HUNGARY: FISCAL STUDY

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CONTENT:

1. POLITICAL BACKGROUND

1. In Hungary, already the third Minister of Health is in charge since the last election in March 2002 in which the socialist party MSZP won the elections. The first minister of health in this term was Dr. Csehák Judit, who was appointed by the Medgyessy Government on May 27 2002. In September 2003, Dr. Kokény Mihály, her former State Secretary, took her place.

2. The current Minister of Health Dr. Rácz Jenő is a part of the Government reconstruction after new Prime Minister Gyurcsány was appointed by the ruling MSZP – Hungarian social party and approved by the Parliament on September 29th 2004. The change of the Prime Minister was a result of internal political battle between the Prime Minister Medgyessy and his Minister of Sport Gyurcsány. The majority of the MSZP members believe that Gyurcsány is more suitable leader for the forthcoming parliamentary elections in April 2006 where he will meet the opposition leader Orbán (FIDESZ – Association of young democrats). Paradoxical, in Hungary the MSZP, which that has "social" in his brand name tends to have more right oriented economic policy and FIDESZ has a very populist, left oriented economic policy.

3. The old-new Hungarian cabinet[1] announced its priorities up to the elections. The Gyurcsány cabinet is ready to support a fair social policy and to reconstruct the state budget to boost competitiveness of the economy.[2] The document says: *"It is necessary to help those, who are in need and higher responsibility must be bared by them, who can afford it."* The program of Prime Minister Ferenc Gyurcsány's government from September 2004 proposes courageous changes in the healthcare system. Under the title "More Efficient, Better Healthcare" the program states that the problems of healthcare in Hungary can only be solved on long term by a healthcare system based on the principles of solidarity and the respect of market conditions.

4. The first issue the new Minister of Health had to deal with was the Referendum called by the opposition party FIDESZ on the legal status and privatization of hospitals. The referendum was a FIDESZ response on weakening government position after the MSZP crisis and its decreasing support by the population.[3] The Referendum took place on December 5th, 2004 with a question: *"Do you agree that the public health care providers, hospitals should stay in state, self-government ownership, and therefore, the Parliament is to cancel the Act that is contradictory with that?"* The referendum was valid, but without a result FIDESZ wanted, because less than 25% of the voters voted "YES" on the question. Therefore, since 2005 hospitals can be privatized in Hungary, but as we will show later, from profound reasons, this will not automatically mean investors' demand towards Hungarian hospitals.

1) Gyurcsány changed only 5 Ministers, among them the Minister of Health
2) "New Dynamism for Hungary!" The Program of the Government of the Republic for a Free and Equitable Hungary 2004-2006
3) According to opinion polls in October 2004, FIDESZ would have 29% and MSZP 24% of all voters

2. Ministry of Health: Problem Definition

5. The Hungarian health care system is based on two main principles. First, it is a solidarity-founded system financed from public resources. Second, local administration is responsible for the provision of health care.

6. The main government objective of the ministry set in the latest Government manifesto is effective, better healthcare, based on solidarity principle with respect to market mechanisms. The second goal is to strengthen the patient rights. As basic tools for the health reform the ministry intends to introduce:

- managerial and decision-making decentralization
- closer healthcare to population with new motivation mechanisms to reduce the amount of informal payments, that is humiliating both for patients and the doctors
- new definition of minimal healthcare benefit package
- support of saving principle and the mutual health insurance funds
- subsidies for the public-oriented private investments
- involvement of outpatient care facilities staff as shareholders

7. The government intends to strengthen the quality of care. To support this objective, in secondary care (specialists) the government will support the shift from functional privatization to real privatization of equipment and other assets. In in-patient care, the cabinet wants to introduce a comfort building program and improve the institutional quality of the system. The second measure is the complex reconstruction of the emergency service. To meet these objectives, and the successful implementation of the above mentioned programs, higher transparency of generation and utilization of scarce resources is inevitable.

8. According to the cabinet, the main health priority is cancer, where the diagnostics and the therapy are to be improved. In cardiovascular diseases the government primarily tends to enlarge the network of heart catheter labs. To improve the health status and the quality of life of population, the government wants to promote healthy life style and sport activities.

9. The Hungarian government prepared a multidisciplinary and intersectoral strategic program ("Johan Béla National Program for the Decade of Health") in the area of public health to fill the gap between Hungary and EU countries in life expectancy. The program was passed by the Hungarian parliament in 2003. It is aimed mainly on primary prevention: lifestyle, environment, prevention and decrease of the burden of most frequent chronic diseases - cardiovascular diseases, tumors, mental and locomotor diseases, involvement of healthy setting programs and development of the human resources.

3. Demography

10. The demography has a strong impact on the health system. Hungary as well as other developed countries faces the consequences of population ageing caused by reduced fertility and mortality rates. Emigration flows of mainly younger people during the communist regime contributed to the ageing process, too.

Table 1: Age structure changes in Hungary, 1901–2050

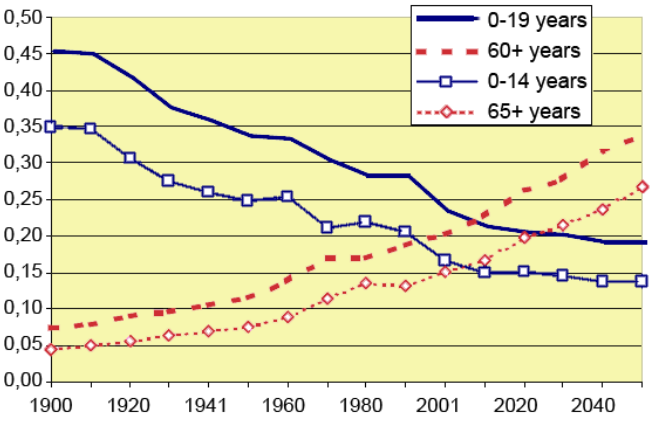
Age group (years)	1901	1949	2001	2050
Population size (in 1000)				
Under 20	3 078	3 067	2 360	1 632
20-59	3 263	5 065	5 761	4 194
60+	514	1 073	2 079	2 941
Total	**6 854**	**9 205**	**10 200**	**8 767**
Percentage distribution (%)				
Under 20	44,9	33,3	23,1	18,6
20-59	47,6	55,0	56,5	47,8
60+	7,5	11,7	20,4	33,6
Ratio of under 20 to 60+	6:1	3:1	1:1	1:2
Average age of population	27,0	31,5	37,2	44,0
Old age dependency ratio	0,15	0,20	0,28	0,59
Total dependency ratio	1,09	0,84	0,71	0,99

Source: Demographic Yearbook at HCSO (2001)

11. The elderly population grows and increases its share of the total population. The share of people aged 60 years and older was 20 % in 2001 and will increase to 33 % in 2050 (Figure 1). The old age dependency ratio and total dependency ratio will sharply rise as well. Another challenging demographic issue is the population decline. Population size has already decreased by 600 thousand since 1981. The decline is expected to continue and by 2050, there will be 8.7 million inhabitants in Hungary, almost 1.5 million less than now (Table 1[4]).

12. Estimations assume that the life expectancy at birth for males will increase from 68.2 years (2001) to 76.5 years (2050) and for females from 76.6 years (2001) to 82.6 years (2050). This will result in a dramatic "upside-down" change of the age pyramid (Figure 2).

Figure 1: Proportion of young and elderly population in Hungary



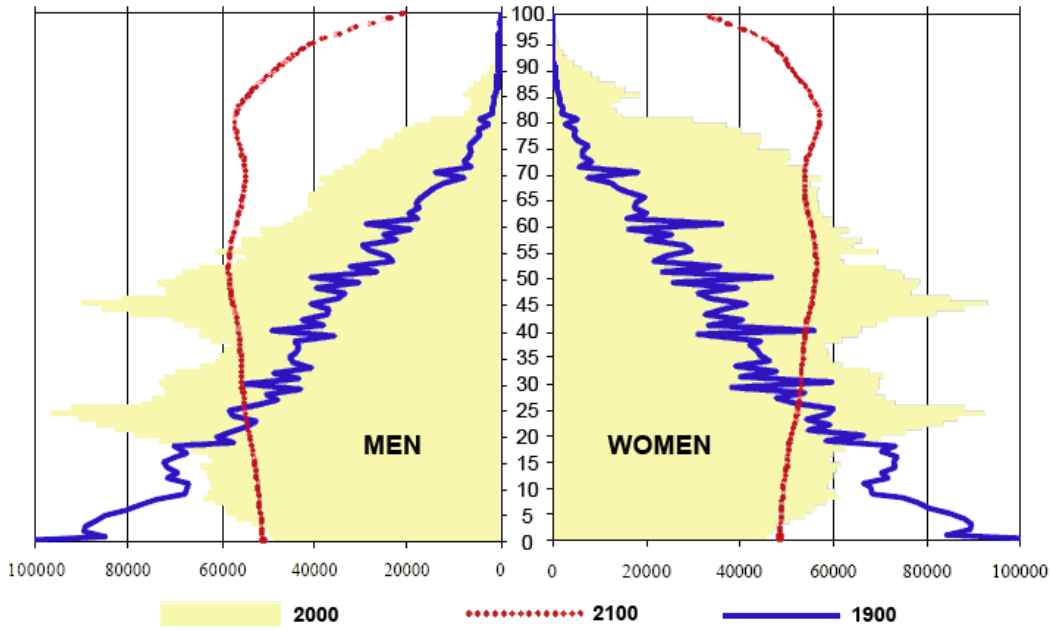
Source: Projection database of HCSO DRI, 2003

4. Health Status

13. Since World War II the health system and the health status of the population went through few phases. After communists rose to power in 1948 all health care and insurance facilities were taken over by the state. The objective of communism was to eradicate infectious diseases, to provide free health care and to improve social and economic conditions. Statistics of infectious diseases and public health improved, mainly as a result of increased vaccination of children and a broader network of medical facilities. In 1949 the Hungarian Constitution was amended to say that health is a right of the citizens for which the state bears responsibility.

