The Hungarian health care reform aims to establish a health care system that provides equitable access to services of high quality, and whose operation can be sustained in the long run as well. Edited by the National Institute for Strategic Health Research, the Health System Scan newsletter deals with the most important changes of Hungarian health care and health policy, including legislation, reforms, and their outcomes. This is the first issue of our newsletter, which will be published every six months. In this first issue we give a general overview about the Hungarian health care reform and its economic background from the change of the regime in 1990.

Macroeconomic review

In 1989-90, Hungary went through a political and economic change of the system, when the country - despite the communist reform process in the late 1980s - suddenly became a capitalist democracy. The first few years were spent dealing with this socioeconomic transformation shock: industries - and workplaces - disappeared, socialist markets collapsed, thus the economy witnessed recession together with a soaring inflation rate (Figure 1). On one hand, the structural change of the economy was substantial by 1994, the public sector's contribution to the economy dropped from 76% in 1990 to 39.6% in 1994, markets and prices were liberalized, freedom of entrepreneurship was established; in short, the framework for a market economy was created. On the other hand, the...
governance, management, role, and the scope of responsibilities of the public sector basically remained unchanged, the paternalist structure still prevailed. The latter also contributed to the increasingly import-funded growth of consumption. As a consequence, in 1994-95, the country was on the edge of financial bankruptcy, so in 1995 a stabilization program labelled the “Bokros-package” was introduced to deal with the situation. It started aching reforms in the field of social transfers - cash transfers in particular -, education and taxes, backed up by a strict, depreciation-oriented monetary policy primarily to enhance international competitiveness. During these years the population suffered from declining wages and even growing inflation, but the measures eventually succeeded in stabilizing the economy for the next few years (Figure 2).

In 1998, the new government temporarily tightened fiscal policy after the loose years before the elections, but gave the control away again in 2001-2002 (Figure 3). It also favoured internal growth over external, which brought more wealth to people, but proved to be unsustainable in the middle run. The new government in 2002 continued this popularity-oriented policy - though with more emphasis on export markets -, which resulted in the ongoing reform wave after the 2006 elections.

Health financing showed a rather similar pattern. The GDP share of health expenditures peaked in 1994, declined or stagnated until 2001 when it started to grow again (Figure 4). In the meantime financing slightly shifted towards private sources, especially out-of-pocket payments, but the basic structure remained the same. After 2002, the Health Insurance Fund produced huge deficits as a result of soaring expenditures on the one side and reduction of itemized health contributions and the subsidy revenues from the government on the other (Figure 5). This situation is going to change in 2006 as the government makes substantial and planned contributions after young people, pensioners, social benefit-receivers and other non-paying entitled persons. Consequently, the deficit of the Fund is expected to be around HUF 140 billion in 2006 compared to HUF 375 billion in 2005.

One persistent structural problem of the Hungarian economy is its labour market. The activity rate dropped significantly in the early 1990s as the working-aged escaped to inactivity (disability pensions, early retirement, housekeeping, etc.) from the peril of
The Hungarian health care system

In Hungary the institution of social insurance remained formally in place during the communist era as well, which concerned financial provisions (sickness benefit) and financed social expenses (pensions, family support). The problems of the communist system accumulated strongly before the change of the regime. To solve these difficulties, it was suggested that the system should revert to the pre-WW II. insurance traditions, complemented with social insurance financing. In 1989, the financing of the operational costs of health care became the responsibility of social insurance, whereas the financing of certain social tasks (family allowance) was taken over by the state budget. In 1992, the social insurance fund was divided into a pension fund and a health insurance fund with separate administrations.

At first, several social groups were exempted from paying health insurance contribution, but these exemptions were gradually tightened. At that time, the management of exemptions was not supported by an adequate informatics background either. Since 1996, every Hungarian citizen is insured and has the right to access all levels of health care from prevention to rehabilitation services. According to the Health Care Services of Compulsory Health Insurance Act (1997), non-curative health care services and those with professionally unproven efficacy and some others (e.g. cosmetic surgery) cannot be utilized in the framework of health insurance. Part of the curative medical services (e.g. compulsory vaccinations, occupational health care, prenatal care, family planning, highly cost-intensive services) are financed from outside of the health insurance.

