Establishment of GYEMSZI

On 1 May 2011 – as part of the policy concept that set in motion the restructuring of Hungarian healthcare as formulated in the Semmelweis Plan – a new methodological centre, the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) was created from the merging of five institutes: the Institute for Healthcare Quality Improvement and Hospital Engineering (EMKI), the National Institute for Strategic Health Research (ESKI), the National Institute of Pharmacy (OGYI), the Institute for Basic and Continuing Education of Health Workers (ETI), and in part the National Centre for Healthcare Audit and Inspection (OSZMK). The new tasks of GYEMSZI include the formulation of the strategy of health quality improvement and patient safety, the elaboration of the concept of development of different levels of care and patient pathway management. Besides its new tasks, GYEMSZI continues to perform the basic tasks of the merged organisations.

ESKI has become the Directorate General of Informatics and Health System Analysis (GYEMSZI IRF), which coordinates health sector IT, ensures the multi-purpose use of sectoral data assets, analyses health systems from an international perspective and maintains the National Health Policy Library. The Informatics Division of GYEMSZI IRF has taken over the informatics tasks of ESKI, coordinates the health sector IT development and supports the IT of the new organisation. The Health System Analysis Division of GYEMSZI IRF is engaged in the most important issues of health policy and research. We wish to continue to provide information in the future on the Hungarian healthcare for the international audience and about the international trends for the Hungarian health policy professionals through a collaboration of different parts of GYEMSZI.
Macroeconomic overview

Table 1: Main macroeconomic figures

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011 (forecast)</th>
<th>2012 (forecast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP growth</td>
<td>1.2</td>
<td>1.4</td>
<td>-0.3</td>
</tr>
<tr>
<td>General government balance as % of GDP</td>
<td>-4.2</td>
<td>4.2</td>
<td>-3.2</td>
</tr>
<tr>
<td>Structural balance as % of GDP</td>
<td>-3.8</td>
<td>-5.0</td>
<td>-2.8</td>
</tr>
<tr>
<td>Current account balance as % of GDP</td>
<td>1.0</td>
<td>2.1</td>
<td>3.8</td>
</tr>
<tr>
<td>CPI</td>
<td>4.7</td>
<td>3.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Government debt as % of GDP (Maastricht definition)</td>
<td>81.3</td>
<td>84.2</td>
<td>85.1</td>
</tr>
</tbody>
</table>

Central Statistical Office, Hungarian National Bank, Eurostat, European Commission, OECD

On 1 March 2011 the Orbán government announced the Széll Kálmán Plan, which aimed at the reduction of public debt and for that a complex series of measures were scheduled. These included serious spending cuts, economic incentives for enterprises, restructuring social benefits and consolidation of the indebted public enterprises (e.g. public transport). Overall, the economic reactions to the Széll Kálmán Plan were positive.

However, the practice of fiscal policy – often titled “non-orthodox” by officials – led to mixed results, and was criticized both by Hungarian and foreign institutions. According to Eurostat estimations the real GDP grew by 1.4 percent in 2011 which was slightly higher than the growth rate in 2010 and also the highest of the last five years. Nevertheless, the forecast for 2012 has been continuously worsening and at the beginning of the year the consensus of the experts was just below zero.

The budget balance in 2011 was significantly above break-even – which has not happened before in Hungary - however this was due to the nationalization of the compulsory private pension funds – worth some 10 percent of the GDP. Not taking into consideration the effect of business cycles and one-off events, the European Commission estimates the structural deficit to be five percent of the GDP, which is less than the average of the European Union, however higher than the requirement of the European Commission which was based on the Maastricht criteria. Even so, government indebtedness grew last year.

As the Hungarian population was heavily indebted in Swiss franc-based mortgage credit and the Swiss franc has significantly appreciated in the last several years against the Hungarian Forint, noteworthy segments of the society were endangered of going insolvent and losing their apartment. To prevent this scenario the government decided to enforce a law which obliged the banks to let their customers pay back in one sum at a fixed 180 HUF/CHF exchange rate that was about 25 percent lower than market level.
The deteriorating economic prospects did not let the government continue its course of tax reduction but forced it to step back in 2012 and increase the Value Added Tax by 2 percentage point to 27 percent and the plan to eliminate the employer social insurance – consisting an extra 27 percent – from the basis of the personal income tax had to be limited to annual incomes below HUF 2 424 thousand. Also the rate of the simplified business tax was raised by 7 percentage point to 37 percent in 2012. 2011 saw the introduction of the cut back of some social policies – for instance the termination of the tax credit for the minimal-wage-earners.

