

Post-Socialist Health Care System in Hungary

Following the introduction of Germany's sickness insurance system effected by Chancellor Bismarck (1815-1898), the first Act on mandatory sickness insurance for Hungary's factory workers was introduced in 1892. Back then, the centralized system of national sickness insurance was laid down for the 20th century.

Later – in socialist Hungary – the system was prepossessed by the Soviet (Semasko) model. In July 1918, half a year after the victory of the Russian revolution, N. A. Semasko (1874-1949) – the first minister of health in the Soviet Union – announced free health care services for every member of the population – for the first time in the world. They achieved great success in reducing epidemics and infant mortality. The Soviet model was financed within the framework of planned economy from the state budget. It ensured relatively equal chances for all citizens.

Development of the Hungarian Health Care System

Sickness Insurance in Hungary (1892-1928)

We can find the initial traces of social insurance even before the introduction of obligatory sickness insurance in Hungary. The early background was developed in the spirit of self-help and common risk-taking in the 13th–14th centuries. In Hungary the first self-help organization was formed in János Thurzó's mine.

Industrial workers also established voluntary mutual benefit societies based on the principle of collective support.

In chronological order, Hungary was the third state in Europe in which the insurance obligation in case of sickness was enacted by law on 1 April 1892. Sick-relief funds provided health care services, medicines, medical aids, sick pay, maternity benefit and funeral allowance. The next milestone in the development of sickness insurance was year 1907, when employers' liability insurance for industrial and commercial workers was introduced. The Act on sickness and employers' liability insurance entering into force in 1928 regulated the services provided by the OTI (National Social Insurance Institute) for decades.

Operation of the National Social Insurance Institute (1929-1950)

The economic crisis of 1929-1935 rendered the economy of the National Social Insurance Institute (Országos Társadalombiztosítási Intézet, OTI) difficult. In 1930 sick pay equal to 75% of the wages was abolished, in 1933 sickness benefit, which was 60% of the salary previously, decreased to 50%, and the insured had to pay for the employer's card, etc. On 1 January 1933 the sickness insurance sector was divided into two independent – general and household – branches maintained by their own incomes. By 1939 the financial balance of sickness insurance was restored. OTI participated actively in the fight against tuberculosis, organised remedial holidays for the young insured, provided health care education for the public, laid down rules of accident prevention, built blocks of flats, headquarters and surgeries. During World War II social insurance was damaged seriously, too. After the war, the first task was to clean up the ruins and to ensure operation. Insurance for agricultural workers was introduced in 1945. The obligation of insurance related to the wage level was abated. The improvement of services began. In 1947 family members became entitled to be treated in hospital for 60 days a year instead of 42, the amount of sick pay increased and the

period of hospital treatment for patients suffering from tuberculosis was extended to 2 years. Merging different insurance institutes started in the sickness insurance sector first.

Operation of Social Insurance (1950-1984)

The unification and amalgamation of social insurance institutes came to an end in 1950.

The Social Insurance Centre of Trade Unions (Szakszervezeti Társadalombiztosítási Központ, SZTK) was set up. At the same time, the county sub-centres and sub-offices of SZTK were also established to carry out the local tasks related to social insurance. Funds paying benefits were instituted in companies and offices employing over 100 people. The obligatory collective insurance for workers at craftsmen's cooperatives was introduced in 1951. The Collective Insurance Institute for Members of Craftsmen's Cooperatives (Kisipari Szövetkezeti Kölcsönös Biztosító Intézet, KSZKBI) operated from 1953 to 1964. This institute provided sickness benefit, maternity benefit and funeral allowance for members.

The circle of the insured was widened gradually. Insurance was extended as far as students, then craftsmen in 1962, and shopkeepers in 1970. According to the new rules of sickness insurance, from 1 January 1956 two types of services were provided. One of them included benefits in kind such as medicines, breast milk, medical aids, hospital treatments, thermal bath treatments; and the other is the financial benefit such as sick pay, maternity benefit, contribution to travel expenses and funeral allowance. After 1 October 1950, sickness benefit was provided from the first day of being incapable of earning. From 1952 patients suffering from tuberculosis were entitled to get sick pay for 2 years instead of 1 year. The level of the sick pay was either 75% or 65% of the daily average wage; it depended on the length of time since the patient had been insured.