Targeted subsidies, largely EU and private funded modernization of public services and citizens who pay their taxes. The Programme distinguishes between two stages. In the first, between 2006 and 2009, macroeconomic stabilization is priority, with relatively low (2-3%) economic growth and declining incomes. This should be the basis of the sustainable growth path of the second period, in 2009-2011. Throughout these years reforms will be carried out in the fields of public administration, health care, education, pension and price subsidy systems. Staff reduction and organizational change will take - and in the central government, has already taken - place in public administration; pension reform will tighten the rules of eligibility for certain benefits, including disability pensions and early retirement; structural and financial reforms will follow in public education to promote effectiveness and equality, while in higher education the adoption of the Bologna process will continue, and a tuition fee system will be introduced everywhere. On the revenue side, most of the measures have already been put into action: the preferential VAT rate, the health contribution rate, and the simplified tax rate were all raised as of September 2006, while other changes are aiming at broadening the tax base. Partly as a result of the above reforms, the Programme also sees increasing productivity and growing activity and employment rates in the upcoming years.

unemployment. This induced an unsustainably low employment rate: 56.9% compared to the EU-15’s 65.2 in 2005. The gap is much more apparent and warning among older workers: the employment rate of 55 to 64- year-olds is 33% in Hungary, while 44% in the EU-15. Beside the labour market, the other often recited burden on the Hungarian economy is that despite continuous reforms in every sector of the economy, the comprehensive reforms of the major redistribution systems - except for the pension system - are yet to be started. That is why the new Convergence Programme of Hungary, submitted to the European Commission in September 2006, aims to move in that direction. It envisages employment-oriented and well

Figure 5. Health Insurance Fund finances

- Nominal GDP (left scale)
- HIF expenditures (right scale)
- HIF revenues (right scale)

Source: Central Statistical Office, ESKI National Institute for Strategic Health Research
The most important operational principle of the health care system is solidarity, which means that the insured pay income-proportionate, rather than risk-proportionate, contribution fees. The National Health Insurance Fund is supervised by the Government through the Minister of Health. Between 1989-2000, the Parliament enacted a separate law for the budget and appropriation accounts of the financial funds of health insurance. Since 2001, it is arranged within the framework of the country's budget and appropriation accounts. The current (operating) expenses are covered from the National Health Insurance Fund, while capital expenditure (refurbishment, development, etc.) is covered by the owners (local governments and the state through various public administration agencies, e.g. ministries). The majority of health expenses are public expenses. The Health Act determines the main operating rules of health care. It concerns all health service providers and health activities in the territory of Hungary, defines the rights and obligations of patients and health care employees, and the state's responsibility for the health status of the population, the system of health services, the professional requirements of the services, and the organisational and management system in the health sector. According to the Local Governments Act (enacted in 1990), local governments are obliged to provide primary health care services for the local population, while county governments are responsible for specialist health care services. For local governments, provision of outpatient health care services is only an optional responsibility. The health sector is a diverse system and has several stakeholders including local governments, who are the primary owners of health care institutions (e.g. 75% of hospital beds are in the ownership of local governments), the state, which is a regulator and owner at the same time (22.1% of hospital beds are in state ownership), a licensing and supervisory authority operated by the state: the National Public Health and Medical Officer's Service, and the National Health Insurance Fund.

Health care delivery system
Primary care services are delivered by family practitioners, who are predominantly entrepreneurs (Figure 6). They can be chosen freely and their remuneration depends on the number of patients on their lists. Outpatient specialist care has two types: general and more specialised outpatient care. General outpatient care must be provided for patients near their place of residence. In the framework of general outpatient care, the patient receives single or occasional specialist health care, involving continuous specialist care in the case of chronic diseases not requiring inpatient care. Special outpatient care is organised for the treatment of diseases that require special expertise or special financial, material and professional skills (special diagnostic background). Financing outpatient care is based on the German point system. Home care, which involves skilled nursing care by the physician's order in the patient's home or place of residence, has been financed by the National Health Insurance Fund since 1996. The objective is to develop this type of health care further, in order to replace much more expensive hospital care. There are three levels of inpatient care in Hungary. The lowest level of hospital care includes municipal hospitals with basic departments. The next level consists of county hospitals which, together with several Budapest hospitals, 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 tertiary care facilities in their special areas. Regarding patient pathways, inpatient services in practice are not carried out according to the above hierarchical structure. Hospitals are financed according to their performance, based on the DRG-system, with performance volume limitation.

