insurance administrations is shifted to the Prime Minister's Office
15. Government Decree No. 137/1998. (VIII. 18.) Korm. on the Prime Minister's Office
 - strengthens the role of the Prime Minister's Office in policy making and coordination
16. Government Decree No. 154/1998. (IX. 30.) Korm. on the Scope of Duties and Authority of the Minister of Health
17. Act LXVI of 1998 on the Hypothecated Health Care Tax (promulgated: 14/11/1998)
 - the original lump sum hypothecated tax was complemented with a proportional component
18. Act LXVII of 1998 on Amendment of Act LXXX of 1997 (promulgated: 14/11/1998)
 - employer social insurance contribution is substantially decreased (6% point) as of the 1 January 1999, while hypothecated health care tax is increased by more than 70%
19. Decree No. 10/1998. (XII. 11.) EüM of the Minister of Health on the Organization and Operation of the Health Care Professional Training and Continuing Education Council
 - the establishment of new body for the coordination and supervision of professional training in health care
20. Decree No. 14/1998 (XII. 11.) EüM of the Minister of Health on Hospital Ethical Committees
 - hospital ethical committees to be set up in the first half of 1999
21. Decree No. 18/1998 (XII. 11.) EüM of the Minister of Health on the Implementation of Provisions of Act CLIV of 1997 concerning Tissue and Organ Transplantation and Storage, and Certain Pathohistological Investigations
22. 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 of 1999
23. 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 whose care the hospital is responsible for
24. Act XCI of 1998 on the Social Insurance Funds' Budget of 1999 (promulgated: 29/12/1998)
 - the pharmaceutical budget is put under closer control (Article 4, section 1, point d)
 - the Minister of Health can reallocate between sub-budgets of preventive and curative services budget of the HIF (Article 5, section 3)
 - launching of the care coordination pilot with a maximum population of 200 000 (Article 16)
 - abolishment of the partial fix element in the payment for specialist services (Article 19)

- primary and secondary dental care are paid for by capitation and FFS points, respectively
 - collection of social insurance contribution is shifted to the Tax Office (Article 24-31)
25. Government Decree No. 229/1998. (XII. 30.) Korm. on the Scope of Duties, Organization and Operation of the National Health Council
- the establishment of the National Health Council for assisting the Government in health policy

1999

1. Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - detailed regulation of payment methods for all services (Article 31, section 1 – chronic outpatient care; Article 32 - CT, MRI; Article 33
 - patient transportation; Article 43 - expensive medical devices and prostheses; Article 44 – not widespread, high cost interventions)
 - national base fee for inpatient services is fixed in advance for a year as of 1 April 1999 (Article 38, section 3)
 - detailed regulations of the care coordination pilot project (Article 50)
2. Act XLII of 1999 on the Protection of Non-Smokers and Certain Rules of the Consumption and Distribution of Tobacco Products (promulgated: 23/04/1999)
 - non-smokers are protected with restriction of places where smoking is allowed and where tobacco products can be sold
3. Government Decree No. 75/1999. (V. 21.) Korm. on the Transitional Rules of Operation, and the Scope of Duties and Authority of the Central Administration of Social Insurance
4. Government Decree No. 90/1999. (VI. 21.) Korm on the Amendment of Certain Regulations Concerning the Control of Social Insurance Administration
 - as of 21 June 1999, the control of social insurance administration is shifted to the Ministry of Finance
5. Decree No. 30/1999. (VII. 16.) EüM of the Minister of Health on the Registration and Licensing of Medical Doctors, Dentists, Pharmacists and Clinical Psychologists and on the Licensing of Non-Registered Persons
 - base registration is operated by the Ministry of Health, while licensing by the relevant professional chambers
6. Government Decree No. 134/1999. (VIII. 31.) Korm on the Reimbursement of Social Insurance Subsidies of Pharmaceuticals, Medical Aids and Prostheses, and Balneotherapy Prescribed in the Frame of Outpatient Specialist Care
 - the rules and procedures of contracting between the county offices of the NHIFA and suppliers of pharmaceutical products, medical aids and prosthesis and balneotherapy
7. Decree No. 47/1999. (X. 6.) EüM of the Minister of Health on Medical Devices
 - regulates the introduction of medical devices into commerce, according to the practice of the EU
8. Act XCII of 1999 on the Amendment of Act XXI of 1996 on Regional and Rural Development (promulgated: 30/10/1999)
 - strengthens the institution of regional development councils