14. Until the end of the 60's the status of public health was comparable to the developed countries because of vaccination, improved social and economic situation and longer life expectancy. The state was exclusively responsible for financing and providing health services through hospitals, clinics and district practitioners (1952). Private practices were not completely prohibited but were only allowed as a part-time occupation (since 1972).

Figure 2: Age pyramid of the population of Hungary, 1900, 2000 and 2100



Source: Projection database of HCSO DRI, 2003

4) László Hablicsek: Demographics Of Population Ageing In Hungary, Project on Intergenerational Equity, Discussion Paper, March 2004

15. In the 60's the improvement of the health situation slows down because the centrally managed economy fails to responds to the changing environment. Poor allocation of resources and strong political influence cause great differences among the services provided. The geographical gap grows. Differences between availability and quality of the provided health services become progressively greater.

16. In the 70's, the country faces extending life expectancy, stagnation and a deepening gap between Hungary and advanced economies. The widening difference between the services provided in Hungary and the rest of Europe caused a strong need for reform in the late 80's.

17. Nowadays, the health status of the Hungarian population is one of the poorest among the region. The country suffers mainly on cancer and cardiovascular diseases.

5. Macroeconomic Development, Employment and Wages

5.1 Growth prospects of the economy

18. After the economic growth stalled in 2003 signs of revival appeared as soon as in 2004. It can be assumed that economic growth will accelerate and will reach between 3.6% and 4.0% in the period of 2005-2007. (This forecast relies on the convergence program and can be deemed conservative). The level of potential GDP growth is 3.5-4.5% in the mid-term. GDP growth will be driven by a gradual rise of employment and by a stabilized annual real growth of productivity of approximately 3%. On the side of GDP use its growth will most likely be driven by increasing formation of fixed capital and growth of export while both elements of consumption (i.e. private consumption and government spending) will grow less than proportionately.

5.2 Employment, income and consumption

18. The accelerating economic growth since the end of 2003 and an active policy of employment promoted a positive development on the labor market: employment in the Hungarian economy is growing and will be increasing by approximately 1% per year until 2007. Hungary still has sizeable reserves of economically active population as the participation rate was only 60.7% in 2003. The predicted, relatively favorable labor market characteristics will, however, lead to an increase of the participation rate to about 62.5% in 2007.

19. In the period of 2001-2003 the increase of real wages and consumption was substantially higher than the growth of labor productivity – this is not a situation sustainable in the long term. In three years real wages increased by 32%, i.e. much more than was the real growth of GDP. This reduced the competitiveness of the economy and contributed to both external and internal imbalance. It is in the interest of the economy's stability and competitiveness of producers to correct this increase in the future and to make sure that wage growth is brought closer to the growth of productivity.

20. In the mid-term, gross average wages will increase by 6%-7% per year, with real wages rising by 3%-3.5%. Compensations of employees (gross wage and deductions) will be close to 53% of the created added value in this period (i.e. 53% of the GDP in base prices or 47% of the GDP in market prices, the highest value of the V4 group[5]). Real private consumption is expected to increase by 3% - 3.5%. During the consolidation of public finance the real consumption of public administration is expected to decrease.

5.3 Price Level

21. In 2004 the process of disinflation was temporarily halted. Due to tax changes (also related to the harmonization of indirect taxes with EU) and due to adjustments of energy prices the inflation rate was relatively high (6.5%). The long-term disinflation process has, however, been continuing since the end of 2004. In the mid-term the inflation rate will continue to decrease gradually and in 2007 it should reach a level close to 3.5%. This inflation rate is higher than the V4 average. According to the most likely scenario the inflation rate convergence criterion will be met in 2008 at approximately 3%.

5.4 Public Finance

22. The most important goal of fiscal policy is to gradually reduce the deficit (which remained very high even despite the consolidation launched in 2003) and the extent of the public sector. The government announced a longer-term program of tax system modernization which focuses on: (1) substantial reduction of the tax burden for businesses and households; (2) creation of a tax system which should stimulate the growth of the economy's performance, promote the creation of savings and investments, and make the economy more attractive to investors. These tax adjustments, however, are included in the government strategies of all new EU members in Central Europe.

5) Slovakia is an opposite extreme with a proportion of 44% in the GDP in base prices and 40% in the GDP in market prices.

Table 2: Overview of estimated basic macroeconomic parameters of the Hungarian economy

Parameter	2003	2004	2005	2006	*2007*
Growth of real GDP in %	2,9	3,3	3,6	4,0	*4,3*
Growth of real private spending in %	7,6	1,8	3,0	3,3	*3,5*
Growth of the price level in %	4,7	6,5	4,5	4	*3,5*
Growth of real wages in %	9,2	1,0	2,0	2,2	*3,0*
Growth of the volume of paid nominal wages in %	15,8	7,9	7,4	7,4	*7,7*
Growth of employment in %	1,3	0,3	0,8	1,0	*1,0*
Participation rate in %	60,7	61,0	61,3	62,0	*62,5*
Unemployment rate in %	5,9	5,9	5,9	5,8	*5,7*
Public sector revenues as % of GDP	44,5	44,2	43,4	42,9	*43,2*
Public expenditures as % of GDP	50,4	48,8	47,5	46,5	*46,3*
Public finance balance as % of GDP	-5,9	-4,6	-4,1	-3,6	*-3,1*
Revenues from social contributions as % of GDP	12,6	12,6	12,2	11,9	*11,7*
Gross government debt as % of GDP	*59,1*	*59,4*	*57,9*	*56,8*	*55,6*

Source: Convergence Program of Hungary, EBRD Transition Report 2004.

23. The defined macroeconomic scenario and the implemented tax reductions will enable an annual reduction of public finance deficit by approximately 0.5 percentage points. Hence, from the base level of 4.6% in 2004 the deficit should decrease to 3.1% while meeting the Maastricht criterion (deficit under 3% of the GDP) by probably 2008.

24. A more significant reduction of taxes and modernization of the tax system can be achieved while simultaneously restricting public expenditures. The proportion of tax revenues of the public sector in the GDP should decrease from 39% to 37% in 2008. Alongside the deficit reduction and the projected reduction of the tax burden the expenditures of the public sector should decrease from 48.8% in 2004 to 46.3% of the GDP in 2007.

25. The total volume of public expenditures in the GDP is scheduled for a reduction but even greater changes to the internal structure of the expenditures are in progress. The proportion of current expenditures should decrease while the proportion of investment expenditures should increase (from 4.0% to 5.5% of the GDP between 2004 and 2008). In the sector of current expenditures visible reduction is expected in collective consumption and natural social transfers (services of the public education, health care and other social services).

26. In 2002 the trend of decreasing gross public debt in the GDP was stopped (the proportion was greater than 59% in 2003-2004). The consolidation program for public finance ensures that the trend of decreasing debt share in GDP should be restarted in 2005. In 2007 debt should decrease below 56% and reach a level below 54% in 2008.

27. In order to achieve a sustainable reconciliation of tensions in the financing of public services the government has begun preparations for the reform of health care financing. The reform should restrict the growth of expenditures and introduce more efficient services with modified financing and motivational mechanisms.

6. Financing of the System

28. Health care expenditures amount to 6.7 % of the GDP with continuous deficits of the Health care Fund (OEP) around 1.3-1.6 % of GDP in last two years what significantly undermines its fiscal stability. It is important to mentioned, that the Fund is responsible not only for benefits in kind in health care, but also for some cash benefits, like sick-pay or some types of pensions (e.g. disability). In 2004 the Fund spent HUF 946 billion on healthcare benefits in kind and paid HUF 422 million on benefits in cash.

29. Public expenditures on healthcare don't exceed 5% of GDP, while private expenditures count for no less than 2% of GDP. This ratio with private expenditures around 28% is fully comparable with the OECD average, with a slight difference, that the OECD countries spend 8.4% of their GDP on healthcare. For comparison, the EU-15 spends on average 8.1% of the GDP on health care at a 78%-share of public resources (World Health Organization, 2003).