Figure 6. Acute care hospital beds and GPs per 100,000 population, 2003 (Hungary=100%)

Source: WHO HFA Database 06/2006
Health care reforms

In the past 15 years, several reforms were carried out in the Hungarian health care system, which has fundamentally changed the former communist type health care system. The major measures after the change of regime are the following:
- 1992 Health Insurance Act
- 1992 Introduction of the family practitioner system
- 1993 Introduction of the performance-based payment system for hospitals
- 1993 Act on voluntary health funds

Major new laws were enacted between 1994 and 1998, such as the new Health Act (1996) and new acts to regulate the social insurance system (1997). With the enactment of the obligation to provide health care and the regional financing normatives, the activity of capacity regulation has started. Professional preparations began for the introduction of GP fund holding and Managed Care systems, which started as a pilot project in 1999.

An essential event of the period 1998-2002 was the announcement of the National Health Programme. In this period the institution of the “right of practice” was introduced in primary care, which transformed the right of operation into a right of assets, thus making the “right of practice” on certain professional conditions marketable.

In order to promote the health status of the population, in 2003, the multidisciplinary and intersectoral National Public Health Programme was passed by the Parliament with the following main goals:
- Creating a Health Promoting Social Environment
- Programmes of Healthy Lifestyles, Reducing Risk Factors to Human Health
- Preventing Avoidable Mortality, Morbidity and Disability
- Strengthening the Institutional System of Healthcare and Public Health to Improve Health.

In 2004-2005 the Regional Health Councils were established, with the main task of preparing regional health care development plans.

In spite of the reforms, the Hungarian health care is still facing problems:
- The ageing of the population imposes a huge burden on the Hungarian health care system.
- The health status of the population is worse and life expectancy is lower than the EU-average. The mortality structure is also less favourable than in the Western European states (Figure 7, 8).
- The attitude of the population is not adequate: health is not a determining value for the individual and the community.
- The structure of the health care delivery system is distorted; it does not satisfactorily reflect the needs, the technological environment, and the demands.
- Injustices in access to health care raise further problems:
  - geographical inequalities (Figure 9),
  - the relative isolation of social groups (including exclusion as a consequence of more and more widespread informal payments),

![Figure 7. Average life expectancy at birth by gender, 1950-2005](image)

Source: Hungary: Central Statistical Office (KSH) (Demographical yearbooks and Stadat), EU-average: WHO Health For All Database
- inequalities in chances of certain diseases,
- injustices in the distribution of resources (which reflects the structure, not the needs),
- inadequate efficiency.

- The resources and the regulation do not follow the growth of needs and demands.
- Distorted interest relations, including informal payments, which are uncontrollable and impose unjust burden on patients, and hinder the structural and financing transformations in the health care system in general.
- As a result of financing conditions and structural disproportionalities, the inner deficit is growing: the infrastructure is out-of-date, the wage gap is increasing.

- Inequalities and lack of regulation in the quality of care.
- The conditions and culture of health care are lagging more and more apparently behind the developmental stage of the country.
- The costs borne by the population (the share taken by households in financing) is still rather high: at the same time, financing is inefficient and it is not associated with adequate consumer protection.
- The potentials of info-communication systems are under-utilised.

- Consumer protection and the enforcement of patient rights are of low standard.
- The growth of needs and demands derives from the rise in life expectancy, technological development, and the expansion of public expectations. Under the new

**Figure 8. Excess mortality of Hungarian men and women in percentage of the EU-15 average, 2003**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumours</td>
<td>320</td>
<td>694</td>
</tr>
<tr>
<td>External causes</td>
<td>240</td>
<td>168</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>182</td>
<td>182</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>110</td>
<td>110</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

**Figure 9. Regional inequalities Percentage deviation from the national average, 2004**

- Southern Great Plain
  - NORTHERN HUNGARY: -4.4
  - CENTRAL HUNGARY: -9.4
  - SOUTHERN HUNGARY: -9.1
  - CENTRAL TRANS DANUBIA: -5.1
  - WESTERN TRANS DANUBIA: 2.7