As a result of a long codification, Act II of 1975 on Social Insurance enacted on 1 July 1975 regulated material and legal rules of social insurance on the basis of unified principles. At the same time, health care services were separated from social insurance and every citizen became authorized to use them. However, this act did not change sickness and maternity benefits for the insured. From 1982 both craftsmen and shopkeepers obtained the right to get sick pay. At the beginning of the 1980s insurance covered practically the whole population. Sick pay in case of accident became the total daily average wage from 1 January 1981.

Act II of 1975 on Social Insurance regulated insurance for members of agricultural cooperatives, members of professionals' cooperatives and members of their families on the basis of unified principles. They were all entitled to every benefit except for sick pay and maternity benefit. Instead of these, they were given sick benefit and maternity grant from the cooperatives.

Pursuant to a new legislation, from 1 March 1992 members of cooperatives work within the framework of employment or self-employment, and benefits for them are also based on these legal relationships.

From 1 July 1984 the government replaced trade unions in the field of social insurance management. The National Social Insurance Directorate-General (Országos Társadalombiztosítási Főigazgatóság, OTF) became the central organisation for social insurance; its regional organisations were county social insurance directorates and their agencies. Both agricultural and craftsmen's cooperatives had to establish funds operating at the places of work if the number of the insured exceeded one hundred. The amounts spent on social insurance increased from year to year over the incomes from contributions.

Municipal Management of Social Insurance

Local authorities have participated in social insurance since the beginning; however, their roles have changed from time to time.

In 1891 the organisation of the funds was built on the principle of self-government. In local authorities employers formed one-third of all the members, while employees constituted two-thirds. From 1907 both the insured and the employers delegated equal numbers of representatives.

In the spring of 1919 the Hungarian Soviet Republic invalidated the appointment held by employers in the local authorities of insurance funds for workers. After the fall of the Hungarian Soviet Republic, the Minister of Public Healthcare suspended the local authority of the National Insurance Fund for Workers and appointed a commissioner to manage the institute. In 1928 the insurance institute for workers was nationalised and the local authority with restricted power was restored, whose organs were as follows: general meeting, directorate, presidency and committees. The local authority was dissolved again in 1944. After World War II, the Temporary National Government restored local authorities by an order and changed their composition: two-thirds of the members were delegated by employees and one-third by employers. From 1 October 1950 trade unions took over the tasks of local authorities; committees of social security were set up in the counties and social security councils were established at the funds. In 1984 statism replaced the role played by local authorities. The majority of the members of social insurance councils were delegated by trade unions, and room was made for representatives of other interest protecting organizations as well as representatives of some of the state organizations. The National Social Insurance Council (Országos Társadalombiztosítási Tanács, OTT) was set up as a central organisation. In addition, county social insurance councils and social insurance councils at the places of work were established regionally. In 1991 the Health and Pension Insurance Inspection Committee was founded in order to control social insurance. It supervised Social Insurance Funds from 1992.

Members of Parliament, interest protecting organisations and the government each delegated 10 members of the inspection committees. The Health Insurance Authority was set up on 18 June 1993. There were 60 people on the staff of the authority, where employers and employees were represented equally. Each of the representatives was admitted to the Health Insurance Authority by election, and it also served the aim of choosing between trade unions. The organs of the Health Insurance Authority were as follows: general meeting, presidency, inspection board, sections, committees and local boards. The Fundamental Rules of the Health Insurance Authority – in the sphere of inspection – was approved by Parliament. The new authorities founded in the summer of 1997 were wound up on 23 July 1998 by Parliament, which ordered state control again over social insurance.

Social Insurance Fund, Development of Health Insurance

According to a decision made by Parliament, from 1 January 1989 social insurance was separated from the state budget, and started operating as a fund benefited from state guarantee. The contribution to social insurance, state subsidy and other social insurance fees served as its sources. The Social Insurance Fund covers social insurance expenditures. Since 1 January 1992 the costs of preventive-curative cares have been financed by the Fund. In 1992 the Health and Pension Insurance Fund was established in order to set up independent insurance branches. The Pension and Health Insurance Inspection Board, which was under the

supervision of Parliament, exercised authority over the separated social insurance funds and controlled their management.

On 18 June 1993 the Health Insurance Authority and Pension Insurance Authority and their central organisations such as the National Health Insurance Fund (Országos Egészségbiztosítási Pénztár, OEP) and the National Pension Insurance Chief-Directorate (Országos Nyugdíjbiztosítási Főigazgatóság, ONYF) were founded.

From 1993 the management boards were controlled by the National Health Insurance Fund. Health insurance funds and their agencies operated in the capital and in 19 county seats ¹.