9. Decree No. 52/1999. (XI. 12.) EüM of the Minister of Health on the Medical Professional Colleges
10. Decree No. 77/1999. (XII. 29.) EüM of the Minister of Health on Patient Right Representatives and the Rules of Procedures

2000

1. Act II of 2000 on Independent Medical Practice (promulgated: 11/02/2000)
 - practising family doctors are granted a right to practice which can be sold and bought
2. Government Decree No. 18/2000. (II. 25.) Korm on the Procurement and Withdrawal of Family Doctor's Right to Practice, and the Terms and Conditions of Loans for Procurement of the Tangible and Intangible Assets and Right to Practice Required for Family Doctor's Practice
 - detailed regulations of buying and selling the right to practice
 - provides subsidized loans to family doctors for buying medical equipment and surgery
3. Decree No. 4/2000. (II. 25.) EüM of the Minister of Health on the Family Doctor, Paediatric and Dental Primary Care Services
 - defines the professional content and rules of the provision of primary care
4. Announcement of the Ministry of Health on the Establishment of the Authority for Medical Devices of Ministry of Health (see the Deed of Foundation in Health Gazette 2000/7)
 - as of 1 April 2000, a newly established organization of the Ministry of Health takes over the registration and licensing of medical devices
5. Government Decree No. 48/2000. (IV. 13.) Korm. on the Medical Aids and Prostheses which can be Prescribed with Social Insurance Subsidy and the Amount of Subsidy and Decree No. 12/2000. (IV. 13.) EüM of the Minister of Health on the Prescription, Distribution, Repair and Renting of Medical Aids and Prostheses which can be Prescribed with Social Insurance Subsidy
 - regulation for medical aids and prostheses
6. Government Decree No. 112/2000. (VI. 29.) Korm on the Scope of Duties and Authority of the Social Insurance Price and Subsidy Committee
 - establishment of an advisory committee in price subsidy matters
7. Resolution No. 2150/2000. (VI. 30.) Korm. of the Government on the Measures to Reduce the Overspending of the Pharmaceutical Sub-budget of HIF
 - measures include price negotiations, the elaboration of a new system of pharmaceutical subsidies, decreasing price margins
8. Act CXIII of 2000 on the Amendment of Various Laws on Taxes, Contributions and Other Government Revenues (promulgated: 14/11/2000)
 - as of 1 January 2001, the ceiling on the health insurance contribution of employees is abolished (Article 153, section 1)
9. Act CXVI of 2000 on Arbitration in Health Care (promulgated: 22/11/2000) and Joint Decree No. 4/2001. (II. 20.) EüM-IM of the Minister of Health and the Minister of Justice on Certain Aspects of Arbitration in Health Care
 - establishes the institution and procedures of arbitration to resolve disputes between patients and health care providers without going to court

10. Government Decree No. 227/2000. (XII. 19.) Korm on the Amendment of Certain Regulations Concerning the Control of Social Insurance Administration
 - as of 1 January 2001, the control of the health insurance administration is shifted back to the Ministry of Health
11. Resolution No. 2329/2000. (XII. 21.) Korm. of the Government on the Agreement with the Pharmaceutical Companies and Wholesalers to Contain the Pharmaceutical Sub-budget of HIF
 - three-year agreement which guarantees price increase below the level of inflation