Table 3: Fiscal position of the health system (HUF million)

	1997	1998	1999	2000	2001	2002	2003	2004e
HIF REVENUES	**499 487**	**561 461**	**653 597**	**734 584**	**884 697**	**1 024 575**	**1 025 437**	**1 115 898**
HIF EXPENDITURES	**555 586**	**632 052**	**701 290**	**798 199**	**914 976**	**1 111 232**	**1 325 550**	**1 393 650**
Benefits in kind	*389 964*	*458 449*	*504 069*	*556 016*	*623 358*	*750 326*	*910 236*	*946 521*
Benefits in cash	*141 809*	*149 657*	*174 739*	*221 061*	*270 772*	*335 753*	*386 383*	*422 710*
HIF BALANCE	**-56 099**	**-70 591**	**-47 693**	**-63 615**	**-30 279**	**-86 657**	**-300 113**	**-277 752**
GDP	**8 541 000**	**10 087 000**	**11 393 000**	**13 172 000**	**14 850 000**	**16 740 000**	**18 574 000**	**20 630 000**
HIF Balance as % of GDP	-0,7	-0,7	-0,4	-0,5	-0,2	-0,5	-1,6	-1,3
HEALTH EXPENDITURES TOTAL	**528 766**	**622 999**	**712 325**	**802 806**	**926 235**	**1 091 751**	**1 302 875**	**1 382 622**
Benefits in kind (HIF)	389 964	458 449	504 069	556 016	623 358	750 326	910 236	946 521
Capital investments								
Household Consumption on Health (COICOP methodology)	138 802	164 550	208 256	246 790	302 877	341 425*	392 639*	436 101*
Health Expenditures as % of GDP	6,2	6,2	6,3	6,1	6,2	6,5	7,0	6,7
Public expenditures as % of GDP	4,6	4,5	4,4	4,2	4,2	4,5	4,9	4,6
Private expenditures as % of GDP	1,6	1,6	1,8	1,9	2,0	2,0	2,1	2,1
Private/public ratio (1:...)	2,8	2,8	2,4	2,3	2,1	2,2	2,3	2,2

Source: Bureau of Statistics of the Hungarian Republic
** - estimation HPI*

Table 4: Parameters of the health insurance system

	1999	2000	2001	2002	2003	2004e
Employer's contribution as a percentage of total wages	11	11	11	11	11	11
Upper limit of employer's contribution	none	none	none	none	none	none
Employee's contribution as a percentage of total wages	3	3	3	3	3	4
Upper limit of employee's contribution, HUF per day	5 080	5 520	none	none	none	none
Upper limit of employee's contribution, HUF per year	1 854 200	2 014 800	none	none	none	none
Percentage of hypothecated health care tax	11	11	11	11	11	11
Fixed amount of hypothecated health care tax in HUF/month/person	3 600	3 900	4 200	4 500	3 450	3 450

Source: Bureau of Statistics of the Hungarian Republic

6.1 Public Resources are chanelled through a dual system

6.1.1 PROVISIONS IN KIND

30. In the past 15 years[6] the system of financing in Hungary has been transforming from a socialist-budgeted model to a Bismarck-defined model of universal health insurance. All citizens are insured[7] and contribute to the Social Health Scheme. For a part of the health care system a Health Insurance fund (hereinafter 'the Fund') is established. Citizens contributing to the fund consist of three groups: (1) employees, (2) non-contributors - pensioners, women on maternity leave, low-income households… - and (3) others + voluntarily insured foreigners. Universal coverage of the population is ensured by these categories, with only 1% of the population remaining uncovered.

31. The amount of the contribution to the Fund is determined by the parliament, on a proportional basis. It is defined as a percentage of the gross salary for the first group of contributors – employees and employers. Employees contribute 3% and employers 11%. Until 2000 there was an upper limit to the employee's contribution, of HUF 5,080/5520 per month. In 2001 this limit was abolished. The government pays on behalf of the second group – the non-contributors – by transfers from tax revenues to the Fund (hypothecated health care tax). The third group of the self-employed and volunteers contribute a percentage of the minimum salary.

32. In 1994, hypothecated health care tax ("health tax") was introduced. Health tax is paid by every employer on behalf of their employee as a fixed amount. Because the employees were the only ones to pay, the government proceeded to extend the assessment base and imposed a health tax of 11% on other types of income which had earlier been exempt from health care taxation. The extension was basically correct because health insurance is a tax and it would not be systematic if it only pertained to some kinds of income and some groups of people.

6) In 1987 the Ministry of social affairs and health announces the beginning of the reform. The insurance fund is separated from the state budget. The foundations of the current system were laid at the end of the 80's, in consequence of changes of the political and economic system of the communist era. The 1989 Constitution declares Hungary a social-market economy where private and public sectors had the same value. (Right to healthy environment, certain level of mental and physical health…)
7) Citizenship principle – since 2002 includes all those employed in Hungary. The disadvantage is a very limited possibility for monitoring the contributions to the fund because they are only paid on the basis of citizenship and the only identification is by an identity card.

Table 5: Revenues of the Fund (HUF million)

	1997	1998	1999	2000	2001	2002	2003	2004e
REVENUES TOTAL	**499 487**	**561 461**	**653 597**	**734 584**	**884 697**	**1 024 575**	**1 025 437**	**1 115 898**
Revenues and Contribution	**471 812**	**534 078**	**591 237**	**653 715**	**762 402**	**883 681**	**927 665**	**1 052 428**
Employers health insurance contribution	323 483	370 621	344 570	373 047	441 869	517 978	580 650	635 284
Employees health insurance contribution	62 474	62 662	76 355	81 314	105 592	128 575	142 717	207 217
Health Contribution	71 974	92 592	156 786	181 379	194 664	209 875	173 315	176 935
Employers contribution to sick pay	7 658	n/a	12 348	13 387	14 625	18 066	21 383	23 177
Others	6 223	8 203	1 178	4 588	5 652	9 187	9 600	9 815
Central budgetary contributions	**2 500**	**2 500**	**30 290**	**70 872**	**103 928**	**135 885**	**85 988**	**57 619**
Other revenues	**15 315**	**4 590**	**3 176**	**2 635**	**15 680**	**3 473**	**9 982**	**4 761**
Revenues from property management (sales of property)	**8 200**	**1 925**	**24 385**	**3 885**	**866**	**75**	**55**	**35**
Revenues used for operations	**1 660**	**2 874**	**4 509**	**3 477**	**1 821**	**1 461**	**1 747**	**1 055**
Revenues from arrears collection	**0**	**15 494**	**0**	**0**	**0**	**0**	**0**	**0**

Source: Bureau of Statistics of the Hungarian Republic

Recommendation 1: Introduce a common tax and health insurance assessment base to avoid tax and health insurance evasion and to improve the reporting of „prescribed health insurance".

33. Health tax was introduced by a specific law, not through the system of health insurance. The reason was that the Hungarian Constitutional Court ruled some measures of the 'Bokros package' unconstitutional. The Constitutional Court argued that health insurance was an insurance contract and towards citizens the state was not free to change its terms arbitrarily – including the extent of free health care. On the other hand, the Constitutional Court was not applying the same reasoning to tax cuts, and so the government did not use the health insurance act to rise funding but opted for a special "tax" law instead. It needs to be noted that this unfortunate Constitutional Court ruling is a precedent which will substantially limit attempts to reduce freely provided health care in the future, although the current government indicated such intensions in the Government Manifesto.

6.1.2 INVESTMENTS

34. Financing channeled through a dual system means that the medical services and current expenditures are financed by the Fund and the capital expenditures (investments) are financed from the budgets of the individual governments. Investment costs are always paid by the founder/owner. For budget-financed organization this is the state budget; for self-governmental facilities the local self-government and for private companies the owner or investor.

35. As much as 90% of the total capital investments are paid by local self-governments because health care is organized on local self-government basis. The local self-government is the owner of the majority of outpatient and other medical facilities and is therefore responsible for all investments into instruments and equipment. Meantime, the real operator of health care can be fully private ('functional privatization'). Local governments draw the funds for capital expenditures from

1. tax revenue transfers (mainly income tax)
2. local taxes
3. target subsidy revenues (e.g. Grants for equipment and instruments)
4. Capital grants from the Ministry of Health (conditional and matching grants)

36. This construction makes taxes the most important source of long-term investments (reconstruction of buildings, equipment and instruments, other investments) into the health care system in Hungary. The greatest weakness of this system is the inefficient allocation of resources and the issues related to centralized management. MOH defends this system arguing that the providers are geographically not evenly localized and that in some areas the discrepancy between the needs and the supply of medical services should be corrected by direct ministerial intervention.

37. On the other hand, this construction of capital expenditure system does not permit the entry of private capital because payments from the Fund do not include amortization. The private sector has very limited access to capital expenditures. The political control over the distribution of capital expenditures is a natural attractor of lobbyist groups, and these factors combined lead to an excessive price of the procured investments and failures of allocation in both geographical and functional terms.

Recommendation 2: Slowly cancel the dual system. The dual system is one of the main reasons, why no private investors can enter market, because the DRG in the hospital sector is not covering the amortization. The dual system is dis-motivating the private providers and investors. This is important with the Government intension to privatize hospital.