Basic Challenges for Health Insurance and Health Care Services² in Hungary after the 1990s

Hungary is a parliamentary republic. After the peaceful change of the regime, the first free, multiparty elections were held in the country in 1990.

The current governments should be intent on visualizing the so-called principle of „Health in All Policies”. In terms of this principle every decision of the government should reflect that the health of the population is a social value. The preservation of health is deemed as an economic and social interest.

The post-socialist states struggle against the same problems in their health care systems, inherited from before year 1990: inadequate equipment, lack of medicine, shortage of health personnel. Moreover, the society insists on traditional services which are accessible to everybody. Since the beginning of the 1990s, every East European state has tried to find the policy of the egress – with more or less success.

The general **effort**, independent of the period or the political power in office, is to preserve health and to provide the highest level of health care services in case of illness.

Health care reforms – Governmental programs

In the following the health care programs of various governments³ after the change of the regime are going to be presented – without aiming at completeness, in an itemized way.

***1990-1994* ”Program of National Revival” The First Years of the Republic**

Necessity and background of the implementation of the aims set:

“The morbidity and mortality rates of the Hungarian middle-aged population are among the highest in Europe. In the first part of the 1990s health preservation in Hungary can aim only to reduce risks damaging health care and to decrease the mortality and morbidity rates. The foundations of the changes affecting the structure of health care need to be laid down, the arbitrary system of state distribution has to be changed.”

¹ from 1 January 2009 in 7 regions of the country

² Within this, curative-preventive care.

³ The fact that the same aims are set again and again also confirms that the predecessors entirely or partially failed to achieve the aims set.

Aims to be achieved:

- revival of the system of social insurance and sickness insurance
- replacement of the system of central state distribution by the health care fund. This makes it possible to avoid the continuous dependence of health care on the budget.
- privatization in health care, efforts to create ownership relations in health care which can be controlled well by society
- putting an end to “gratitude payment” – this can be realized through the possibility of the free choice of physicians, the introduction of the insurance system and salaries paid in proportion to justified and utmost medical work.

1994–1998 Program of the Government of the Republic of Hungary

Necessity and background of the implementation of the aims set:

“The prolonged crisis of Hungarian health care was brought about jointly by the deterioration in the population’s health status, economic recession and the difficulties of the institutions of the health care system. The conditions of health preservation, health prevention as well as those of the development of the health care system and health insurance further deteriorated during the past four years.

The increasing deficit of health insurance also made it evident that the state cannot withdraw from health care. At the same time the role of the state is preponderant, therefore the gradual decentralization of health insurance is necessary. A new direction must be taken in the transformation of the health care system.”

Aims to be achieved:

- to create a comprehensive health policy, interest reconciliation with the participants of health care for this purpose
- to develop a financing system for the operational costs of health care, including the amortization ratio as well
- to work out a new system of patient referral (to specify the range of outpatient specialist care which can be used without a doctor’s referral)
- to encourage privatization – as to primary care, reform and modernization in the field of dentistry and occupational health care, too
- to raise the salaries paid to health personnel

1998-2002 „On the Threshold of the New Millennium” – Governmental Program for the Bourgeois Hungary

Necessity and background of the implementation of the aims set:

“The health status and life expectancy of the Hungarian people are among the worst ones in Europe. A modern health policy and health care institutions adjusted to the justified expectations of the citizens are indispensable for providing efficient cure and prevention.

We have to do all we can to ensure the efficiency of programs of health preservation. We have to put an end to waste and corruption in social insurance.”

Aims to be achieved:

- to decrease the controlling function of the state – it fulfils legislative and official tasks
- to effect privatization in primary and specialist care
- to keep hospitals in the ownership of local governments but organs operating on a non-profit base should also have a role

- to ensure that financing should cover the operational costs as well as the maintenance and replacement of the buildings and instruments of curative-preventive care
- to abolish social security self-governments
- to provide financing on the principle of solidarity, based on contributions

Health Insurance in the Years of 1993-2003

In the first part of the 1990s, during the economic changes entailed by the change of regime, the circle of employers was rearranged. Employers employing small numbers of people replaced large companies and cooperatives employing huge numbers of workers. The number of private companies and enterprises rose by leaps and bounds. It had effects on the system of funds of companies operating for decades. The number of funds was not reduced significantly, but the proportions of workers insured by them were nearly halved. Thus the number of people benefited directly by the health insurance management boards increased. On 1 January 1997 contribution to the health insurance was introduced, which is paid by employers to supplement the funds for healthcare services. The decrease in the proportion of those paying contribution, the relatively high number of unemployed people and the spread of the “black market” contributed to the deficit of the Fund significantly.