During the fall and winter of 2011 the Hungarian Forint has depreciated against the Euro – its exchange rate dropping from some 290 HUF/EUR to around 310 HUF/EUR. Also, the Hungarian government debt has been downgraded by all three major credit rating agencies to a not recommended level. The International Monetary Fund declined to negotiate about the possibility of an emergency credit in case the national debt could not be financed from the market. Last but not least, also the European Union was stepping up against Hungary. Recently the government seems to change its course and initiates more conventional fiscal consolidation measures in order to secure the country’s solvency.

Health financing overview

In 2011, the revenues of the Health Insurance Fund remained virtually unchanged in comparison to the previous year, while in 2012 revenue estimates show a growth of 25 percent in nominal terms, which means an increase of HUF 329 billion. The greatest impact in the increase was the fact that from 2012 the HUF 342 billion source of financing of disability and rehabilitation benefits is transferred to the Health Insurance Fund. These items are partly in the central budget compensations, partly in the other revenues connected with health insurance activities. Another factor in the increase was that the health insurance contributions paid by insurees have risen by one percentage point, which resulted in a surplus of about HUF 114 billion in contributions. The appearance of new income items (accident tax, which is 30 percent of the annual insurance fee of the compulsory motor insurance, and public health product tax, see page 11) in the other revenues connected with health insurance activities resulted in an increase of HUF 45 billion in revenues. Despite revenue increase, the central budget contribution after eligible but not insured persons - pensioners, youngsters, homeless, etc. – decreased by HUF 247 billion.

Although it does not lead to changes in the resources, it is worth noticing that from 2012 the social insurance contribution paid by employers - which consists of pension, health insurance and labour market contributions - appears as social contribution tax, thus paying it does not induce eligibility to healthcare. It continues to amount to 27 percent.

According to budget estimates of the Health Insurance Fund, revenues are planned to be HUF 1371 billion in 2011 and expenditures are planned to be HUF 1460 billion. For 2012, the budget foresees a revenue of HUF 1700 billion, and an expenditure of HUF 1735 billion. The deficit in 2012 is thus planned to be HUF 35 billion.
There seems to be a significant increase in the expenditures of the Fund estimated for 2012, which is a result of the appearance of disability and rehabilitation benefits within cash benefits. After a decrease of 3 percent in 2011 compared to 2010 in nominal terms, a year-to-year increase of 7 percent can be observed in 2012 in curative-preventive provisions. Within this segment, a growth of 11 percent can be observed in inpatient care. From 2012, the service of dispensaries is completely financed from outpatient care provisions.

The expenditure reduction targets of the convergence programme include the reduction of pharmaceutical expenditures with the help of a generic programme, the introduction of the therapeutic review system (review of particular areas of therapy for determining the extent of reimbursement), the establishment of a system evaluating patient adherence, international reference pricing, the transformation of the reimbursement system and the increase of inpayments of pharmaceutical companies. From 2012, the effect of these measures to reduce costs appears to be more robust, the pharmaceutical reimbursement expenditures are planned to be cut by 26 percent (compared to 2010).

Table 2: Revenues of the Health Insurance Fund, HUF millions

<table>
<thead>
<tr>
<th></th>
<th>2010 (final account)</th>
<th>2011 (budget estimate)</th>
<th>2012 (budget estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues of Health Insurance Fund</td>
<td>1 384 992</td>
<td>1 370 937</td>
<td>1 700 068</td>
</tr>
<tr>
<td>Contribution revenues</td>
<td>677 734</td>
<td>676 782</td>
<td>856 896</td>
</tr>
<tr>
<td>Central budget compensations</td>
<td>617 271</td>
<td>642 370</td>
<td>579 381</td>
</tr>
<tr>
<td>Other revenues connected with health insurance activities</td>
<td>88 273</td>
<td>51 345</td>
<td>263 351</td>
</tr>
<tr>
<td>Revenues for operation</td>
<td>1 702</td>
<td>425</td>
<td>425</td>
</tr>
<tr>
<td>Revenues from asset-management</td>
<td>12</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: NISHR, http://www.eski.hu/alaptabla/English/Ealapbe_e.xls
Table 3: Expenditures of the Health Insurance Fund, HUF millions