- Northern Great Plain
  - NORTHERN HUNGARY: -10.7
  - CENTRAL HUNGARY: -9.1
  - SOUTHERN HUNGARY: -9.1
  - CENTRAL TRANS DANUBIA: -5.1
  - WESTERN TRANS DANUBIA: 2.7

- Central Hungary
  - NORTHERN HUNGARY: -9.4
  - CENTRAL HUNGARY: -4.4
  - SOUTHERN HUNGARY: -4.4
  - CENTRAL TRANS DANUBIA: 2.7
  - WESTERN TRANS DANUBIA: 2.7

**Source:** WHO HFA MDB
circumstances, the technological development of prevention and medical treatment offers such high-cost and large-volume therapies that cannot be maintained in the framework of the current health care delivery system and with the present financial background.

The proclaimed basic principles of the system - solidarity, equity, gratuitousness - do not suitably prevail. In part, this is the consequence of the obsolescence of the contribution payment (and registration) system and the inequality in access to health care, and the vastly widespread system of informal payments, which is against all legal interests. According to data of the Central Statistical Office, the estimated sum of informal payments amounted to HUF 40.6 billion in 2002.

The change of needs, demands and technologies, together with the injustices in health care, require the comprehensive transformation of the financing (health insurance) system and of the structure and capabilities, and also of public expectations towards, the health care system.

In Hungarian health care, equality before the law and the good principles of operation are reduced to formality. The system is becoming more and more wasteful: its tendency is constantly declining, which the patients have come to disapprove of, too.

structure. According to the government's proposal, emergency and „common” cases should be attended to in the framework of outpatient care as much as possible, while more serious and expensive interventions should be restricted to hospitals where all necessary conditions exist.

The government advocates that a co-payment system should be introduced similar to other EU countries to eliminate informal payments and reduce unjustified utilisation of the health care system. The patients will pay a user fee for health care services, but screening would still be free in the future too, and in some cases exemptions from paying user charges would be possible.

The government aims at stopping the growing burden of drugs by making the whole system of pharmaceutical prices and price subsidies transparent and continuing the generic programme. The administration also wishes to change doctors' prescribing practices. The government proposes steps to liberalize the establishment of pharmacies and the general retail availability of OTC products.

After finishing public discussion, the Government accepted the conception of the first steps of the reform, and the Ministry of Health prepared the first reform acts that aim at transforming the health care system.
Reform legislation

1. Act on the safe and economical supply and distribution of medicines and medical appliances

The new Act aims at creating safe and easily predictable circumstances and financial stability to all the actors and consumers of the pharmaceutical market instead of preserving an uncontrollable situation based on casual bargains and the explosive rise of costs affecting social insurance and the insured alike.

In the future, manufacturers of pharmaceuticals will have to bear greater responsibility in controlling pharmaceutical costs: they will be obliged to pay a rebate based upon their turnover. Exceeding the pharmaceutical budget will result in financial risk sharing between the insurer and the manufacturers. To secure an effective and efficient distribution of drugs, manufacturers’ promotion will be controlled by stricter regulation on advertisements and medical visitor activities.

Prescribing physicians will also take part in risk sharing. In order to practice quality and efficient prescribing, GPs and specialists are required to use software accredited by the insurer. If they regularly do not comply with the rules of quality and efficient prescribing a certain amount will be charged against their, or their institution’s income.

Regulations on the inclusion and subsidization of drugs are changing (introduction of regular fixing of prices based on the reference price, facilitating the inclusion of inexpensive generics, making controlling procedures stricter, etc.).

The gratuitousness of pharmaceuticals will be abolished (except for citizens on public welfare) and patients will be charged in all cases for all medicine financed by social insurance. The minimum charge for pharmaceutical preparations will be HUF 300. Every patient will have to consider that choosing the more expensive medicine of those of identical efficacy will bring about extra charges.

Access to medicines is facilitated by the following provisions of the law:

- Lifting of population and proximity based restrictions for the opening of new retail outlets if the pharmacy provides extra services (e.g. round the clock opening hours, extended opening hours, permanent duty, etc.)
- Establishment of the right of sale of some OTC medications outside pharmacies
- Returning of the authorisation of „Personal right”

2. Act on professional associations operating in health care

The recently enacted Act aims at re-regulating the function of professional associations (chambers) operating in healthcare and providing a unified framework for the entitlement to establish associations by persons employed in health care with appropriate qualification. According to the government intention this new Act re-regulates the professional association system so as to help to direct its activities toward the original goals: representation of the general interests of healthcare workers and promotion of continuing education, giving larger scope to self-regulation and self-government based on voluntary membership.