Recommendation 3: Introduce a shift from functional privatization to real privatization in secondary care. We recommend changing the financial flows, canceling capital expenditures and transferring the total sum spent on capital investments form state budget to the FUND. This might by risky, because it means to re-think one of the pillars of the Hungarian health system – the key responsibility of municipalities in health care provision.

6.2 Private Resources

38. Private sources in Hungary account for approximately 28% of health care expenditures, while the major share (71%) of total direct payments has the form of a co-payment towards pharmaceutical products and therapeutic appliances (Table 6). Direct payments of the population are divided into three categories: (1) fees for services not covered by the Fund, (2) direct co-payment for services partly reimbursed by the Fund and (3) informal payments – the 'envelope fees'.

39. The first group consists of services excluded from health insurance. These include payments for pharmaceuticals, therapeutic appliances, medical aids, prostheses, prosthodontics, some dental services, spa care, and "hotel" services of medical facilities, aesthetic surgery and other non-indicated medical treatments.

40. The second group – direct co-payment depends on the health care provider. These may operate on the basis of contracts with the Fund or as private entities, without the contract. The services are reimbursed from the Fund when provided on a contractor basis. When provided by a physician without a contract, they are paid by the patient. Officially, co-payment does not exist in the primary, secondary and tertiary domains. Providers, however, may bill the patients for 'above-the-standard services' which is complicated, because "the standard" is not defined in law. The provider is therefore free to determine what constitutes extra service and what does not. The second legal direct payment is a payment to the provider if the patient comes for a visit without referral. In such case the whole cost of the provided medical care is borne by the patient. The price of drugs and medical aids is agreed every year between the Fund and the producers, and is either specified as a percentage of the market price, or as a fixed amount. Here it is also significant whether a pharmacy has a contract. The services partially paid by the patient also include long-term chronic illness treatment (HUF 400 per day).

41. The third group includes informal payments. These are sometimes called 'envelope fees', or bribes. They used to make up a significant part of the physicians' income and since 1989 are taxable. They are distributed disproportionately, with the majority flowing to the hospital sector and specialized care.

42. The amount of informal payments of the population is a controversial item. National health care accounts (OECD methodology) deny the existence of informal payments. There are various sources of data which differ in the determination of the amount and proportion of informal payments. Judging by several surveys we can estimate their proportion to be 2.5 to 4.5% of the total health care expenditures. Nominally, this could be HUF 25 to

Table 6: Annual per capita expenditure in details by COICOP classification, in 2000, in HUF

	1. quintile	2. quintile	3. quintile	4. quintile	5. quintile	total
Health	**6 245**	**9 602**	**13 544**	**17 325**	**21 873**	**13 719**
Medical products, appliances and equipment	4 501	7 270	10 170	12 528	14 167	9 727
Pharmaceutical products	4 005	6 511	8 970	10 722	11 458	8 333
Other medical products	51	44	112	89	131	86
Therapeutic appliances and equipment	444	715	1 088	1 716	2 577	1 308
Outpatient services	1 602	2 181	3 234	4 509	7 490	3 803
Medical services	533	567	816	1 490	1 850	1 051
Dental services	1 037	1 503	2 283	2 822	5 312	2 591
Paramedical services	32	112	135	198	328	161
Hospital services	143	151	150	288	217	190
TOTAL	**206 738**	**266 783**	**323 979**	**395 240**	**610 697**	**360 668**
Health consumption as % of total consumption	3,0	3,6	4,2	4,4	3,6	3,8

Source: Bureau of Statistics of the Hungarian Republic

50 billion. It is very interesting to follow the distribution of this amount. Firstly, as much as 90% of the gratitude money goes to physicians and only 10% to nurses and other paramedical staff. Secondly, the distribution of the gratitude money is not symmetric even among various professions of physicians. Only 30,000 of the total 43,000 physicians can receive it (technical and laboratory professions are excluded) and among those who can receive such payments, 2/3 of the gratitude money is given to specialists and 1/3 to family doctors. These informal payments amount to 60 – 200% of the net salary of a specialist or 70% to 250% of the net income of a family doctor. There are also regional differences (with these gratitude payments higher in Budapest) and in the hierarchy of physicians in hospitals (head physician vs. attending physicians). In general we can conclude that even though the amount of the resources seems to be large, its distribution is uneven and benefits a small group of physicians.

Recommendation 4: Introduce legal user fees in primary, secondary and tertiary care. Increasing of the total co-payment level is not desirable, since it reaches already the level of OECD average. It is important to change the structure of these co-payments and to legalize the sum that is paid through informal payments. In primary care we can imagine a user fee in the amount of HUF 100 per visit. We do not recommend any kind of exemptions. The systematic approach would lead us to provide the vulnerable groups a special allowance from the Social Security System.

43. The last component of private financing sources is the nascent private supplementary insurance. Since 1993 when the necessary legislative framework was created voluntary insurance funds have been gradually on the rise. For a specified membership fee some part of the services not covered by compulsory insurance is paid. It is a form of a health savings system. In 2000 this form of financing accounted for 1% of private health care spending.

6.3 The Fund has no real responsibility, it only distributes resources

44. The health insurance is administrated solely by the Fund. Collection of premiums, however, is performed on behalf of the Fund by the tax authorities. All non-eligible insurance payers pay their contributions to the tax authorities from where the resources are transferred to the Fund. This construction leads to some difficulties. Who is the owner of a claim? The claim belongs to the tax authorities, and hence to the state. The collection rate of insurance premiums is rather low, with poor application of receivables management and controlling. This leads to a high amount of claims and unpaid premiums.

Recommendation 5: Introduce better management of receivables.

45. The health care system as a whole faces even more fatal consequences. The Fund becomes the administrator of the system. Health care is not purchased efficiently, it is only paid regularly. On the side of premium collection the Fund must remain passive and depends on the success rate of the tax authorities, and on the other the deficit is covered by the state budget. The Fund is a re-distributor of public resources without the necessary motivation on the side of selection and purchase of health care. **The Fund is not responsible for unpaid premiums or the arising deficit.**

Recommendation 6: Increase the responsibility of the Fund on both ends: on the revenue side and on the purchasing side.

46. Despite all the parametric changes and a minor paradigmatic change (introduction of health tax) the system suffers from a general under-financing. The health insurance fund generates a chronic deficit (in 2000 the deficit was 1.3% of the GDP). It is mainly caused by:

1. Fact, that the largest debtor of the Fund is the state (on behalf of the second group of citizens).
2. Fact, that the Fund is responsible also for the sickness pay and other parts of social insurance system (disability pensions) and these cash benefits are paid from health insurance. The deficit is generated mainly in the sickness insurance area. The possible responses are to increase revenues or reduce the extent of free health care.

Recommendation 7: Increase resources. Change the structure of expenditures. Increase the insurance rate. Separate the health insurance and the sickness insurance on both ends: the revenue side and the expenditure side.

Recommendation 8: Reduce the extent of free healthcare. This might by complicated due to the Constitutional Court precedent from past, which determines the health insurance as a social contract and does not allow any stricter reduction of benefit packages for population.

Table 7: Crowding out effect of the cash benefits

Type of benefit	1997	1998	1999	2000	2001	2002	2003	2004e
Provisions in kind	70,2%	72,5%	71,9%	69,7%	68,1%	67,5%	68,7%	67,9%
Provisions in cash and retirement provision	25,5%	23,7%	24,9%	27,7%	29,6%	30,2%	29,1%	30,3%

Source: Own calculations based on HSO data

6.4 The structure of expenditures is dominated by drugs and hospitals

47. In the period of socialist health care the health care budget was determined centrally and it only depended on the budget income and on political decisions. In consequence of reform measures in the 90's the purchase and provision of health care were separated, the budgets were decentralized and new payment mechanisms were introduced. Despite all of these measures the national government still retains control over health expenditures through the Fund.