On 1 January 1999 the Tax Control Office (APEH) took over the collection and executive tasks connected with contributions to social insurance, which had approximately 2 million current accounts. Since that time APEH has been responsible for collecting and administrating contributions. The health insurance system provides benefits for the insured, those entitled to health care services in terms of the law, their dependents and Hungarian citizens paying contributions to health insurance. Health insurance finances care provided for foreigners who have entered into an agreement with it. A milestone of the reform process of social insurance was 1990, when within the framework of dividing tasks between social insurance and the state budget, financing health care services became the task of social insurance and later the task of health insurance.

In 1992 the Sickness Insurance Card was introduced. It links the use of health care services with being benefited by social insurance, in other words, the title to insurance. The Introduction of the card made choosing physicians possible for patients.

In 1995 the Social Insurance Number (TAJ) was initiated. It identifies people entitled to services provided by health insurance, and ensures health care services for them this way. The owner of the database of social insurance numbers is the National Health Insurance Fund (OEP).

The foundation of an independent health insurance sector did not have an impact on the system of awarding and paying out benefits. The system of sick pay was not changed, however, a couple of small modifications were made, and the vast majority of them depended on the bearing capacity of the economy. Since 1996 employers have covered one-third of the sickness benefit, and the sick leave increased up to 15 days a year. The level of sick pay became 60% or 70% of the daily average salary. Later, due to the global crisis, these values were reduced to 50% or 60%, respectively.

On 1 January 1998, the Act on compulsory health care benefits entered into force. Its fundamental principles are as follows:

- Health care services can be used to the extent justified by the patient’s medical condition, and users are entitled to equal treatments.

- Financial benefits are in proportion to the contribution to health insurance paid by the claimant.
- The state guarantees benefits.
- The health insurance management board is obliged to inform the insured about their rights and obligations, and provide them with help to enforce their rights.

According to the Act on compulsory health care benefits, cares related to *accidents* such as health care services provided due to accidents, accident sick pay and accident allowance belong to health insurance services. At the moment the pension insurance division awards and pays out accident allowance. Medicines taken and medical aids used by the insured due to deteriorated health caused either by occupation disease or works accident are free. The calculation of accident sick pay is not based on general rules, it is equal to the daily average wage.

In 1997 a package of acts was enacted in order to restructure and redefine the social insurance system. Acts No. LXXX and LXXXIII of 1997 define the scope of citizens eligible to social insurance services, private pension, the financing of the above benefits, and the benefits of mandatory health insurance. In 1999 the newly elected Parliament decided upon the supervision of the social insurance funds by a State Secretary.

Following the election in May 1998, the supervision of the National Health Insurance Fund was assumed by the Prime Minister's Office. In 1999 the supervision of the institution was transferred to the Ministry of Finance and in the year 2001 it was taken over by the Ministry of Health. Due to a merger of ministries, the supervision power is exercised on both main branches of Social Security (health and pensions) by the Ministry of Health, Social and Family Affairs, then Ministry of Health. After the elections held in April 2010, a new ministry called the Ministry of National Resources was set up in this field (liable for – inter alia-employment, social security - health, pension -, education, culture, sports).

At the moment Hungary's Health Insurance Fund is a separated monetary fund within the State Budget. The budget of this fund is approved by the Parliament usually for one calendar year. The National Health Insurance Fund (NHIF) is a separate administrative organization as well under the supervision of the competent ministry. The NHIF directs the administrative functions of the health insurance branch and controls the calculation and payment of sickness and maternity benefits.

The collection of contributions, the operation of the contribution accounts and the financial control have been the functions of the National Tax Office since January 1 1999.

In Hungary compulsory health insurance operates as an independent branch of the social security system, *based on the principle of solidarity*. In West European health care systems the principle of solidarity means that persons contribute to financing the system in proportion to their income, while the use of the services is based on the principle of access according to need.

On the basis of Act LXXX of 1997 **the insured are the following:**

- Employees, civil servants and clerks, employees of the administration of justice, professional adoptive parents, members of the armed forces including law enforcement

bodies as well as civil national security services, regardless of whether they are employed full-time or part-time.