2001

1. Decree No. 7/2001. (III. 2.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of Minister of Welfare
 - introduction of version 4.3. of Homogeneous Diseases Groups (HDGs)
2. Decree No. 19/2001. (V. 23.) EüM of the Minister of Health on the Commercial Price Margins of Pharmaceutical Products (see also Decree No. 22/1992. (VIII. 19.) NM of the Minister of Welfare)
 - decreases the wholesale and retail price margins for expensive pharmaceuticals
3. Resolution No. 1052/2001. (V. 30.) Korm. of the Government on the Measures to Reduce the Overspending of the Pharmaceutical Sub-budget of HIF
 - determines the objective to rationalize prescribing
4. Decree No. 22/2001. (VI. 1.) EüM of the Minister of Health on the Sales Promotion and Representation of Pharmaceuticals for Human Use
 - regulates sales promotion and representation, including medical representatives
5. Act XXXIV of 2001 on the Territorial Supply Obligation of Specialist Health Services, further more on the Amendment of Various Laws in Connection with Health Care (promulgated: 12/06/2001) and Government Decree No. 77/2001. (V. 9.) Korm. on the Amendment of Government Decree No. 217/1997. (XII. 1.) Korm.
 - capacity norms are abolished, inclusion of new capacities to be approved by the Minister of Health, local governments are allowed more flexibility to restructure and reduce capacities
6. Government Decree No. 109/2001. (VI. 21.) Korm. on the Pharmaceuticals which can be Prescribed with Social Insurance Subsidies and on the Extent of Subsidies
 - the extension of fixed amount subsidies
7. Act LXII of 2001 on the Hungarians, who Live in Neighbouring Countries (promulgated: 7/7/2001)
 - provides benefits to Hungarian ethnic minorities in neighbouring countries
 - those, who work in Hungary must participate in the social health insurance scheme, and entitled for health services (Article 7)
 - those, who do not work in Hungary, but utilize health services in Hungary can apply for the reimbursement of actual expenses (Article 7)
8. Resolution No. 1066/2001. (VII. 10.) Korm. of the Government on the Principles of the Healthy Nation Public Health Programme, 2001-2010.
 - public health action programme with targets of increasing life expectancy of men and women to 70 and 78 years respectively

9. Decree No. 24/2001. (VI. 29.) EüM on the Amendment of Certain Decrees in Connection with the Reorganization of Certain National Institutes and Announcement of the Minister of Health on the Establishment of the National Health Promotion Centre (see the Deed of Foundation in: Health Gazette 2001/13; see also Welfare Gazette 1997/16 and Health Gazette 2000/5 on the National Institute of Prevention, and Health Gazette 1999/5 on the Health Promotion Research Institute)
 - in October 2001 the Health Promotion Research Institute and the National Institute of Health Promotion are merged into a new institute, which is integrated into the National Office of the NPHMOS
10. Act LXX of 2001 on the Amendment of Various Acts Concerning Health Care, Supply of Pharmaceuticals, and Social Care, and of Act LXXXIII of 1997 on the Compulsory Health Insurance, and of Various Acts Concerning Social Insurance Contribution and Hypothecated Health Care Tax (promulgated: 25/10/2001) and Decree No. 34/2001. (X. 17.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of Minister of Welfare
 - dental co-payments on tooth preserving treatments are abolished from 1 November 2001
11. Act CVII of 2001 on Provision of Publicly Funded Health Care Services and on the Forms of Practising Medicine (promulgated: 24/12/2001)
 - widens the range of organizational options open to institutional and individual providers of health services, including the possibility of corporatization of hospitals and self-employment of medical doctors and pharmacists ("free-lance" medical doctors and pharmacists)