<table>
<thead>
<tr>
<th></th>
<th>2010 (final account)</th>
<th>2011 (budget estimate)</th>
<th>2012 (budget estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure of Health Insurance Fund</td>
<td>1 476 691</td>
<td>1 459 614</td>
<td>1 735 412</td>
</tr>
<tr>
<td>Provisions in cash of the Health Insurance Fund</td>
<td>221 238</td>
<td>232 518</td>
<td>555 524</td>
</tr>
<tr>
<td>Provisions in kind</td>
<td>1 207 983</td>
<td>1 188 795</td>
<td>1 166 355</td>
</tr>
<tr>
<td>Curative-preventive provisions in kind</td>
<td>790 973</td>
<td>770 120</td>
<td>824 906</td>
</tr>
<tr>
<td>Primary care</td>
<td>119 882</td>
<td>122 552</td>
<td>121 346</td>
</tr>
<tr>
<td>Service of dispensaries</td>
<td>4 556</td>
<td>2 300</td>
<td></td>
</tr>
<tr>
<td>Special nursing at home</td>
<td>3 520</td>
<td>4 405</td>
<td>4 098</td>
</tr>
<tr>
<td>Outpatient specialist care + CT, MRI (with laboratory fund)</td>
<td>133 436</td>
<td>139 441</td>
<td>144 142</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>440 058</td>
<td>445 164</td>
<td>494 432</td>
</tr>
<tr>
<td>Other curative-preventive provisions in-kind</td>
<td>89 522</td>
<td>56 257</td>
<td>60 889</td>
</tr>
<tr>
<td>Expenditures on pharmaceuticals</td>
<td>357 206</td>
<td>343 544</td>
<td>277 700</td>
</tr>
<tr>
<td>Pharmaceutical reimbursement</td>
<td>342 213</td>
<td>296 244</td>
<td>219 000</td>
</tr>
<tr>
<td>Reimbursement of therapeutical appliances</td>
<td>44 195</td>
<td>44 772</td>
<td>43 313</td>
</tr>
<tr>
<td>Other provisions in-kind</td>
<td>15 609</td>
<td>15 358</td>
<td>15 436</td>
</tr>
<tr>
<td>Health insurance budgetary agencies and centrally managed estimates</td>
<td>20 939</td>
<td>10 964</td>
<td>9 272</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>26 531</td>
<td>27 337</td>
<td>4 260</td>
</tr>
</tbody>
</table>

Source: NISHR, http://www.eski.hu/alaptabla/English/Ealapki_e.xls
In 2011, several modifications and austerity measures were introduced in the provisions of sickness benefit (not yet seen in the data of the budget estimates): the maximum sum of sickness benefit decreased by 50 percent and the so-called passive sickness benefit submitted after cessation of the insuree status was abolished. In order to avoid abuse of sickness benefit, the doctor who unrightfully identifies incapacity to work is obliged to share in paying back the cash benefits received unduly.

At the end of 2011, the Hungarian Government raised the budget estimate for several areas of curative-preventive care. The greatest sums were allocated to primary care (HUF 3.5 billion) and specialist care (HUF 4.2 billion). At the end of the year, health care workers were granted an ad hoc income supplement of HUF 5.6 billion to compensate for their low income level.

In addition, using the difference between the budget estimate and the actual spending of curative-preventive care, more than HUF 21 billion were dispensed: HUF 14.7 billion was allocated to the publicly financed inpatient and outpatient institutions, HUF 1.3 billion was allocated to supplement the emergency and accident care and to compensate the income of health care workers working in this field, HUF 1 billion was given to intensive care and HUF 200 million to neuro-invasive care. HUF 800 million was given for incentivizing both outpatient care and day surgery. Primary care and certain health care providers received HUF 300 million to reimburse additional costs.

At the end of 2011, health care providers also received an extra HUF 27 billion consolidation support in order to decrease the expired debts towards suppliers. In addition, the Government increased the budget on pharmaceutical reimbursement and therapeutical appliances by HUF 1.5 billion.

Restructuring in the Hungarian healthcare

In Hungary, a new model of care, based on state-owned providers, is under plan that can respond to needs and is able to ensure financial sustainability. The planned delivery system is envisaged to have stronger cooperation among institutions, better management of patient pathways, higher level of quality and safety and equality of access. Special attention will be given to developing emergency care, primary healthcare and outpatient specialist care.