- Members of co-operatives, excluding full-time student members of school co-operatives if they participate in the activity of the co-operative within the framework of economic enterprises.
- Apprentices on vocational training under a study contract.
- Individuals receiving income supplementing benefits, unemployment benefits, pre-pension unemployment benefits.
- Self-employed persons whose activity is not to be qualified as supplementary.

Additionally, the scope of Act LXXXIII of 1997 on mandatory **health insurance extends to the following groups of individuals:**

- The persons insured by virtue of Act LXXX of 1997 as well as individuals under a special health insurance contract.
- Persons and organizations paying social insurance contributions.
- The providers of health services on the basis of contract.

The tasks of the National Health Insurance Fund are as follow:

- Purchasing health care services for the insured.
- Directing the regional and other administrative bodies.
- Operating the health insurance branch system.
- Getting involved in the preparation of legislation.
- Preparing and implementing the interstate agreements regarding health insurance.
- Developing and operating the data base of the health insurance system.
- Collecting, processing and analyzing the statistical data of the health insurance system.

Dominant political trends in Hungary in the two years before and after accession to the European Union

2002-2006 "To Act Now and for Everyone" – Governmental program of the national centre, of the democratic coalition

Governmental program:

"The Government strives to achieve a noticeable improvement in the health status of the Hungarian population and in order to realize this aim it is going to restructure the system of health care service and finance. Change of ownership in health care, realization of financial security."

Aims to be achieved:

- the role of prevention and cure should be equal
- settlement of the issue of hospital ownership – working out of new forms of institutions and operational mechanisms
- securing additional resources for the operational costs (pay rise for health care personnel)
- reform of financing – development of a fair, equitable and efficient system maintained from public funds
- employment of patient rights representatives and proper information of citizens

European Integration of Health Insurance (1994-2004)

On 1 May 2004 Hungary became the Member State of the European Union. The European Union does not aim at introducing unified European law of health care replacing the systems of the Member States; therefore, there is no legal harmonisation. One element of the “principle of four freedoms”, which is the free movement of people, cannot be realised without health care. That is why the harmonization and coordination of the system is indispensable. The legal sources of coordination are Regulations EC 883/04 and 987/09 - applicable from 1 May 2010. At first, the new Regulation will apply only to EU citizens. The previous regulations (EEC 1408/71 and 574/72) will continue to be applicable to nationals of third countries and to nationals of Norway, Iceland, Liechtenstein and Switzerland.

On the basis of the regulations above

1. our rights obtained at home is also respected by other Member States,
2. we do not need to take out insurance again in another Member State if we are insured at home, in other words, taking out double insurance is forbidden,
3. we are not discriminated in any Member States on the basis of our nationality, and
4. we do not lose our previous insurance, because the duration of being insured is always taken into account in case of providing services.

In Hungary the National Health Insurance Fund (OEP) is responsible for giving effect to orders in the field of health care.

Use of Benefits and Settlement of Accounts

The main rule of health insurance regulations is that everyone has to be entitled to full service in their places of residence, and if someone stays in another Member State, they have to be given emergency care at least. Financial benefits (e.g. sick pay) are always awarded in accordance with rules being in force in the country of insurance. But benefits in kind are regulated by the current legislation of the place of temporary stay. Regulations cover only social security services. In other Member States tourists are entitled to emergency care necessary immediately, however, those moving to other Member States have to be given all the essential cares. Patients travelling to another Member State in order to get medical cares can use services only if their national health insurance institutes enter into a written engagement to fund the costs of the cares. On the basis of the principle of equal judgement, the National Health Insurance Fund (OEP) covers the same health care services financed by insurance institutes of other EU Member States for their citizens. At the same time, Hungarian citizens have to pay for those services for which citizens of the EU Member States also have to pay. It also applies to EU citizens visiting Hungary.

Patients do not have to give money for cares beforehand; they are also entitled to free cares for the insured of any Member State. This is the reason why patients do not have to cover those parts of expenditures of cares that are financed by insurance companies, national insurance institutes directly settle up with one another. OEP contributes to the costs of treatments provided abroad if beforehand a medical expert's opinion justifies the necessity of cares provided abroad. Depending on the type of medical treatments, the competent national institute issues the medical expert's opinion. If the professional committees of the competent national institutes agree on the necessity of the treatment received abroad, health insurance subsidises the expenditures.

Dominant political trends in Hungary in the period after accession to the European Union

2006-2010 - Reform in health care

Governmental program:

“The aim of the Government of the Republic is to increase the population’s age spent in good physical and mental health, to provide equal chances for everybody to preserve their health and to have access to the necessary, high-level health care services in case of illness. In the following four years we are going to carry out the comprehensive renewal of health care and to clarify private and public liability.”