2002

1. Government Decree No. 50/2002. (III. 26.) Korm. on the Technical Conditions of Modifying Specialist Health Care Capacities and on the Regulations of its Procedure and of Contracting New Providers
2. Decree No. 11/2002. (III. 26.) EüM of the Minister of Health on the Implementation of Certain Provisions of Act XXXIV of 2001 on the Territorial Supply Obligation of Specialist Health Services, further more on the Amendment of Various Laws in Connection with Health Care
3. Decree No. 12/2002. (III. 28.) EüM of the Minister of Health on the Rules about the Professional Development Plan of Public Health Care Institutions
4. Decree No. 13/2002. (III. 28.) EüM of the Minister of Health on the Qualification Requirements of the Director and Deputy Directors of Public Health Care Institutions as well as on the Detailed Regulations of Application for These Posts
 - top managers of public health care institutions are required to have a masters degree in management
5. Decree No. 14/2002. (III. 28.) EüM of the Minister of Health on the Terms of Contracting Out Publicly Funded Health Care Services
6. Decree No. 15/2002. (III. 28.) EüM of the Minister of Health on the Operation and Professional Governing Body of Public Health Care Institutions
7. Government Decree No. 58/2002. (III. 29.) Korm. on the Detailed Regulations of Contracting Out Service Provision and Production and of Tendering Procedures
8. Government Decree No. 69/2002. (IV. 12.) Korm. on the General Conditions of Practising Medicine, on the Practice Licences and on the Health Services, which can be Provided as a Private Entrepreneur

9. Government Decree No. 70/2002. (IV. 12.) Korm. on the Detailed Regulations of the Contract on Practising Medicine
10. Government Decree No. 116/2002. (V. 15.) Korm. on the Detailed Regulations of the Establishment, Operation and Closing Down of University Centre of Clinical Departments, as well as of the Cooperation between the University and the University Centre of Clinical Departments
11. Act XI of 2002 on the Enumeration of the Ministries of the Republic of Hungary (promulgated: 22/5/2002)
 - the Ministry of Health and the Ministry of Social and Family Affairs are fused into Ministry of Health, Social and Family Affairs
12. Ministry of Health Guideline for the Economic Evaluation of Health Care Interventions (Health Gazette 2002/11; issued on 23/5/2002)
13. Government Decree No. 142/2002. (VI. 28.) Korm. on the Scope of Duties and Authority of the Minister of Health, Social and Family Affairs
14. Government Decree No. 148/2002. (VII. 1.) Korm. on the Prime Minister's Office
15. Act XXIII of 2002 on the Amendment of Act CXXXIII of 2000 on the 2001 and 2002 Budget of the Republic of Hungary (promulgated: 19/7/2002)
 - the salary of health workers (and other public employees) are raised by an average 50% as of 1 October 2002
 - suspends those clauses of Act CVII of 2001, which restricted the scope of those, whom the provision of publicly funded health services can be contracted out
16. Government Decree No. 163/2002. (VII. 26.) Korm. on the Amendment of Certain Government Decrees on the Implementation of the Provisions of Act CVII of 2001 on the Provision of Publicly Funded Health Care Services and on the Forms of Practising Medicine
 - suspends the implementation of government decrees No. 116/2002, 69/2002 and 58/2002 till the 1 March 2003 in accordance with Act XXIII of 2002
17. Act LXII of 2002 on the 2003 Budget of the Republic of Hungary (promulgated: 26/12/2002)
 - Expansion of the care coordination pilot project up to 1 million inhabitants (Article 68)

2003

1. Resolution No. 46/2003. (IV. 16.) OGY of the National Assembly on the Johan Béla National Programme for the Decade of Health
 - ten-year national public health programme
 - launching national screening programs for breast cancer and cervical cancer, from 2005 also for colorectal cancer
2. Decree No. 34/2003. (VI. 7.) ESzCsM on the Health Care Scientific Council
3. Act XLIII of 2003 on Health Care Providers and on the Organization of Publicly Funded Health Care Services (promulgated: 30/6/2003)
 - less restrictive regulation on the privatization of hospitals and polyclinics
4. Act XLIV of 2003 on the Repeal of Act CVII of 2001 on Provision of Publicly Funded Health Care Services and on the Forms of Practicing Medicine (promulgated: 30/6/2003)
 - along with the passing of Act XLIII of 2003, the previous act on corporatization and privatization has been repealed