The government passed a resolution in June on the implementation of tasks regarding the restructuring of the healthcare system formulated in the Semmelweis Plan (reform plan of the Hungarian healthcare, see Health System Scan Issue January 2011). The tasks include:

- Establishment of the institutional system of national care management built on regional units that are responsible for the care of 1-1.6 million inhabitants.

- Establishment of the National Healthcare Management Centre as an organisational unit of GYEMSZI, as well as the regional healthcare management centres that promote the functional cooperation of healthcare institutions (professional connections, background services, joint procurements) and perform the tasks of regional health service management. The National Healthcare Management Centre also performs the tasks of governance and institutional supervision of state-owned healthcare institutions.

- Establishment of the National Patient Right and Documentation Centre for creating a single-gate protection of patient rights and managing the documentation of malpractice and the
patient records of the ceased healthcare institutions.

- Review of the human resource situation of healthcare workers (wages, work conditions, circumstances of training and living), elaboration of human resource strategies.

According to the government resolution, the resources that are freed as a result of improved efficiency arising from the restructuring of the healthcare system and its management will mainly be used for increasing healthcare workers’ income.

**Regional organisation of healthcare provision, regional health promotion programmes**

Starting on 1 January 2012, specialist care is the responsibility of the state (inpatient, integrated outpatient, and independent outpatient specialist care). According to legislation passed in November 2011, 43 hospitals and outpatient care institutions owned by county local governments, as well as the healthcare institutions operated by the Budapest municipal government became the property of the state on 1 January 2012. According to further plans, in 2012 the state will take over the inpatient and outpatient specialist care institutions owned by municipal governments. From 1 May 2012, healthcare delivery will take place in a system that is built upon special healthcare regions.

Eight regions has been established in which patient care can be provided from the basic level of progressivity to the highest level. It is a basic principle that simpler services that can be provided in bulk should be available close to the patients’ place of residence, whereas complex, specialised interventions and services should be provided in centres of high professional level. The task of optimal organisation and supervision of healthcare taking place in the regions, as well as the management of patient pathways will be performed by the regional (territorial) healthcare management centres established within GYEMSZI. The capacities for inpatient care and the connected areas will be restructured until 1 May 2012, and the capacities for outpatient specialist care and the connected areas will be restructured until 31 December 2012, taking regional borders into consideration. An objective is to centralise capacities that do not justify the maintenance of several, parallel sites of care for efficiency reasons. Taking into consideration transport infrastructure as well as healthcare capacities, it will be determined that access to a given service can be secured to citizens within the shortest time. The expert position statements of the departments of the National Advisory Board of Healthcare are used in the process.

Connected to reorganisation, the system of referrals will also change. The passed legislation ensures patients the free choice of service provider within the region. Since the basis of capacity planning and patient pathway management for specialist services will be the healthcare region, a regional waiting list for determined provisions will be created until 30 April 2012. At the same time service providers will have the opportunity to record institutional appointments for scheduling services for provisions not included in the regional waiting lists. Coordination between the two waiting lists will be ensured by the national waiting list register.

In the healthcare regions the Regional Health Council will be the body that takes part in formulating health policy. Its tasks include support for the work of the regional healthcare management centres, professional support for determining the obligatory catchment areas, advising in decisions concerning regional health promotion goals, offering opinion on
the long-term development and the developmental priorities of healthcare providers in the region. Members of the Council include representatives of the region’s local governments (county and capital), government agencies in the region, public health administrative bodies, representatives of the operators of healthcare institutions (ministries, churches), regional healthcare providers, patient organisations, professional associations, regional healthcare management centres.

Every healthcare region should work out a regional health promotion programme including the following: expected change in size and age of population, in health status, expected demand on health services, characteristics and development plans of regional healthcare providers.

GP services

The Semmelweis Plan considers primary care a priority of the healthcare delivery system. There are several measures introduced in 2011 and early 2012 that target the strengthening of primary care. The practice right is renewed from 2012. On the basis of practice right, independent physician activity can be performed with territorial obligation to provide care in a determined district. To register practice rights and purchases, a practice management centre will be established, which publishes and advertises practice rights on sale and provides loans to GPs for the purchase. At present, an application procedure helping to buy practice rights can be used to support young GPs in starting a career or elderly GPs in retiring. The physicians may apply for a grant of HUF 1-4 million (EUR 3400-13600) for the purchase of practice rights.