48. The Health insurance fund is divided into more than twenty sub-budgets (kasszas) according to the type of provided services. These sub-budgets are unified on the national level, and are not mirrored on the regional level. Every year the National Assembly specifies a (prospective) ceiling for each sub-budget and the system of methods of payment to the providers guarantees that the ceiling will not be exceeded. The sub-budgets are enclosed and no transfers between them are possible. The only exception is the pharmaceutical budget – from 1999 the Minister of Health may reallocate resources from the sub-budgets to cover excessive expenditures of the pharmaceutical budget. *The same concerns the benefits in cash "kasza" – its expenditures and deficits are covered from health insurance and the state budget.*

49. The main problems on the expenditures side are:

- Inefficiency of the provided services (hospital care for diagnoses where outpatient care would be sufficient…)
- Growing costs of drugs (liberalization of the pharmaceutical industry, large consumption of drugs) – the need to control prescriptions of drugs by physicians, introduction of margins for drugs, sales limits…
- Open sickness pay "kasza"

Table 8: Expenditures of the Fund (HUF million)

	1997	1998	1999	2000	2001	2002	2003	2004e
EXPENDITURES TOTAL	**555 586**	**632 052**	**701 290**	**798 199**	**914 976**	**1 111 232**	**1 325 550**	**1 393 650**
Provisions in kind	**389 964**	**458 449**	**504 069**	**556 016**	**623 358**	**750 326**	**910 236**	**946 521**
Curative-preventive health provisions	265 779	299 092	338 877	376 069	410 304	502 852	622 766	657 068
GPs' and GPs' emergency service			*35 355*	*36 608*	*41 138*	*45 453*	*58 106*	*59 572*
MCH service, mother, child and youth care			*7 816*	*8 334*	*9 235*	*9 978*	*13 790*	*14 148*
Dental care			*9 679*	*10 410*	*12 076*	*16 199*	*20 496*	*21 144*
Service of dispensaries			*7 269*	*8 157*	*9 501*	*8 616*	*10 107*	*10 465*
Transport of patients and corpses on medical order			*3 451*	*3 687*	*4 174*	*4 812*	*6 014*	*23 594*
Outpatient special care			*46 608*	*51 620*	*61 260*	*72 923*	*96 529*	*102 425*
CT, MRI			*6 484*	*7 058*	*7 842*	*8 492*	*10 735*	*10 519*
Kidney dialysis			*8 736*	*10 143*	*11 606*	*13 061*	*15 896*	*16 119*
Home special nursing			*1 120*	*1 274*	*1 463*	*1 587*	*2 236*	*3 134*
Inpatient care			*211 456*	*222 795*	*249 944*	*294 576*	*373 832*	*379 100*
Others			*712*	*15 782*	*1 797*	*26 923*	*15 027*	*16 848*
Balneological services, breast milk supply	1 574	2 010	2 445	3 235	4 071	4 347	4740	6024
Subsidization of Medicaments	100 876	135 474	139 461	150 753	179 465	209 033	241 972	238 905
Subsidization of therapeutic equipments	16 782	19 618	20 589	22 668	25 002	28 915	34 957	37 997
Refunding of travel expenses	2 561	2 255	2 697	3 291	3 836	4 274	4 750	4 906
Expenses resulting from international agreements	n/a	0	0	0	680	905	1 051	1 622
Provisions in cash and retirement provision	**141 809**	**149 657**	**174 739**	**221 061**	**270 772**	**335 753**	**386 383**	**422 710**
Retirement provision (disability and accident disability pensions)	97 982	99 927	115 949	132 243	157 964	194 284	213 888	238 617
Sick pay	36 138	41 255	49 205	56 140	64 206	80 864	98 936	101 480
Child care fee	0	0	0	20 381	29 646	37 807	45 589	53 019
Pregnancy and confinement benefit	6 013	6 924	7 768	10 047	12 470	15 777	20 207	21 348
Accident benefit	n/a	n/a	n/a	n/a	4 249	4 986	5 605	5 911
Others	1 676	1 551	1 817	2 251	6 486	7 021	2 158	2 335
Other expenditures	**4 803**	**2 614**	**3 219**	**3 290**	**2 156**	**2 631**	**4 791**	**3 573**
Asset management	**n/a**	**141**	**n/a**	**n/a**	**564**	**531**	**413**	**16**
Operational costs	**19 010**	**21 332**	**19 263**	**17 832**	**18 126**	**21 991**	**23 726**	**20 830**

Source: Health Care Fund (OEP)

50. Trends in expenditure structure

1. Unlike the western countries, expenditures are growing slowly than the GDP
2. The provisions in cash are crowding out the benefits in kind. While in 1997 the benefits in kind amounted more than 70% of all expenditures, in 2004 it is lower than 68%. In the same time period, the weight of provisions in cash rose from 25.5 to 30.3 percent (Table 7)
3. In curative care, there is a satisfactory structural change with decreasing weight of inpatient care, increasing outpatient care and very stable level of primary care expenditures.
4. There is a satisfactory slow down in medications expenditures, but they always exceed the prescribed sub-budget.

7. Payment Mechanisms

51. Providers of medical services need to conclude contracts with the Fund in order to get reimbursed for the services provided to the insurees. The contracts define the capacities of the providers in acute or chronic hospital beds, consulting hours of outpatient specialists, etc. On the basis of these contracts individual health care providers receive reimbursement from the sub-budgets using several methods.

52. The reform process in the 90's brought many changes to hospital and outpatient care. The payment system was initially built on the performance principle and payment mechanisms are focusing on the type of service instead of type of institution. In 1992 a capitation system was introduced for family physicians and in 1993 a point-based catalog for outpatient specialists was followed by DRG payments for acute hospital care and payments for hospitalization days in chronic care.

7.1 Primary Care

56. In the socialist health care system all primary physicians were state employees with a fixed salary while private practices only functioned as supplementary, part-time source of income. Primary care is provided by family doctors. These may conclude a contract with the Fund or the local government or they can operate a private practice. Private practitioners without a contract with a Fund are financed by direct payments of the patients for the provided services, while the fees are not regulated by state.

57. Contract physicians are paid on the basis of capitation which was introduced as a payment mechanism in 1992. The citizens can choose their family physician freely and the number of registered citizens is the basis for basic financing. The income of general practitioners consists of the capitation payment for the patient and a fixed amount depending on the size of the practice, and a payment for visits of non-registered patients.

58. The capitation payment is based on the number of registered patients. The patient list must be regularly updated and adjusted to the age structure of the registered, and the profession and practical experience of the family physicians. The population is divided into 5 groups.

- infants aged 0 – 4 years – 4.5 points
- children aged 5 – 14 years – 2.5 points
- persons aged 15 – 34 years – 1 point
- 35 – 60 years – 1.5 points
- more than 60 years – 2.5 points

59. Above a specified level (2400 points for adults or children, 2600 for mixed practice) the family doctor does not receive a full value of the capitation. The total number of points is multiplied by a coefficient depending on the expertness and experience of the physician – 1.2 if the physician has a relevant qualification, 1.1 if the physician does not have relevant qualification, but has 25 years of experience in primary medicine. If the physicians have contracts directly with the Fund, they receive payments from it, if they are employed by local governments; the Fund transfers payments to these governments which then pay the physicians. A number of specialists still receive some informal payments directly from patients, although these are very unevenly distributed.

Table 9: Expenditures on primary care (HUF million)

	1999	2000	2001	2002	2003	2004e
Curative-preventive provisions in kind	**338 683**	**375 869**	**410 036**	**502 622**	**622 766**	**657 068**
GPs' and GPs' emergency service	**35 355**	**36 608**	**41 138**	**45 453**	**58 106**	**59 572**
Financing of practice	**31 288**	**32 416**	**36 276**	**40 275**	**51 572**	**54 164**
Fixed amount	7 352	7 558	8 178	8 445	10 941	
Area allowance	432	434	585	2 247	2 250	
Performance remuneration ("card money")	23 504	24 425	27 513	29 583	38 381	54 164
Remuneration of episodic care	**249**	**256**	**330**	**368**	**468**	**477**
Duty service	**3 818**	**3 936**	**4 532**	**4 810**	**6 065**	**6 431**

Source: Health Care Fund (OEP)

7.2 Specialized Outpatient Care

60. The majority of specialized outpatient services are reimbursed by a point-based system. Every procedure is assigned a number of points depending on its experience requirements and resource intensity. Specialists report the number of points monthly to the appropriate Fund authority. Before 2000 the performance points were added up on the national level and the monthly value of the point was calculated as the quotient of a pre-determined budget divided by the total number of points. The payment was then determined as the product of the adjusted point value and the number of 'collected' points.

61. From the half of 2000 the point value is defined as a fixed preliminary amount. A part of the sub-budget is laid aside at the beginning of the year to compensate for performance growth and seasonal differences. The value of the point is only recalculated when these reserves are spent.

7.3 Hospital Care

62. In-patient services are refunded according to the individual types of cases: a prospective payment system based on DRG for the reimbursement of acute care and rehabilitation except for some tertiary care services paid by the national government. High-cost cases – like bone marrow transplants – are financed on a per-case basis. Chronic, long-term care is paid by the days of hospitalization.

63. The basic principle of the DRG system is that it classifies the individual cases in a manageable number of categories derived from complexity and costs. The current Hungarian version of DRG (homogenous disease groups – HDG) contains 736 categories. Each has its weight or number of points which is higher for more demanding and costly cases. Every month the hospitals report executed cases which are classified using the DRG system at the Information Center for Health Care, the administrator of the system.

64. The second important element of DRG in addition to the relative weights is the standard day which is used to determine the length of hospitalization. Every DRG group has a low and upper limit for the length of stay in hospital, expressed as the minimum and maximum number of days spent in the hospital. The bottom level is important to prevent under-treatment. The upper level enables an increase of the DRG payment. The payment for a patient who spent less than the minimum limit in the hospital is not refunded fully, but at 80% only. We already mentioned that because of DRG the Hungarian system has a tendency to overproduce while minimizing costs. This means that the providers try to reduce the length of stay of their patients as close as possible to the lower limit for hospitalization. This leads to a gradual reduction of the value of the standard day.