Aims to be achieved:

- To change the attitude according to which the *state bears unlimited liability* for providing services and the *users of the service* have only *rights and obligations* (in other words they want the highest level of service in exchange for a low level of contributions). The primary responsibility – preserving health – is vested in the individual, the state has to provide the possibility of preserving and restoring it.

To accomplish health care services based on the principle of insurance and solidarity according to the 100 STEPS program announced in 2007. Objectives:

- to keep a record of and to control contribution payment
- to set up the official and professional supervision of the health insurance system
- to employ new methods in organizing work – to implement EU directives
- New Hungary program – funds for health care investments

Some – successful and less lasting⁴ – measures of the health care reform

Health Insurance Supervisory Authority

Health care is a market based on the dominance of public property, operating with insurance and service provider monopolies, with exclusive and special rights, regulated primarily in an administrative manner.

The expenditure of the Health Insurance Fund was previously not supervised by any authority on behalf of the insured persons. No regular assessments or records were made about the efficiency of curing activities in hospitals or about the proportion of complications. Hungarian health care today is characterized by uninformed and defenceless patients as well as by expenditure not supervised sufficiently enough from financial or professional aspects. The service and insurance systems are not fair or accountable, and the quality of services varies greatly. Patients are not familiar with the quality or professional indexes of the service providers, which adds to their defenceless situation and uncertainty, at the same time making way for the black market of health care, for gratitude payment.

At present institutions which do not satisfy quality requirements and treat patients under humiliating circumstances are financed in the same way as the ones providing high quality care because in the effective legal framework – with reference to the above reason – it is impossible to withdraw financing.

The Act on Supervision set up a new, independent authority with the important role of providing information and supervision. In accordance with this, the Supervisory Authority,

⁴ They were not integrated into the system in the given period, under the given circumstances.

run as an office, supervises the lawful operation of the entire service providing system and the waiting lists. As such, it is the highest level organization for protecting the patients (and the insured).

It started its operation on 1 January 2007. At the start, its primary task was to protect the patients' rights (and to inform them). In the years 2007-2009 more than 5,000 complaints were investigated, hundreds of procedures were started and several penalties of national importance were imposed.

The new government elected to office in 2010 abolished the Authority.

Visit fee, hospital daily fee – antecedents and purposes of the introduction of co-payment

In Hungary the number of physician-patient contacts is unnecessarily high. Patients are under the false sense of health care being free of charge, they do not realize that they buy a health care service and they accept the unprincipled and unfair custom of gratitude payment. The unnecessary use of services imposes great burdens on the Health Insurance Fund for several reasons. On the one hand, the maintenance and improvement of the safety and quality of care becomes more difficult as the unnecessary examinations reduce the available capacity and the time to be spent with real patients. On the other hand, each physician-patient contact involves costs itself, which is to be met by the Health Insurance Fund operating from the contributions paid by the insured and by their employers. Besides financing the care, the subsidy of the medicines prescribed during unnecessary care represents an even greater burden for the Fund. For these reasons, co-payment in health care was introduced in Hungary, similarly to two-thirds of the European countries. Based on foreign experiences, the introduction of the visit fee and hospital daily fee was hoped to turn the insured persons into cost-conscious service buyers and to strengthen individual responsibility, and thereby to make the use of health care services more reasonable and to greatly contribute to fighting against gratitude payment.

The wide social protection net practically excluded the possibility that the introduced co-payments would keep the really needy away from receiving the care. Exemptions from co-payment are the following:

Material exemption – that is services for the use of which co-payment is not necessary:

- certain *emergency* services
- *compulsory epidemiological measures*
- *health care services in situations of catastrophe*
- *screening examinations for public health purposes* (e.g. mammography or gynaecological cytological screenings)
- *pre-natal care*
- *chronic medical treatment*

For example: causal and symptomatic treatment of patients suffering from malignant tumours, treatment of renal patients and diabetic patients, persons waiting for organ and tissue transplant, care for patients after transplantation, treatment of AIDS.

- examinations related to *donating blood*.

Subjective exemption – that is persons who do not have to pay:

For example:

- children and adolescents *under 18 years of age* at the time of using the service
- *homeless people*
- *detained persons*
- the socially needy

As a result of the introduction of co-payment, the patient workload of general practitioners decreased by about 20 % - they received approximately HUF 150,000 – 200,000 in the form of visit fee every month. The decrease in outpatient care was about 6-10 %. The loss in days of care provided in inpatient institutions came to 200,000 per month, which was offset by the revenue of about HUF 5-10 million per institution.