In the future, the professional chambers will be organized voluntarily. The three designated chambers (Chamber of Hungarian Doctors, Chamber of Hungarian Pharmacists, Chamber of Hungarian Health Workers) remain public bodies, but their public tasks will reduce and the state will not intervene in the formulation of their inner structure.

Beside the chambers of public body, other professional chambers can also be organised on a voluntary basis.

In case of a suspicion of ethical misdemeanor, the professional association conducts ethical proceedings. They must be completed within 30 days. Ethical penalties can be as follows: warning, censure, fine, suspension of membership, expulsion.

The Minister of Health exercises legal control over the operation of professional chambers.
3. Act on the reform-related amendment of certain laws concerning health care (regulating co-payment in health care, insurance benefit packages, waiting lists)

Co-payment in health care

By introducing token fees for treatment, the new Act intends to symbolise that health care is not free of charge. Paying fees makes the system transparent, and helps to constrain gratuity payments.

Amounts of fees:
- The visit fee per day is HUF 300 for primary care, paediatric care, dental care and outpatient specialist care.
- An amount of HUF 300 is charged in inpatient institutes for each day of care.
- There is a HUF 6000 limit of payment for each level of care.
- Visit fees must be paid no more than 20 times a year, daily fees must be paid for up to 20 days of hospital care.

Increased visit fees apply when the patient chooses a different treatment path, or a certain proportion is to be paid if the patient:
- Chooses to use services in other than their designated medical office (HUF 600).
- Uses services of other than their chosen primary care physician unless for emergency care (HUF 600).
- Uses on-duty services for no justifiable reason (HUF 1000).
- Uses outpatient specialist services without referral, or uses services outside the institute named in the referral (HUF 600).

Exemption from fees is granted to:
- Users of services associated with state responsibilities like disaster relief, compulsory public health services, screening in defined areas, pregnancy care, care for mothers with infants, obstetric services,
- Children under 18 years of age,
- Emergency services,
- Patients receiving long-term treatment (e.g. dialysis, oncological care),
- The socially deprived are eligible for benefits to cover 12 visits.

In parallel with the introduction of visit fees, it will be compulsory to issue itemized receipts. By reason of this, the patient can monitor what intervention or treatment the provider is claiming reimbursement for from the insurance fund, including the pecuniary worth of such reimbursements, while the insurance fund will have a verification of the interventions made as the patient signs the receipt.

Insurance benefit packages

- By exactly defining the content of the packages, the eligibility of users and the range of services can be regulated unambiguously; the cost-bearer and the specific treatment can be identified.
- They help to single out those who evade contribution payments.
- Healthcare delivery will be more continuous with the introduction of benefit packages.
- With the introduction of benefit packages, the expenditures of the insurance fund will be better planned.

Three benefit packages are proposed:
- Basic package: all legal residents in Hungary are entitled to it independently of insurance status (ambulance services, emergency care, epidemiological services, immunisation, maternal and infant care).
- Insurance package: provisions available to all insured persons free of charge or with partial payment (access to necessary and general care independent of place of residence and financial situation).
- Supplementary package: insurance by voluntary payment of fees, purchasing extra services (luxury services, free choice of doctor, separate room in hospital, cosmetic surgery, etc.).

Waiting lists

There are two types of waiting list: central and institutional. The central waiting list is managed by the authority designated by government order, while the institutional waiting list is managed by the particular health care provider.

The goal of the regulation is to establish transparency, public control, fairness, strengthening of trust, equitable access and resource allocation in non-emergency health care. The instrument for this is to create a regulated, controlled and open system of waiting lists, along with a supervisory body.
Managament of waiting lists:
- patients are put on a waiting list by their attending physician
- waiting lists contain all the important personal data, though on public websites patients are listed only by code numbers
- sequence of patients can be defined only by the sequence of their appearance on the waiting list, it cannot be altered unless for a properly established and well documented reason
- patients may not, even for co-payment, request the alteration of the sequence of the waiting list, but they may apply to the Supervisory Authority for their treatment by an another provider
- waiting lists are made public on the websites (central waiting list on the website of the National Blood Transfusion Service, institutional waiting lists on the website of the establishments offering treatment for the patients). Only personal identification and time of treatment are disclosed on the list.