5. Decree No. 40/2003. (VII. 16.) ESzCsM of the Minister of Health, Social and Family Affairs on the Amendment of Various Ministerial Decrees in Connection with Age-related Screening Programmes
 - launching national cancer screening programmes
6. Announcement of the Minister of Health, Social and Family Affairs on the Deed of Foundation of the National Institute of Child Health (Health Gazette 2003/17, published on 21/7/2003)
7. Announcement of the Minister of Health, Social and Family Affairs on the Amendment of the Deed of Foundation of the National Health Promotion Center (Health Gazette 2003/17, published on 21/7/2003)
 - removes the National Health Promotion Centre from the organization of the National Public Health and Medical Officer Services and puts it under the Ministry of Health, Social and Family Affairs, renames it to National Health Promotion Institute and transfers the professional supervision and coordination of youth health care to the newly established National Institute of Child Health
8. Government Decree No. 1085/2003. (VIII. 19.) Korm. on the Upcoming Tasks of Modernization of the Health Care System
 - declares the objectives of health care reform
 - determines the main directions of health care reform including regionalization (2.1), the enhancement of the purchasing function of the National Health Insurance Fund Administration (2.2), encouragement of privatization of outpatient specialist services (2.3), introduction of insurance for long term care and medical savings accounts (2.4), evaluation and further development of the care coordination pilot (2.5, 2.6), further development of information systems in the health sector (2.7)
9. Call for proposals of the Ministry of Health, Social and Family Affairs for the Establishment of Regional Health Councils and for the Elaboration of Regional Health Care Development Plans (Health Gazette 2003/22, 10/6/2003)
 - provides financial assistance to set up Regional Health Councils and Regional Health Care Development Plans on a voluntary basis within the framework of the statistical-planning regions of Hungary
10. Decree No. 60/2003. (X. 20.) ESzCsM of the Minister of Health, Social and Family Affairs on the Minimum Standards of Providing Health Care Services
11. 61/2003. (X. 27.) ESzCsM the Minister of Health, Social and Family Affairs on Health Care Services that can be Provided exclusively on the Basis of Waiting Lists
12. Government Decree No. 184/2003. (XI. 5.) Korm. on the Health Care Investment Loan Programme and on the conditions of Bank Guarantees
 - Provides subsidized loans for the privatization of health care facilities
13. Act LXXXIII of 2003 on the Chamber of Non-medical Health Professionals (promulgated: 6/11/2003)
 - establishment of professional self regulation for non-medical qualified health personnel
14. Act LXXXIV of 2003 on the Various Aspects of Practicing Medicine (promulgated: 11/11/2003)
 - regulates the various employment options for health workers
15. Resolution No. 1115/2003. (XI. 26.) Korm. of the Government on the Scope of Duties and Authority of the Governmental Commissioner Responsible for the Implementation and Coordination of Health Sector Reform

16. Decree No. 68/2003. (XII. 13.) ESzCsM of the Minister of Health, Social and Family Affairs on the Corrective Coefficient to be Applied for the Reimbursement of Social Insurance Subsidies of Pharmaceuticals for Human Use and of Nutritional Products for October 2003
 - Pharmaceutical companies have to pay the subsidies for the quantity of drugs, which exceeds the volume agreed on with the National Health Insurance Fund Administration
17. Ruling No. 63/2003. (XII. 15.) AB of the Constitutional Court
 - Act XLIII of 2003 is annulled for procedural reasons
18. Act CXVI of 2003 on the 2004 Budget of the Republic of Hungary and on the Three-year Principles of the State Budget (promulgated: 22/12/2003)
 - Expansion of the care coordination pilot project up to 2 million inhabitants (Article 77)
19. Government Decree No. 264/2003. (XII. 24.) Korm. on the Amendment of Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services
 - introduction of payment limits in specialist care, for performance above the 2003 level (Article 12 modifies Article 27)

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2. National Health Insurance Fund Administration (<http://oep.hu>) (in Hungarian only)
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Statistical Yearbook: 1993, joint publication with the National Pension Insurance Administration
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3. Ministry of Health, Social and Family Affairs (http://www.eum.hu/English/English_main.html)
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(<http://www.gyogyinfok.hu/angol.htm>)