According to a 2011 decree on equipment support, healthcare entrepreneurs providing GP, paediatric GP and dental care may receive grants up to HUF 1.5 million (EUR 5100) per provider for buying medical and IT equipment, with a monthly cap of HUF 50,000 (EUR 170) in the reimbursement of the invoices. For the devices not covered in the equipment support, young GPs and paediatric GPs may apply for HUF 1 million (EUR 3400) for the development of medical office equipment and the establishment of circumstances for cultured patient reception. The source of the grants is an earmarked target provision managed by the Health Insurance Fund Administration.

In 2009, a P4P system based on indicators was introduced to encourage the quality of care in GP and paediatric GP services. Based on practical experiences of the last two years and on international trends, an indicator system serving a more appropriate assessment of GPs was created in 2011. To obtain financial support rewarding quality care, a predetermined target value should be achieved for some indicators instead of the earlier variable averages. The priority goal is to provide higher quality care.

In the evaluation of adult and mixed GP practices, there are 15 indicators defined (in place of the earlier 12), 4 of which apply to pharmaceuticals. In the case of pharmaceutical indicators cost-efficient prescription is examined.

The indicator set includes the following: 65+ population receiving influenza vaccination, women aged 45-65 participating in organised breast cancer screening, people receiving care for high blood pressure in several age-groups, patients with high blood pressure undergoing serum creatinine examination in the previous 12 months, patients with high blood pressure or diabetes undergoing lipid metabolism examination, appropriateness of drug treatment of patients with ischemic heart disease, diabetes patients undergoing Hb1Ac and ophthalmologic examination in the previous 12 months.
months, rate of specialist care referrals, incidence of antibiotic treatment among adults.

In the evaluation of paediatric GP practices, there are 6 indicators defined in place of the earlier 4. The criteria of evaluation are the following: rate of children under age 1 receiving Pneumococcal vaccination, rate of children under age 2 receiving Meningococcal vaccination, rate of girls aged 10-18 receiving iron supplement treatment, patients receiving on-duty care, incidence of antibiotic treatment.

The indicator list is under yearly supervision.

Health human resources

Scholarship programme for residents

There is an increasing discontent among healthcare workers in Hungary and other Eastern European countries like the Czech Republic and Slovakia. The doctors and residents in these countries have been threatening to resign due to their frustration over salaries and working conditions. The medical staff are leaving for Western Europe in large numbers and patient care is at risk due to staff and funding shortages.

In Hungary, resident doctors demanded wage increase and improvement of their working conditions, and threatened to quit their jobs if their demands are not met. They demanded an average doctor’s salary to reach three times the amount of the national average, the minimum salary to be net HUF 200,000 for general doctors and HUF 300,000 for specialist doctors. About 2500 resident doctors submitted their letter of resignation, which originally would take effect at the beginning of 2012. As a response, the Secretariat of State for Health at the Ministry of National Resources launched a scholarship programme in the summer to improve the financial situation of resident doctors and specialist pharmacology trainees and to provide them with incentives to stay in the country (Markusovszky and Than Scholarships). To be entitled to the programme, a resident must take part in specialist medical training and a pharmacologist in hospital pharmacology or clinical pharmacology training for at least three years. The applying residents would receive net HUF 100,000 a month above their salary till the end of their training if they meet certain conditions. After completing their specialist training they must work in Hungary at a public healthcare provider for at least as long as they were receiving grants in the scholarship programme. The applicant resident doctors must also pledge not to accept informal payments in health service. Altogether about 600 applicants have been accepted for the programme.

In the meantime, the residents suspended their resignation for three months as the Hungarian Alliance of Residents has been offered a “reasonable deal” in early January by Miklós Szócska, Secretary of State for Health. Whether the residents’ resignation will be activated depends on the results of the negotiations.