4. Act on supervision performed in health insurance

The Health Insurance Supervisory Authority is a central office under the direction of the Minister of Health. Its competence comprises the whole health insurance sector, including both compulsory and voluntary health insurance. It is directed by a chairman who is supported by a Supervisory Council consisting of 7 members. Both the chairman and the members are appointed by the Prime Minister for six years.

The Supervisory Authority oversees the appropriateness of contracts between the insurer and the provider, makes sure that professional rules are put in practice, and examines the quality of provided services. Other activities of the Health Insurance Supervisory Authority: consumer protection, quality assurance, inspection of fair market conduct among actors of health care, control of the utilisation of health insurance contributions, and other associated authority functions. It has also planning, evaluating and advisory competences in connection to the Health Insurance Fund and the central budget.

5. Act on the development of health care system

The Act aims to establish an equitable health care delivery system of European quality and to stop wastefulness. The main objective of the transformation is to develop a sustainable, effective health care delivery system of high quality that promotes the recovery of patients in as much safety as possible.

Following the reconstruction tender invited in the autumn, about 4000 active hospital beds will be terminated or transformed by the hospital owners and their institutions. The Act orders the termination or transformation of additional 12000 active beds.

On the whole (as a result of the tender and the Act), the number of beds in chronic inpatient care (e.g. rehabilitation, long-term care) will increase by 7500.

The new health care delivery system will consist of 4 levels:
- hospitals of high priority;
- territorial hospitals;
- outpatient centres;
- family doctors.

The hospitals of high priority that work with the most advanced technology and with doctors who have a great deal of experience will provide care with nearly equal access for patients suffering from serious or special diseases. These hospitals double as emergency centres: they receive patients who need urgent care within 24 hours all the 365 days of the year. They get one part of their capacity guaranteed, beyond this they can compete for further capacities at regional level. The majority of hospitals (territorial hospitals) are engaged in „general” care which covers the larger part of the cases. In the future, the territorial hospitals will play a more important role in the fields of rehabilitation, chronic care and long-term care. The Regional Health Council will decide on the capacities of the territorial hospitals on the basis of regional allowances determined by the Act on the development of health care system.

Territorial health care centres will operate around the hospitals in order to provide outpatient care. The patient can utilize the majority of outpatient care services near their place of residence. These centres can also provide services like day-care, one day surgery, chronic and long-term care, in close professional cooperation with primary care.
Hungarian public opinion on the reforms

The population is ambivalent about the reforms. In general it can be said that the population insists on the acquired rights, but on the other hand, people are unsatisfied with the services provided by the health care delivery system. A survey of a representative sample of the population conducted in the summer of 2006 indicates that the service Hungarian people are most satisfied with is primary health care. This form of care was evaluated at 74 points on a scale of 100, whereas outpatient specialist care scored 62 points, and inpatient care, 57 points. However, the health care delivery system as a whole received only 56 points. In their evaluation, people placed the greatest emphasis on crisis situations and interventions demanding hospital treatment. Another survey, the Euro Health Consumer Index 2006 conducted by the Health Consumer Powerhouse (HCP), ranks the EU-25’s health systems from the customer point of view. The ranking has been done for 28 indicators covering patient rights and information, waiting time for treatment, outcomes/quality, generosity of the healthcare system, and pharmaceuticals. Among 26 European countries, Hungary ranked 14th. Health care performance was rated negatively, the second worst among the EU-25, still being below expected quality after 60 years of public financing.