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WHO Regional Office for Europe health for all database: <http://www.who.dk/hfdab>

WHO Regional Office for Europe "Highlights on Health in Hungary": <http://www.who.int/whosis>

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OECD Statistics on health care: <http://www.oecd.org>

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Acronyms and glossary

Acronyms

CSEC	Central and south-eastern European countries
CPI	Consumer Price Index
DRG	Diagnosis Related Groups
EU	European Union
GDP	Gross Domestic Product
HDGs	Homogenous Disease Groups, the Hungarian adaptation of Diagnosis Related Groups Hungarian acronym: <i>HBCS (Homogén Betegségcsoportok)</i>
HIF	Health Insurance Fund Hungarian acronym: <i>EA (Egészségbiztosítási Alap)</i>
KÖZGYÓGY	Co-payment exemption system for the poor
MCH	Mother and Child Health Nurse (or Nurse Service) (Védőnői Szolgálat)
Ministry of Health	Ministry responsible for the health care sector: Ministry of Health till 1988, Ministry of Social Affairs and Health (1988–1990), Ministry of Welfare (1990–1998), Ministry of Health (1998–2002), Ministry of Health, Social and Family Affairs (since 2002) Hungarian acronym for Ministry of Health: <i>EüM (Egészségügyi Minisztérium)</i> Hungarian acronym for Ministry of Health, Social and Family Affairs: <i>ESzCsM</i>
NHA	National Health Accounts Hungarian acronym: <i>NESZ (Nemzeti Egészségügyi Számlák)</i>
NHIFA	National Health Insurance Fund Administration Hungarian acronym: <i>OEP (Országos Egészségbiztosítási Pénztár)</i>
NPHMOS	National Public Health and Medical Officer Service Hungarian acronym: <i>ÁNTSZ (Állami Népegészségügyi és Tisztiorvosi Szolgálat)</i>
OECD	Organisation for Economic Cooperation and Development
WHO	World Health Organization

Glossary

Authority for Medical Devices of the Ministry of Health

Authority responsible for the registration and licensing of medical devices since April 2000. It took over responsibility from the Institute for Medical and Hospital Engineering.

County

The second level of the public administration system in Hungary. The country is divided into 19 counties and the capital, Budapest. Each county covers an area between 2000 and 9000 km², with a population between 200 000 and 1.1 million, except for the capital which had 1.8 million residents in 2001.

Earmarked and target subsidies

Conditional (“earmarked”) and matching (“target”) grants of the national government for county governments and municipalities to cover the capital costs of health services including replacement of outdated equipment, refurbishment of buildings, as well as new investments. Local governments can apply for conditional grants without their own financial contribution, but matching grants are only available for those local governments that cover a certain part of the total investment costs.

Family doctor service

A form of primary care provided by medical doctors for the local residents.

Family doctor

A medical doctor who provides family doctor services. Family doctors can either be family physicians or family paediatricians.

Family paediatrician

A family doctor with a specialization in paediatrics, who provides family doctor services for children, usually in larger municipalities only, such as cities and their vicinities.

Family physician

A family doctor who provides family doctor services for adults and, in smaller municipalities, also for children.

Health Care Professional Training and Continuing Education Council

The advisory body of the Minister of Health on health care education and training.

Acronym: *ESZTT (Egészségügyi Szakképzési és Továbbképzési Tanács)*.

Health Care Scientific Council

The advisory body of the Minister of Health on health sciences and health policy.

Acronym: *ETT (Egészségügyi Tudományos Tanács)*.

Health Insurance Fund

The pool of money collected from social insurance contributions and the hypothecated health care tax. It is part of the state budget, but separated from the national government budget,

and is administered by the National Health Insurance Fund Administration (NHIFA). Until 1992 health and pension insurance funds were unified in the Social Insurance Fund. Since then the Health Insurance Fund operates separately from the Pension Insurance Fund; together they are referred to as social insurance funds.