65. The hospitals are paid monthly by the Fund according to the total number of DRG points multiplied by the monetary value of the point (nationwide fee). This value is determined by the Fund preliminarily at the beginning of the year and applies to all hospitals equally. Part of the sub-budget is held aside to compensate for performance growth and seasonal differences. The value of the point is only adjusted when these reserves are spent – just like in the system for specialists.

66. The major disadvantage of this system is that DRG does not include amortization and so the relative weights do not reflect wear and tear on instruments or dissolving production to fixed costs. DRG therefore does not reflect the break-even point in producing individual diagnoses.

67. At the beginning of 2004 a new mechanism was introduced in hospital and specialized outpatient care. The providers will only receive a full-value refund for 98% of their performance in the previous year. They receive 60% for performance exceeding this level by 5% and 30% for performance exceeding the level by 5-10%, and only 10% of the monetary value of the point for any services exceeding the benchmark by more than 10%.

Table 10: Expenditures of the Fund on in-patient care (HUF million)

	1999	2000	2001	2002	2003	2004e
Inpatient care	**211 456**	**222 795**	**249 944**	**294 576**	**373 832**	**379 100**
Acute inpatient care	182 477	191 141	214 863	254 713	327 211	327 526
Task financed under special rules	7 063	7 802	8 303	10 369	10 591	13 538
Chronic inpatient care	21 132	22 949	25 754	28 359	34 854	39 623
Other	718	753	805	860	953	1 113
Extra financing	65	150	218	275	222	300

Source: Health Care Fund (OEP)

8. ORGANIZATION

68. The Constitution of the Hungarian Republic guarantees all citizens the right to the highest possible level of health and social security in cases when they are unable to secure them with their own means. The current health care system of Hungary is based on the solidarity principle where contributions are derived from income and not risk. The system ensures pluralism among providers of medical services which are provided partly under contracts. Financing is based on universal health insurance; capital expenditures of the hospitals are covered by taxes. The services are operated by local governments which are the proprietors and facilitate the operation of providers who communicate with the department of administration of the Health Insurance Fund.

8.1 Execution of the Health Policy - Stakeholders

69. The National Parliament is the key decision-making player on the national level for all sectors involving health care. The parliament decides about the planned budget – the final expenditures. It also decides about the annual contributions to the Fund. Most of the parliament's decisions require a simple majority (like in the local governments…). Before an act becomes effective, it needs to be signed by the president.

70. The national government executes statutory supervision of the Fund and controls the Fund. It provides capital grants for the public health sector and some tertiary services. The national government formulates the health policy and is one of the most important regulators.

71. The National Health Committee was established in 1999 and is responsible for ensuring coherence of health priorities and for facilitating the implementation of health laws. The members have a 4-year mandate and are experts in various areas, representatives of associations and local governments.

72. Since the Fund was separated from the budget, the government is no longer the main financier of health services. The government is the financial backer of the hi-tech sector in health care, of emergency services and medical education. It pays for the capital expenditures of local governments which have grants for the renovation of medical facilities. It transfers the hypothetical health taxes to the insurance fund to compensate for the health insurance on behalf of non-contributing groups. It also covers the costs of certain medical services and provides tax relief for the salaries of volunteers.

73. The local administrations and districts are responsible for most of the health services since 1990. The government directly operates some public health services through the system of national public health and medicine officer, emergency services, transfusion stations, medical education and research.

74. The legislation in the government is coordinated by the office of the prime minister which has reference centers responsible for the coordination of sectoral administration led by chief officers. It is responsible for the administration of the national health fund.

75. The role of the Ministry of Health, Social Affairs and Family is to execute the health, social and family policy of the state. It directs the Fund. Its entrusted areas include hygiene, prevention and public health. Its responsibilities include licensing and inspection of provided services. It operates the national emergency service, the national blood program, professional training/education and 6 state hospitals. It is responsible for primary medical education.

76. The National Public Health and Medical Services Office is an administrative agency. It is responsible for executing state tasks, and it implements a unified system of medical administration in the following areas:

- public health and epidemiology
- regulatory licensing
- supervision of the professional sector
- monitoring, control and supervision of prevention
- training in health care

77. Medicine research committee. Fulfils an advisory and consulting role for the ministry of health, and coordinates research activities of the government. Makes proposals and is responsible for clinical trials.

78. Professional chambers. There are three – medical chamber, pharmaceutical chamber and chamber of nurses and paramedical staff. They defend professional interests, monitor the growth of the standard of medical and pharmaceutical care.

79. Medical colleges. Financed by the ministry of health, are also scientific institutions. There are 37 medical colleges, 3 pharmaceutical colleges and 2 nurse schools.

80. Local governments. On the basis of contracts the local governments become owners of primary health care facilities, specialists' ambulances and hospitals, and are the main link in providing health care. Municipalities own primary facilities and, if larger, some smaller clinics. District governments own large hospitals with prevailing secondary and tertiary care.

8.2 Primary Care

81. Since 1992 primary health care is provided by family doctors. Citizens may choose their doctor freely, irrespective of their place of residence. The family physicians are remunerated according to the number of patients they serve and are hence motivated to keep their patients. This element of competition contributes to increasing the quality of the services provided. The family doctor should provide the patient as much care as possible before referring him/her to a specialist.

82. The organization of the network follows the principle of responsibility of the local self-government for health care. The network consists of providers owned by the local administration, although in most cases there is functional privatization, i.e. the local self-government outsource an activity to non-state and private physicians while retaining the outpatient premises and their equipment in its ownership and bearing responsibility for capital expenditures. The local self-government is also primarily responsible for the selection of provider - if it decides to include a provider in the network, the Fund automatically concludes a contract with the provider.

83. In primary care ('home doctors') the local self-government draws 'precincts' for first-contact physicians. The precincts are rigid and have not changed since the law was enacted. In order to ensure free access to market changes were made which support free choice of doctor for the patient and enable every first-contact physician to open a practice. Once the requirement of having at least 200 patients is met the Fund must conclude a contract with the physician (note – a practice becomes profitable with 1200 to 1500 patients). At a relatively low sensitivity of the patients to the change of doctor, however, the precincts remain an important part of the system. Firstly, they form a security network, because a doctor is never allowed to refuse a patient from his own precinct. Secondly, the law allowed the "sale of practice".

84. The "sale of practice" only applies to those who were chosen by the local self-government to provide health care (i.e. those with a precinct) and does not apply to those who entered the system later after the market was liberalized and have no precinct. Another provider may only enter a precinct by reaching an agreement with the local self-government and buys local health care provision monopoly from one of the current precinct physicians. The intention behind this arrangement was to increase the reputation of home doctors and reduce their average age because the older generations of doctors were self-employed and hence not required to retire at a certain age. Therefore the access to the market of precinct physicians was completely closed. It was a privilege reserved to those who had already been in the system.

85. Hungary also applies the model of Managed Health Care under which the Fund enters into contracts with providers of health services. The system is currently used by 298 family doctors for 2 million inhabitants. On the basis of contracts the local sel-governments become owners of primary care facilities and hospitals and are one of the crucial elements in providing health care (another is MISSZIO).

8.3 Out-patient Care

86. Out-patient care is divided into general and specialized. General is provided close to the place of residence, on referral of a family doctor, and is rather sporadic. Specialized is aimed at treating

Table 11: Physician contacts (thousands)

	1999	2000	2001	2002	2003
Family doctor's services total	**66 297**	**65 966**	**66 379**	**66 791**	**68 787**
Adult and mixed services	52 996	53 292	53 794	54 762	56 114
Pediatrician services	10 978	10 504	10 501	10 046	10 540
Central emergency services	2 323	2 170	2 084	1 983	2 133
Outpatient services total	**56 598**	**58 775**	**61 469**	**64 166**	**64 868**
Clinical professions	38 492	39 779	40 165	41 258	41 657
Diagnostics	16 970	17 754	19 385	20 824	21 143
Laboratory diagnostic	*10 182*	*10 858*	*12 218*	*12 982*	*13 176*
Imaging diagnostics	*5 696*	*5 804*	*6 008*	*6 599*	*6 681*
Pathology and morbid histology	*1 092*	*1 092*	*1 159*	*1 243*	*1 285*
Other diagnostics and therapies	1 136	1 242	1 919	2 084	2 068
Inpatient services total	**2 556**	**2 610**	**2 655**	**2 708**	**2 749**
Active inpatient services	2 374	2 423	2 463	2 520	2 559
Chronic inpatient services	182	187	192	188	190

Source: Bureau of Statistics of the Hungarian Republic

Table 12: Absolute interventions in out-patient care compared to previous year (%)

	1999	2000	2001	2002	2003
Outpatient services total (absolute)	**104**	**98**	**103**	**114**	**83**
Clinical professions	106	98	101	113	71
Diagnostics	101	110	112	115	99
Laboratory diagnostic	*102*	*114*	*114*	*116*	*99*
Imaging diagnostics	*97*	*90*	*102*	*110*	*99*
Pathology and morbid histology	*90*	*79*	*88*	*109*	*90*
Other diagnostics and therapies	101	56	52	126	88

Source: Bureau of Statistics of the Hungarian Republic

diseases which require extraordinary diagnostic support. It focuses on out-patient care and relieves hospitals by providing one-day surgery. It also includes specialized home care provided by qualified nurses at home.

