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The Recovery of Hungarian Healthcare

Economic Context

After election victory in the spring of 2010, the Orbán administration took over the governance of Hungary in adverse circumstances. The economic crisis in the world had only slightly abated and the economy of the European Union was also hit hard, shown in bad economic indicators of some euro zone countries. Naturally, Hungary could not be exempt from outside influences and strict measures had to be taken to meet the convergence conditions necessary for joining the euro zone in the future.

The planned budget deficit in 2010 was 3.8 percent and in 2011 it is 3.0 percent. This must be achieved in an economy that is still stagnant and starts to grow very slowly, and unemployment is relatively high. Despite all this, Hungary is in a favourable economic situation compared to several euro zone countries.

The healthcare system cannot be independent of the economic situation. All actors of healthcare feel that the time is ripe for a thorough reconstruction of the system, while keeping basic values preserved. Such basic values are solidarity and autonomy.

Demography and Health Status

We would like to introduce the healthcare situation of Hungary with some data and indicators. One significant problem in the country is the decline of the population, as a consequence of an excess of the number of deaths compared to the number of births. Natural decrease of the population was between 3-4 per thousand inhabitants per year in the last decade. The population is ageing – the proportion of inhabitants aged 65 years and over was 16.5 percent in 2010.
Despite improving tendency compared to the European Union average, life expectancy of the population at birth is still low: In 2009 it was 70.05 for men and 77.89 for women (8 and 5.6 years below EU average).

Unfortunately, with some diseases – neoplasms, diseases of the circulatory system, external causes, suicide – the number of potential years of life lost is quite high.

The functioning of the healthcare system is further aggravated by the ageing of health workers. Fewer and fewer people choose healthcare as a vocation, which is especially true for nursing professionals. Brain drain - particularly the migration of young doctors - is a problem to be addressed by all means. Problems to be solved are the financing situation of healthcare institutions, the elimination of debts, and on longer term the incorporation of depreciation in the financial system. Territorial inequalities in care must also be remedied.

After the general elections, the new government policy established a new system of administration. The sectors that involve human resources are concentrated in one department, the Ministry of National Resources led by professor Miklós Réthelyi. This ministry integrates the governance of healthcare, social affairs, culture, education and sport, each with a state secretariat. The head of the Secretariat of State for Healthcare is Miklós Szócska, who is at the same time the director of the Health Services Management Training Centre at Semmelweis University.

It is expected that with the new structure the state secretariats will become a united force for better utilising resources instead of competing with one another. One example of this effort may be the harmonisation of the activity of services that operate on the border of health and social care.

The Healthcare Delivery System

Primary care in Hungary is based on private GPs (who people can freely chose) and a well-developed district nursing system. GPs work in solo practice, the premises are principally public. In 2009, there were altogether 6,752 GP services in the country. One GP or pediatric GP covers about 1,500 inhabitants.

Outpatient specialist services are mostly provided by polyclinics, mainly owned by local governments, though CT-MRI, dialysis and home care have significant share of private ownership. In 2009, the number of outpatient care institutes was 419.

In 2010, 177 publicly financed institutions were in operation in inpatient care. Of these institutions 142 had acute care or acute and long-term care, and 35 had only long-term or rehabilitation care. The total number of operating hospital beds in 2009 was 70,992 or 707 per 100 thousand population.

Local governments are the main owners of hospitals owning 66 percent of the institutions. This rate is 72 percent in acute care institutions and

40 percent in institutions providing only long-term care. The majority of institutions (57 percent) providing only long-term care are owned by churches or foundations, generally they are facilities with a small number of beds. On the basis of acute and longterm bed numbers, public or local government ownership is predominant (97 percent).

In the first half of 2010, more than half of inpatient care institutions (55 percent) operated as public institutions. The proportion of public institutions owned by local governments tends to decrease, and more and more of them are transformed into commercial companies, mostly non-profit limited liability companies with local government ownership. In 2010, nearly one third of local government-owned institutions operated as commercial companies.

Health System Financing

The total expenditure on health was 7.3 percent of gross domestic product in 2008. 71 percent of the expenditure was public and 29 percent was private. Private health expenditure is dominated by out-of-pocket payments (for prescribed and over-the-counter medicines, medical devices, informal payment, etc).