Acronyms: HIF, *EA*.

Homogenous Disease Groups

The Hungarian adaptation of the American Diagnosis Related Groups (DRGs).

Acronym: HDGs, *HBCs*.

Hungarian Central Statistical Office

National government institution responsible for collecting and publishing official data including the National Health Accounts and the annual household budget survey.

Hungarian acronym: *KSH (Központi Statisztikai Hivatal)*

Hungarian Medical Chamber

Professional organization operating since 1988, with compulsory membership for practising physicians and dentists since 1994. The Chamber can discipline those who violate its rules, has right to express opinions on a range of medical issues and to veto contract conditions between medical doctors and the NHIFA.

Acronym: *MOK (Magyar Orvosi Kamara)*

Hypothecated health care tax

An earmarked tax collected by the national government for the HIF in order to compensate for otherwise non-contributing groups such as pensioners. It consists of a lump-sum and an 11% proportional tax. The latter is levied on the income, which is not part of the social insurance contribution base.

Information Centre for Health Care of the Ministry of Health

The agency responsible for running and continually refining payment systems in Hungary.

Acronym: *Gyógyinfok. (Egészségügyi Minisztérium Gyógyító Ellátás Információs Központja)*

Institute for Basic and Continuing Education of Health Workers of Ministry of Health

The organization responsible for continuing education and compulsory registration of non-medical health professionals.

Acronym: *ETI*

Institute for Medical and Hospital Engineering

The agency formerly responsible for the registration and licensing of medical devices, including medical aids and prosthesis, until 2000 when this responsibility was taken over by the Authority for Medical Devices of Ministry of Health. Since then it continues to perform functions of quality control and audit in the field of medical and hospital engineering, which it has been responsible for since 1990.

Acronyms: *ORKI*.

Level of specialization

A health care provider's grade of qualification to treat complicate cases in a certain speciality is relevant for determining the catchment area of this provider for the given speciality.

Maintenance obligation

A responsibility of owners of health care providers under the territorial supply obligation, to keep the facilities in working order, that is, to cover the capital costs of services.

Mother-and-Child-Health Nurse Services

A form of primary care by highly qualified non-medical health professionals, the mother and child health nurses. It includes pre- and postnatal care of women and their babies as well as health education and prevention for children till the age of 14.

Medical aids and prostheses

Sometimes referred to as therapeutic equipment, medical appliances or medical devices, but including only those devices used directly by the patient that can be bought in retail shops (for instance orthopaedic shoes, hearing aids, etc.).

Ministry of Health

The ministry responsible for the health sector before 1988 and from 1998 until 2002.

Acronyms: Ministry of Health, *EüM*.

Ministry of Health, Social and Family Affairs

The ministry responsible for the health sector since 2002.

Acronyms: Ministry of Health, *ESzCsM*

Ministry of Social Affairs and Health

The ministry responsible for the health sector between 1988 and 1990.

Ministry of Welfare

The ministry responsible for the health sector between 1990 and 1998.

Municipality

The third and lowest level of public administration in Hungary. The inhabitants of a municipality (a village or a town) elect the mayor and local representatives, which form the assembly, the decision making body on local affairs.

National base fee

The uniform fee for one point in the Homogeneous Disease Group (HDG), the payment scheme used in Hungarian acute inpatient care.

National Health Council

An advisory body of the national government in health policy, comprised of the representatives of various health sector stakeholders. Its main task is to discuss the National Health Promotion Programme.

Acronyms: *NET*.

National Health Insurance Fund Administration

The organization administering the Health Insurance Fund (HIF). It has a deconcentrated structure, with offices at the county level responsible for contracting, payment, and enforcement of contracts, while the central office is responsible for strategic issues, such as pharmaceutical price negotiations.

Acronyms: NHIFA, *OEP*.

National Health Promotion Programme

A long-term plan for the improvement of the health status of the population. The National Health Promotion Programme has to be prepared by the government, discussed by the National Health Council and accepted by the National Assembly.