87. Specialists are also organized by the local self-government. In 1996 the law specified a limit of performance as the number of hours of a specialist in the territory of the local self-government. The centrally defined formula specified how many services of what type the local self-government was to order with specialists. The law was repealed in 2001 but the mechanism of ordering by hour remained the 'status quo'.

8.4 In-patient Care

88. Hospital care is provided on three levels:

- District hospitals with basic departments and a range of 25 – 30 km
- Local self-government hospitals – operated as large regional centres with specialized care
- National health institutes and university centres – provide mainly tertiary care

Recommendation 9: Definition of a minimal network, both geographical and structural. Unnecessary centralization of highly specialized services and irregular geographic location of hospitals are problems. 40% of the beds are located in the city of Budapest where only 1/5 of the population lives.

89. Owners of the hospitals are local governments, the national government (university hospitals), churches and charities. One hospital has on average 458 beds.

90. In terms of organization the law specified the number of beds and their structure that the local self-government had to operate. The hours of specialists and hospital beds are defined by an upper limit. The local administration has the power to reduce the number of beds and the network of hospitals but every such decision is subject to approval of ANTSZ. Establishment of a new facility and beds must be approved by MOH and MOF.

9. Regulation

91. Balance of incentives is important. Due to its main principle (DRG) the Hungarian system has a tendency to overproduction at the lowest costs. This generates extra performance which is not always paid and is therefore adjusted through reductions of the nominal price of the German point and the basic DRG rate.

9.1 Drug Policy

92. The pharmaceutical industry is mostly privatized. Several large pharmaceutical companies have gained prominence. Approximately 2000 pharmacies operate on the Hungarian market and their owners may only be professional pharmacists. Expenditures on drugs are the second largest item in the total hospital care costs. According to WHO Hungary annually spends $280 per citizen on drugs (UK, $240, Czech Republic $242). The prices of drugs continue to grow, pharmaceutical companies advertise aggressively, offering commissions on prescribed and sold drugs. This leads to overprescription of drugs. In 2002 the price of drugs increased by 6.2%, in 2003 by 3.6%.

93. Drugs and drugs policy. Every drug released on the internal market must be registered with the National Institute of Pharmacy. There are three types of drugs in the system:

- OTC
- Prescription drugs paid by the patient (e.g. contraceptives)
- Prescription drugs covered by the health insurance

94. Coverage of drugs by health insurance has two forms. The Fund pays a percentage of the drug's price (ranging between 10 and 100% of the price). There is also a system of fixed coverage based on a nominal value in HUF. A special commission at the Ministry of Health decides how much of the price will be covered by insurance. This decision is subsequently issued as a government decree. In cases where the commission specifies a percentage of the

price it also specifies the retail price. The percentage-based system of refunds from health insurance leads to a higher consumption of more expensive drugs – and higher margins of the logistic chain.

Recommendation 10: Introduce degressive margin in pharmacies.

95. Spending on drugs decreased on the previous year by 1.2% after a hard-hitting administrative measure was adopted by the ministry, reducing payments for drugs by 15%. Such hard administrative measure can not be repeated, however. We recommend the government to adopt very clear changes to the drugs policy leading to a transparent classification process and introduction of market mechanisms and price negotiations.

96. 'Kozgyogyellátás' means public provision of drugs and aids for selected groups of citizens (in total approximately 500,000 people). This system gives some groups of people access to drugs and medical aids for free, even if they would normally have to be paid for in full. The local self-government decides who will be included in the group and issues a special identification document. This system naturally leads to a huge abuse of resources because the identification documents are used to obtain prescription drugs for friends and family members.

Recommendation 11: Cancel special benefits for vulnerable groups. Principally, the role of the health policy is not to compensate social inequities. It is more feasible to introduce a universal system for everybody and rather provide the vulnerable groups with a special allowance from the Social Security System. Another solution is to individualize these exemptions through a treasury system. The patient pays first and later is reimbursed by the Fund. This would lead to lower abuse of the system.

97. The drugs policy is one of the weakest links of the Hungarian health care. It is the only Fund sub-budget without a macro limit. The other sub-budgets for primary care, secondary care and hospitals have limits and are obliged to create reserves throughout the accounting period. When the reserves are not sufficient, and this happens every year, the ministry responds by an inflation of the price of the German point and the DRG base rate price so that the planned budget of the sub-budget is met. Drugs, however, have no capped budget and regularly cause Fund deficits which the government then pays from the state budget.

98. The second reason for a permanent deficit of the drugs 'treasury' is the introduction of new products and drugs to the market. New drugs increase the prices, and where refunds are percentage-based, the financial burden for health insurance increases too.

99. The drugs policy has one strength – total control of the drugs chain from prescription of the drug using a unique and special prescription form to its issue and refund. The Fund knows who drew the recipe, to whom it was drawn, when and where it was used by the patient, and when the Fund paid it.

Recommendation 12: Introduce a reference pricing system combined with direct fix ratio after categorization procedure between the Fund reimbursement and the patient co-payments.

10. Conclusion

100. In the Hungarian health care system – the main channel of financing is the Health Insurance Fund, which is in last years permanently in deficits due two main reasons. First, the benefits in cash are crowding out the benefits in kind. Second, the drug sub-budget is stable only because of dramatic administrative interventions, which are not sustainable in a long term. For the next two years, if no reforms will be implemented, the health Insurance Fund will face in next two years a deficit approx 1.4 % of GDP (Table 13).

Recommendation 13: Separate internally the benefits in cash and create a clear cut also on the revenue side and also on the expenditure side on which resources are linked to which expenditures. It is also a question, if the Fund has enough administrative capacity to handle both, the payments in benefits in cash and also to effectively purchase health care services. Other countries around have separate health insurance and separate sickness insurance and separate disability insurance, so there are no cross-subsidizing mechanisms.

101. The revenues of the Fund for employees, employers and self-employed are a function of employment and gross nominal wages. For the projections of the revenues we used a following model (Since the P-value is less than 0.01, there is a statistically significant relationship between the variables at the 99% confidence level):

Revenues = -245395.0 + 105.058*(Employment and SE) + 5.75558*(Gross nominal wages)

Table 13: Revenues and Expenditures of the Health Insurance Fund (HUF million)