This sum was retained by the service providers, and the quantity of medicines used also decreased. The Health Insurance Fund made considerable savings.

In the end, the introduction of the two forms of co-payment in February 2007 did not confirm previous worries: the Hungarian society accommodated itself to the new system in a disciplined manner. Needless to say, it was not a popular measure, but as a matter of fact it never entailed serious problems. The visit fee and the hospital daily fee were actually accepted by the profession, no professional organization raised significant objections during the consultations. The greatest problem was the high cost of introduction (e.g. a person had to be employed specifically to collect the fee).

Co-payment, in addition to its workload-decreasing and financial effects, also contributed to shaping attitude – probably this would have been the most important of all. It symbolized individual responsibility and shed light on the huge sums of money involved in health care. These could have resulted in visit fee / hospital daily fee assuming a major role in the fight against gratitude payment.

They were abolished as from 1 April, 2008⁵.

Transformation of hospital structure (capacities)

Firstly, Hungarian hospitals were arranged in a new structure; secondly, steps were taken towards organizing progressive care; and thirdly, the unnecessary, **unused** capacities of the system were decreased.

Logically, the reduction in the number of beds should have been followed by the reduction in the number of institutions – however, the political intention to this end was not strong enough. Thus only three institutions maintained by the state were closed; some others were “merged” into other institutions and active inpatient care was removed from the profile of several institutions, thereby transforming them into institutions providing chronic care.

The restructuring necessarily resulted in the transformation of tasks, thus income loss suffered in this way was compensated for by increasing the basic fees of financing. Financing conditions improved for 60 % of hospitals, remained approximately the same for 15 % while they decreased in proportion to the expected performance for 25 %.

The above described transformation of hospitals was expected to bring about significant mobility in the **human resources of the sector**, too. According to previous estimations, approximately 1,000-1,500 physicians and 3,000 specialist workers would have had to find new employment. The ministry worked out the Mobility Program to help this process, it was

⁵ A referendum was initiated by the opposition and held on 9 March 2008, in which more than 4 million (50.5 %) voters took part. 3.39 (84.1 %) million and 3.32 (82.4 %) million voted for the abolition of the hospital daily fee and the visit fee, respectively.

primarily meant to help those who would have been willing to move to far places (typically to areas without sufficient care) in exchange for considerable financial support.

However, the profession resisted “to the very end”, the institutions were not willing or were reluctant to make the necessary workforce reduction. Thus the previously expected mobility failed to take place and the supporting Program withered away in the absence of interest.

At the same time, health care struggles with the significant shortage of professionals. The following questions, which could solve the present anomaly, remain unanswered:

- What does the greater number of doctors available for carrying out fewer tasks do, why do they not find employment in institutions lacking in doctors?
- To what extent can the obvious immobility of human resources contribute to the potential indebtedness of a hospital?

The **waiting lists** were introduced.

They would help the organization of care by showing what is lacking or is in excess and where. They could make the service fairer by excluding (reducing) the possibility that patients can be ranked higher in the lists in exchange for money (typically gratitude payment). It is not a coincidence that although no serious objections were raised against waiting lists, their use was practically sabotaged by the profession.

The extremely long period of waiting (measured in years), the enforcement (or to be more precise the lack) of patient rights, the relationship between the technical questions of financing and the analysis of possible solutions could form the subject of a separate study.

Introduction of the supervision of **insurance legal relationship**: in 2007 1 million people used the services on grounds which were not clarified.

At the end of the year the number of unsettled legal relationships came to about 200 thousand. Thus the general, compulsory checking of legal relationship could be introduced, this is carried out each time a patient visits a health care provider. It is very important to emphasize that patients cannot leave untreated even in the case of an unsettled legal relationship.

Governmental program - nowadays

2010 - “The Program of National Cooperation”

Necessity and background of the implementation of the aims set:

“During the past eight years, in spite of their reform rhetoric, the governments treated health care adversely. The effects on economic policy led to health care suffering a loss of resources. As a result, the burdens on patients increased and long waiting lists were drawn up. The great majority of hospitals became severely indebted.”

Aims to be achieved:

To determine the health care needs of geographical areas and the number of hospital beds financed from public funds accordingly. To assess the outstanding total debt of hospitals and to develop alternatives for their management.