Acronyms: *NEP*.

National Institutes of Health

The top organizations of the Ministry of Health, each responsible for a particular medical speciality. They supervise and support clinical work across the country, undertake continuing education, scientific research and in certain cases prevention activities and patient care.

National Public Health and Medical Officer Service

The largest and most important agency of the Ministry of Health, it is responsible for public health and it is the authority for many regulatory functions.

Acronyms: NPHMOS, *ÁNTSZ*.

Non-profit corporation

A special non-profit organization for the delivery of public benefit services, but free from public service regulations.

Acronym: *Kht*.

Non-profit organization

An organization for the funding and/or delivery of public benefit services on a non-profit basis.

Professional colleges

Professional organizations of particular medical specialties, acting as advisory boards to the minister of health on special medical issues.

Reform communist era

The last period of the communist regime, the second half of the 1980s, when a reform-oriented, liberal faction of the communist party governed the country. The reform communists elaborated various reform proposals, started different pilot projects and even implemented some changes, including the establishment of the Social Insurance Fund.

Region

Hungary is divided into seven regions, which serve mere statistical and planning purposes. Each region comprises three counties, except for the region of Central Hungary which is made up of Pest county, and the capital, Budapest.

Self Government of Health Insurance

A quasi-public body for the supervision of the Health Insurance Fund (HIF), and the control of the National Health Insurance Fund Administration (NHIFA). It was first established in 1993, and comprised the elected representatives of employees (trade unions) and the delegated representatives of employer organizations on the principle that those who contribute should supervise the HIF. It was abolished in 1998 when the national government took over its supervisory and control tasks: first the Prime Minister's office, later the Ministry of Finance and, since 2001, the Ministry of Health.

Social insurance contribution

Contribution partly for social health insurance and partly for pension insurance, with both health and pension insurance contributions paid partly by the employer and partly by the employee. Until 1992 the contribution was unified, and in 1992, the social insurance contribution was split into a health insurance contribution and a pension contribution.

Social Insurance Fund

Until 1992 health and pension insurance funds were unified in the Social Insurance Fund. Since then the Health Insurance Fund operates separately from the Pension Insurance Fund; together they are referred to as social insurance funds.

State-socialist health services

A highly centralized model of health care system, in which health services are exclusively funded from the government budget and exclusively delivered by government owned and controlled providers.

Synonyms: Semashko system, Soviet model of health care system.

Sub-budget (*kassza*)

A smaller part of the total budget of the Health Insurance Fund (HIF) for the reimbursement of a particular type of service, such as acute inpatient care, family doctor services, acute outpatient specialist care, chronic outpatient specialist care, pharmaceuticals and so on. The total budget of HIF is divided into more than 20 sub-budgets, most of which are capped and were formerly sealed, that is, transfers between sub-budgets were not allowed.

Subsidiarity principle

The guiding principle for the division of tasks between county governments and municipalities. According to the primary division of tasks, municipalities are responsible for basic services (primary care) and counties for specialist services (secondary and tertiary care). However, the principle of subsidiarity means that if a municipality is willing and able to provide specialist care, the county government cannot take it away. The principle of subsidiarity is directed at preventing unnecessary centralization by ensuring that county governments play a complementary role, that is, provide services that smaller communities are unable to do.

Territorial supply obligation

The responsibility for making health services available to the population. It lies with local governments, but does not comprise any obligation for the production of services. It implies, however, a maintenance obligation, that is the responsibility for covering investment and maintenance costs.

The Health care systems in transition profiles

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Turkey (1996, 2002^{g,i})
Turkmenistan (1996, 2000)
Ukraine (2004^g)
United Kingdom of Great Britain and Northern Ireland (1999^g)
Uzbekistan (2001^g)

Key

All HiTs are available in English.
When noted, they are also available
in other languages:

- ^a Albanian
- ^b Bulgarian
- ^c French
- ^d Georgian
- ^e German
- ^f Romanian
- ^g Russian
- ^h Spanish
- ⁱ Turkish