	1997	1998	1999	2000	2001	2002	2003	2004e	2005p	2006p
REVENUES TOTAL	**499 487**	**561 461**	**653 597**	**734 584**	**884 697**	**1 024 575**	**1 025 437**	**1 115 898**	**1 146 383**	**1 207 543**
Revenues and Contribution	**471 812**	**534 078**	**591 237**	**653 715**	**762 402**	**883 681**	**927 665**	**1 052 428**	**1 090 383**	**1 151 543**
Employers health insurance contribution	323 483	370 621	344 570	373 047	441 869	517 978	580 650	635 284		
Employees health insurance contribution	62 474	62 662	76 355	81 314	105 592	128 575	142 717	207 217		
Health Contribution	71 974	92 592	156 786	181 379	194 664	209 875	173 315	176 935	167 396	167 396
Employers contribution to sick pay	7 658	n/a	12 348	13 387	14 625	18 066	21 383	23 177		
Others	6 223	8 203	1 178	4 588	5 652	9 187	9 600	9 815		
Central budgetary contributions	**2 500**	**2 500**	**30 290**	**70 872**	**103 928**	**135 885**	**85 988**	**57 619**	**50 000**	**50 000**
Other revenues	**15 315**	**4 590**	**3 176**	**2 635**	**15 680**	**3 473**	**9 982**	**4 761**	**5 000**	**5 000**
Revenues from property management (sales of property)	**8 200**	**1 925**	**24 385**	**3 885**	**866**	**75**	**55**	**35**	**0**	**0**
Revenues used for operations	**1 660**	**2 874**	**4 509**	**3 477**	**1 821**	**1 461**	**1 747**	**1 055**	**1 000**	**1 000**
Revenues from arrears collection	**0**	**15 494**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
EXPENDITURES TOTAL	**555 586**	**632 052**	**701 290**	**798 199**	**914 976**	**1 111 232**	**1 325 550**	**1 393 650**	**1 463 332**	**1 536 499**
Provisions in kind	**389 964**	**458 449**	**504 069**	**556 016**	**623 358**	**750 326**	**910 236**	**946 521**	**987 749**	**1 024 845**
Curative-preventive health provisions	265 779	299 092	338 877	376 069	410 304	502 852	622 766	657 068		
GPs' and GPs' emergency service			*35 355*	*36 608*	*41 138*	*45 453*	*58 106*	*59 572*		
MCH service, mother, child and youth care			*7 816*	*8 334*	*9 235*	*9 978*	*13 790*	*14 148*		
Dental care			*9 679*	*10 410*	*12 076*	*16 199*	*20 496*	*21 144*		
Service of dispensaries			*7 269*	*8 157*	*9 501*	*8 616*	*10 107*	*10 465*		
Transport of patients and corpses on medical order			*3 451*	*3 687*	*4 174*	*4 812*	*6 014*	*23 594*		
Outpatient special care			*46 608*	*51 620*	*61 260*	*72 923*	*96 529*	*102 425*		
CT, MRI			*6 484*	*7 058*	*7 842*	*8 492*	*10 735*	*10 519*		
Kidney dialysis			*8 736*	*10 143*	*11 606*	*13 061*	*15 896*	*16 119*		
Home special nursing			*1 120*	*1 274*	*1 463*	*1 587*	*2 236*	*3 134*		
Inpatient care			*211 456*	*222 795*	*249 944*	*294 576*	*373 832*	*379 100*		
Others			*712*	*15 782*	*1 797*	*26 923*	*15 027*	*16 848*		
Balneological services, breast milk supply	1 574	2 010	2 445	3 235	4 071	4 347	4740	6024		
Subsidization of Medicaments	100 876	135 474	139 461	150 753	179 465	209 033	241 972	238 905		
Subsidization of therapeutic equipments	16 782	19 618	20 589	22 668	25 002	28 915	34 957	37 997		
Refunding of travel expenses	2 561	2 255	2 697	3 291	3 836	4 274	4 750	4 906		
Expenses resulting from international agreements	n/a	0	0	0	680	905	1 051	1 622		
Provisions in cash and retirement provision	**141 809**	**149 657**	**174 739**	**221 061**	**270 772**	**335 753**	**386 383**	**422 710**	**450 706**	**485 534**
Retirement provision (disability and accident disability pensions)	97 982	99 927	115 949	132 243	157 964	194 284	213 888	238 617		
Sick pay	36 138	41 255	49 205	56 140	64 206	80 864	98 936	101 480		
Child care fee	0	0	0	20 381	29 646	37 807	45 589	53 019		
Pregnancy and confinement benefit	6 013	6 924	7 768	10 047	12 470	15 777	20 207	21 348		
Accident benefit	n/a	n/a	n/a	n/a	4 249	4 986	5 605	5 911		
Others	1 676	1 551	1 817	2 251	6 486	7 021	2 158	2 335		
Other expenditures	**4 803**	**2 614**	**3 219**	**3 290**	**2 156**	**2 631**	**4 791**	**3 573**	**2 927**	**3 073**
Asset management	**n/a**	**141**	**n/a**	**n/a**	**564**	**531**	**413**	**16**	**0**	**0**
Operational costs	**19 010**	**21 332**	**19 263**	**17 832**	**18 126**	**21 991**	**23 726**	**20 830**	**21 950**	**23 047**
BALANCE	**-56 099**	**-70 591**	**-47 693**	**-63 615**	**-30 279**	**-86 657**	**-300 113**	**-277 752**	**-316 949**	**-328 956**
GDP	**8 541 000**	**10 087 000**	**11 393 000**	**13 172 000**	**14 850 000**	**16 740 000**	**18 574 000**	**20 630 000**	**22 744 059**	**24 387 545**
Revenues as % of GDP	5,8	5,6	5,7	5,6	6,0	6,1	5,5	5,4	5,0	5,0
Expenditures as % of GDP	6,5	6,3	6,2	6,1	6,2	6,6	7,1	6,8	6,4	6,3
Balance as % of GDP	-0,7	-0,7	-0,4	-0,5	-0,2	-0,5	-1,6	-1,3	-1,4	-1,3

Source: Bureau of Statistics of the Hungarian Republic
e…estimate
p…projection of Author

102. Special case is the item Health Contribution (or Hypothecated Health Care Tax), which is a linear function of its measure set by the Ministry. The equation of the fitted model is:

Health contribution = 40066.3 + 36.9072*HCCT measure

103. Debt settlement. The government attempts to consolidate the health care and pays the accrued debts directly through hospitals. In his package Lajos Bokros tried to introduce hard budgetary restrictions but the subsequent governments eliminated the effects of this effort by a package of debt discharges. Those, who tried to save and did not create more debt, were actually punished. Eventually the government decided that hospitals will receive financial aid from the Fund in the form of a loan, to be paid by the hospitals later by offsetting against the payments from the Fund. This system is currently in operation. The fund operates as the hospitals' creditor.

Recommendation 14: Establish a special Consolidation Agency owned by the Government for debt settlement.

104. The debt of hospitals is approximately HUF 50 billion. The debt of OEP is HUF 300 billion (the 2002 deficit reached HUF 100 billion). This debt does not arise by failure to pay for health care itself, but by outstanding payments for drugs and sickness allowances.

Recommendation 15: Generate reserves for the debt settlement in future. This, according to ESA95 will create a pressure on public deficits. Work out a debt settling plan – and refresh the Convergence program by adding the debt settling deficit.

105. The entry of private capital to hospitals is despite of the governmental attempts very complicated and from beginning non profitable due to three reasons:

- First, the payments from the Fund do not cover the amortization, only the operational costs. This causes discrimination of private providers before the state and self-government providers, who has free access to capital expenditures.
- Second, every new facility with new capacities has to be approved by the MOH and MOF.
- Thirdly, the planning is very complicated, because the MOH changes the basic rate of DRG within a accounting period (4 times a year!).

Recommendation 16: Allow the change of the hospitals into joint stock companies followed by privatization and imposing hard budgetary constraints. The precondition is to calculate the amortization into DRG system. This decision can also be supported by the unsuccessful referendum initiated by the FIDESZ party.

Table 14: Recommendations for Hungarian Health Policy

Recommendation 1:	Introduce a common tax and health insurance assessment base to avoid tax and health insurance evasion and to improve the reporting of „prescribed health insurance“.
Recommendation 2:	Slowly cancel the dual system. The dual system is one of the main reasons, why no private investors can enter market, because the DRG in the hospital sector is not covering the amortization. The dual system is dis-motivating the private providers and investors. This is important with the Government intension to privatize hospital.
Recommendation 3:	Introduce a shift from functional privatization to real privatization in secondary care. We recommend changing the financial flows, canceling capital expenditures and transferring the total sum spent on capital investments form state budget to the FUND. This might by risky, because it means to re-think one of the pillars of the Hungarian health system – the key responsibility of municipalities in health care provision.
Recommendation 4:	Introduce legal user fees in primary, secondary and tertiary care. Increasing of the total co-payment level is not desirable, since it reaches already the level of OECD average. It is important to change the structure of these co-payments and to legalize the sum that is paid through informal payments. In primary care we can imagine a user fee in the amount of HUF 100 per visit. We do not recommend any kind of exemptions. The systematic approach would lead us to provide the vulnerable groups a special allowance from the Social Security System.
Recommendation 5:	Introduce better management of receivables.
Recommendation 6:	Increase the responsibility of the Fund on both ends: on the revenue side and on the purchasing side.
Recommendation 7:	Increase resources. Change the structure of expenditures. Increase the insurance rate. Separate the health insurance and the sickness insurance on both ends: the revenue side and the expenditure side.
Recommendation 8:	Reduce the extent of free healthcare. This might by complicated due to the Constitutional Court precedent from past, which determines the health insurance as a social contract and does not allow any stricter reduction of benefit packages for population.
Recommendation 9:	Definition of a minimal network, both geographical and structural. Unnecessary centralization of highly specialized services and irregular geographic location of hospitals are problems. 40% of the beds are located in the city of Budapest where only 1/5 of the population lives.
Recommendation 10:	Introduce degressive margin in pharmacies.
Recommendation 11:	Cancel special benefits for vulnerable groups. Principally, the role of the health policy is not to compensate social inequities. It is more feasible to introduce a universal system for everybody and rather provide the vulnerable groups with a special allowance from the Social Security System. Another solution is to individualize these exemptions through a treasury system. The patient pays first and later is reimbursed by the Fund. This would lead to lower abuse of the system.
Recommendation 12:	Introduce a reference pricing system combined with direct fix ratio after categorization procedure between the Fund reimbursement and the patient co-payments.
Recommendation 13:	Separate internally the benefits in cash and create a clear cut also on the revenue side and also on the expenditure side on which resources are linked to which expenditures. It is also a question, if the Fund has enough administrative capacity to handle both, the payments in benefits in cash and also to effectively purchase health care services. Other countries around have separate health insurance and separate sickness insurance and separate disability insurance, so there are no cross-subsidizing mechanisms.
Recommendation 14:	Establish a special Consolidation Agency owned by the Government for debt settlement.
Recommendation 15:	Generate reserves for the debt settlement in future. This, according to ESA95 will create a pressure on public deficits. Work out a debt settling plan – and refresh the Convergence program by adding the debt settling deficit.
Recommendation 16:	Allow the change of the hospitals into joint stock companies followed by privatization and imposing hard budgetary constraints. The precondition is to calculate the amortization into DRG system. This decision can also be supported by the unsuccessful referendum initiated by the FIDESZ party.

Source: authors