To introduce simple, predictable and calculable financing. In the field of health insurance:

- to increase the controlling role of the insurance fund
- to develop a patient- and service provider-friendly social insurance system - with the maintenance of a unified insurance system based on the principle of solidarity and national risk sharing.

Finance in the Hungarian Health Insurance System

The National Health Insurance Fund is operating with the guarantee of the State. The Fund's principal source of revenue is made up by health insurance contributions. Health insurance contribution⁶ constitutes 8% of the payroll expenses, 2% paid by the employer, 6 % by the employee. The self-employed – whose activity qualifies as supplementary – and people who do not belong to the insured pay an additional flat rate health contribution of HUF 4950/person/month. Estimating the overall amount and share of the various sources is difficult. The magnitude of gratuity is unknown. Government revenue is composed of central, local and general sources. The National Health Insurance Fund is the main source of health care financing. The fund defrays the recurring costs of services, while maintenance costs are funded from the central and local governments' budgets. Local governments have their share of responsibility due to ownership, while the country's government provides earmarked and target subsidies. Private health insurance does not exist in Hungary. However, there are a limited number of private providers.

On the financing of curative-preventive care services in general

Since 1996 every Hungarian citizen living in Hungary is entitled to health care benefits in kind provided by compulsory health insurance to the extent justified by their medical condition. Practically all health care services from preventive care to rehabilitation services are part of the insurance system, within the limits listed in Act 1997 on the benefits of compulsory health insurance.

In Hungary the health care system is financed predominantly from public funds and to a smaller extent from private funds, their proportion more or less corresponds to the proportions seen in developed countries, and the proportion of state expenditure is among the lowest ones in the countries of Central Eastern Europe. The greatest part of public funds is constituted by the health insurance contribution paid by employers and employees.

Health care services

Primary care

The system of district doctors dating back to more than four decades was transformed into a system of general practitioners (family doctors) in 1992. This meant the introduction of the free choice of doctors in primary care. General practitioners competing for patients aim to provide definitive care, which reinforces the gatekeeper role of primary care. The vast majority of primary care practices (93.6 %) is under the obligation to provide territorial care: this means that the general practitioner is obliged to treat the inhabitants in his/her district. However, practices without the obligation of providing territorial care also exist or can be established. The condition for this is that the physician, who otherwise satisfies the requirements of working as a general practitioner, should have a practice including at least 200 persons⁷. Since 1992 general practitioners have had the possibility to carry out their medical activity not as public employees but as entrepreneurs.

⁶ Table 1

⁷ At least 200 persons qualifying as insured or their legal representative make a written statement that they want to choose him/her to be their general practitioner.

Between 1998 and 2002 the “right of practice”⁸ was introduced in primary care, which made it possible for participants of primary care (general practitioners, dentists) to transform the right of operation into a right of assets, thus making it marketable on certain professional conditions. Consequently, by 2003 the proportion of family doctors working as entrepreneurs was as high as 91.6 %.

Outpatient specialist care

One of the major, permanent objectives of health care reform processes is to lessen the flow of patients to hospitals by providing complete care partly in primary care and even more so in outpatient specialist care. However, outpatient specialist care is increasingly connected to inpatient specialist care, outpatient clinics are mainly operated by hospitals.

Inpatient specialist care

There are three levels of inpatient care in Hungary. The lowest level of hospital care includes municipal hospitals with basic departments, to which everybody can have access within 25-30 km of their place of residence. The next level consists of county hospitals which, together with several hospitals in Budapest, also operate as regional centres for selected disciplines. The national institutes and university clinical departments have both regional and national competences. The national institutes of health are responsible for curative, methodological and health policy tasks. The national institutes of health and university clinical departments are the top institutions of progressive care in their respective fields.

The main structural problem of the Hungarian health care system lies in its being hospital-centred: care is provided on the highest and most expensive level of service too frequently and in many cases unnecessarily – instead of and so to say bypassing primary care and/or outpatient specialist care.

Hospitals are owned by the local governments in the first place and by the state in the second place. The ministry of health exercises the right of ownership over clinical departments and national institutes on behalf of the state, so they can be regarded to be in quasi state ownership. In addition, there are church-owned hospitals and hospitals operated by foundations, too.

The current expenses of hospitals are financed by the National Health Insurance Fund (OEP) (which still does not cover amortization), while the owners (first of all local governments) meet capital costs.

⁸ Right of practice = right of operation. It is a licence of operation of a specific practice, giving authorization to participate in publicly funded primary care.