The sources of public health expenditure are mainly health insurance contributions, normative funding from the central budget to the Health Insurance Fund (HIF) – chiefly for pensioners and the young – and local taxes. In 2010, the share of contributions and central government expenditures in the national pool, the Health Insurance Fund was 50 percent and 45 percent, respectively. In 2010, the Health Insurance Fund with a revenue of HUF 1385 billion closed the year with the expenditure of HUF 1477 billion, thus with a deficit of HUF 92 billion. Little over four-fifths of its expenditure (82 percent) was allocated to the cost of in-kind benefits of health insurance (54 percent of the expenditure were allocated to curative-preventive services, 24 percent to pharmaceutical costs) and 15 percent to cash benefits.

The operational expenditures of healthcare providers are covered by health insurance on a contractual basis with the National Health Insurance Fund Administration. GPs are financed mainly by capitation. There is an additional fixed payment for GPs, depending on the location of practices and on the size of the district (where the practice is). Payment incentives for GPs has been introduced in 2010 based on clinical quality indicators. Outpatient clinics are reimbursed by a German-type point system, acute inpatient providers receive DRG payments, while long-term care is financed on a weighted day basis. From 2004, performance volume limit controlled costs in inpatient and outpatient care, it was tightened in 2006 and loosened again in 2010. Depreciation and investment costs are financed by owners and by EU funds.

Current and Future Developments

The newly formed Secretariat of State for Healthcare launched into vigorous action and its activity is characterised by an effort to reconcile interests and seek compromise. Among its measures it can be emphasised that at the end of 2010 the health sector received significant surplus funds and their distribution had taken place by means of harmonisation with legitimate interest groups. These surplus funds allowed for the reduction of accumulated debts and the relief of health policy tensions.

The new government aims to reach the EU average in public health expenditure, reduce the proportion of private health expenditure, and rearrange its structure.

The formulation of the career path model of health workers was also launched. There are serious professional discussions taking place with resident doctors about their future. The system of membership in medical associations has been newly regulated. Membership in the Hungarian Medical Chamber, as well as in all other chambers of health professionals will be mandatory again (it was abolished in 2007). The tasks, structure and the funding of investment costs of new healthcare institutions constructed from EU resources have been reconsidered.

The legal situation concerning pharmaceutical policy and drug prescription has been modified. Up until 2010, physicians whose prescription practice widely differed from the average were obliged to follow a special training on the subject. From 2011 on, penalties will be replaced by rewards, and physicians who keep in sight efficiency in the use of the pharmaceutical fund will be rewarded by the Health Insurance Fund.

There was a change in the system of supervision of providers. The structure of public administration meshes with the system of government offices established on 1 January 2011. The government offices – in Budapest and in the 19 counties – integrate territorially organised administration authorities, among them the Regional Health Insurance Institutions and the regional institutions of the National Public Health and Medical Officer Service. The newly opened 29 customer service bureaus of the government offices are the first step to a singlewindow administration system for official issues related to the state. Parallel to this, the New Széchenyi Plan was worked out, which will hopefully stimulate the economy of the whole country. One important chapter of the plan is called Recovering Hungary, which at last recognises the importance of the healthcare industry and will hopefully give momentum to health and medical tourism.

The main elements of the sectoral strategy are drafted in the discussion paper "Revived healthcare, recovering Hungary – Semmelweis Plan to save healthcare". According to the plan, among other things, the vertical and horizontal integration of the work of healthcare institutions will start and in a short time patient pathways will be reregulated. The whole process of restructuring is governed by two guiding principles: The solidarity principle is to be preserved and the savings made in the system should stay within healthcare. It is also an important principle that no healthcare institution will be terminated, at most its function will change. The basis of the organisation of healthcare services will be the "supraterritorial" level, which is larger than the county, but smaller than the region.

The government makes efforts to ameliorate psychiatric care, which became worse after the closing of the National Institute of Psychiatry and Neurology in 2007. In the near future a new institution will be opened. The health policy leaders are negotiating with the professional leaders of psychiatry, addictology, neurology on the profile of a new national institute.
The workers of healthcare institutions support the government's endeavour for change in the hope that a new healthcare system will come about

that meets the expectation of 21st century Europe and will be trusted by everyone.

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Figure 1. Population by sex, age marital status, 1 January 2010

Figure 2. Life expectancy at birth by sex, 1950-2009

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