Public opinion in the Hungarian survey concerning reforms regards only those items as necessary that increase expenditures (improvement of medical care, short waiting times, raise of health personnel’s wages, improvement of institutions’ equipment), but neglects the objective of creating or increasing resources (retaining free care, keeping present drug prices). The fact that only one-third of the population knows what services they can get for their insurance indicates a lack of appreciation of health care. The rest of the population are ignorant or indifferent of this issue. More than 60% of the adult Hungarian population would not be willing to pay officially for health care services beyond social insurance contribution (for better conditions of care, state of the art care, shorter waiting times, free choice of institute and doctor). 20-28% of the population would be willing to pay for services, mostly those in higher positions of active employment and people residing in the capital. At the same time more than one-third of the adult population give informal payments to health workers, most of them to hospital doctors, and most frequently to family doctors. Patients give about HUF 16,000 to the hospital doctor, HUF 6000 to the family doctor, and HUF 2,000-3,000 to nurses and other health workers on a single occasion. Although people mention conventions and the subordinate situation of the patient as causes for informal payments, half of the people paying under-the-table payments suppose that the doctor expects it. Although public opinion is divided about the present health care system based on social insurance, the majority (68%) think that the system could work economically in its present form, and only a minority (28%) think that improvement will happen only if competing insurers enter the market. The majority of the population (84%) think that the health insurance “manages contribution payers’ money badly”. The common logic finds rationalization and strict control the best solution.

Professional opinion on the reforms

Although the Government is very optimistic and committed to the reforms, health professionals and the opposition are against the approved reform steps. However, some professional organisations are not free from political bias. The Chamber of Hungarian Doctors raises objections especially against the “Act on the development of health care system”, arguing that this measure does not promote equitable access to health care services, and could even increase inequalities. They are worried that there would not be sufficient financial and human resources to operate the hospitals of high-priority in 24 hours. The Chamber wants to maintain the unified, compulsory health insurance system, which covers every citizen and refuses the Government’s plan about a competitive health insurance system with multiple insurance funds. Besides, the Chamber finds the new “Act on professional associations operating in health care” unfair.
The Chamber of Hungarian Pharmacists criticise the “Act on the safe and economical supply and distribution of medicines and medical appliances”, for failing to set up professional requirements on pharmaceutical service outside pharmacies, while only qualified pharmacists can dispense medicines in pharmacies. According to the “Act on the development of health care system”, negotiations are in progress about the termination and transformation of active hospital beds, with the protest of many organisations and hospitals.

Sources:
- Health and social services in Hungary, http://www.eski.hu
- A gazdasági átalakulás számokban. (Economic change in figures) http://www.pm.gov.hu

National Institute For Strategic Health Research (ESKI)

ESKI is a methodological research institute carrying out activities in the fields of health informatics, health economics, health system sciences and technology assessment in connection with the sector’s health policy strategy. One of the basic tasks of the institute is to make data produced in different areas of the health care system available to the public and to organise them into an integrated system. This task is achieved by means of an Internet-based data warehouse, which is continually expanding in terms of both content and function. The newest service of ESKI is the Healthcare Episode Database. The pseudonymised results of data presenting outpatient and inpatient specialist care as well as CT and MRI examinations are accessible from our website.

The Health System Science Division is engaged in the most important issues of health policy. Utilising international and Hungarian literature, the Division builds a health policy database and prepares studies on the health care of different countries, paying special attention to innovative approaches that provide efficient and adaptable answers to the challenges of health systems. Current topics include the role of co-payment, determination of health baskets and capacities, regulation of pharmaceutical markets, and patient information about the performance of health systems.

Much of the research done at the Health System Science Division involves analysing the operation of health systems and comparing their performance. Two studies have been published in this subject. By the spring of 2005 the first study was prepared about the 10 new EU member states entitled “Health care systems in Eastern Europe”. A more recent study, published in the autumn of 2006, introduced the health care systems of the 15 western member states of the European Union. These studies are available on our website in Hungarian.

The studies analyse important issues in the health systems of the member states with their political, economic background: demographic tendencies, structure of health systems, resources and methods of financing, health care services and reforms. Health reforms play a central role in our research including issues of financing, public-private partnership in the delivery of health care, as well as strategies to reduce inequalities in health and to enhance access to services.

Our databases and researches are available on our website - www.eski.hu - and also as printed editions.

Some foreign newspapers featured coverage on Hungarian health care reforms. For instance, the Dow Jones wrote that „Hungary’s health care sector has not undergone a major reform since the country broke away from communism in 1990”. The international service of Czech Radio wrote that Hungary’s medical professionals are divided over the health reform. Pester Lloyd, a German weekly paper published in Hungary, wrote that the Chamber of Hungarian Doctors and the Semmelweis University of Medicine found these reforms thoughtless.

Sources:
- A gazdasági átalakulás számokban. (Economic change in figures) http://www.pm.gov.hu