The Secretary also announced that in 2012 all surplus resources in the health sector will be used for health workers’ wages. He acknowledges that there is a crisis in human resources for healthcare, thus all possible reserves should be used to ease the situation. According to the Secretary, there are reserves to be found in the system and savings can be made. One source of surplus revenue in the health sector comes from the so called „public health product tax” introduced in September for foods and drinks with high sugar, salt or caffeine contents. The money from this tax was granted in December to 42,000 frontline healthcare workers at publicly financed institutes as a one-time payment.
Regulation of health workers’ duty time

There have been changes in the regulation of duty time in healthcare. A new element in the regulation is that starting in 2011 the time worked on-call can be ordered to count as part of ordinary working time, with maximum length of 16 hours/week. Every hour of duty time qualified as ordinary working time should be compensated with at least the hourly rate of a person’s salary. If the on-call service falls on weekly rest day or legal holiday, then it must be compensated with a rest period of identical duration. For duty time ordered as ordinary working time on the weekly rest day, the health worker is entitled to supplemental payment. It remains unchanged in the regulation that the total amount of healthcare activity that can be performed in a calendar week by a health worker cannot exceed 60 hours per week as a six-month average, and cannot exceed 12 hours in a calendar day, even if the healthcare activity is performed within the framework of several employment arrangements.

Major changes in the rules of the supply of pharmaceuticals

The Széll Kálmán Plan determining the basic directions for the development of Hungarian economy, drafted the need for structural changes in many areas in order to promote economic growth and to secure the reduction of state debt. The targets of the Széll Kálmán Plan included among others the restructuring of the system of pharmaceutical reimbursement in a multiple-stage procedure. In order to guarantee the balance of the pharmaceutical fund and the long-term effectiveness of the reimbursement policy, new measures for reimbursement policy have been introduced since July 2011. The so-called preferred reference price band was introduced, the fee for the registration of a pharmaceutical sales representative, as well as the levy charged on the revenues of pharmaceutical companies from the sale of reimbursed drugs in the country were increased and the rules on the promotion activity of pharmaceutical manufacturers became stricter.

There are two cases for pharmaceuticals in the preferred reference price band: (1) pharmaceuticals with fixed reimbursement on the basis of their active substance exceeding the daily therapeutic costs by a maximum 5% the daily therapeutic costs of the reference price drug, (2) the pharmaceuticals in the group with normative fixed reimbursement on the basis of their therapeutic value, and the daily therapeutic costs exceeding the group-average daily therapeutic costs by maximum 10%. The pharmaceuticals in the preferred reference price band receive the sum of reimbursement for the reference product. The drugs falling out of the price band are reimbursed with a sum decreased by 15% compared to the reimbursement of the reference. (Manufacturers do not obtain reimbursement for their generics, if they are more than 30-60% above the reference price. The percentage depending on whether the drugs are clustered as to their chemical or therapeutic equivalence.)

Since the year 2012 additional changes have been introduced. Among others these are the following: setting the concept of payment by results in some price-volume agreements (cost sharing agreements concluded by the Health Insurance Fund Administration and the distributor concerning the price and quantity of products falling under reimbursement). Thus the following pharmaceuticals (in price-volume agreements) may be reimbursed by results:

- those pharmaceuticals that have newly been
involved in the scope of reimbursement and at which a results-based parameter may be identified, and which meet the determined requirements (number of patients and daily therapeutic costs),
- orphan drugs,
- pharmaceuticals reimbursed for equity
- pharmaceuticals under itemized accounting
- pharmaceuticals used for treating diseases determined by a ministerial decree, and achieving the number of patients and the value of daily therapeutic costs fixed therein.

It is determined by the law that inappropriate patient adherence (the behaviour of the patient adequate to the recommendations of the health practitioner in relation to drug intake, nutrition and lifestyle) may be considered for providing reduced pharmaceutical reimbursement.

The regulation of incentive measures for generic prescribing will be changed. According to this, pharmacies may obtain an allocation from the budget of the Health Insurance Fund, if in case of an active substance based fixed group they sell a pharmaceutical pertaining to the preferred reference price band, or they sell the reference product or a pharmaceutical of the same or lesser daily therapeutical costs as those of the reference product. In lack of the fixed group, they receive financial incentive if selling a pharmaceutical the daily therapeutic costs of which are less than those of the pharmaceutical prescribed but being of the same therapeutic value and offering the possibility for substitution.

The distributor of pharmaceuticals and medical appliances must inform the patient in a well documented manner on the pharmaceutical of lesser price containing the same active substance or offering the same therapeutic value, as well as on the medical appliance of lesser price utilized for the same purpose as that prescribed and falling under reimbursement. Information must also be given on the prices of the products, the extent of the reimbursement and the differences among the fees reimbursed.

According to the concepts of the European Union, a system of pharmacovigilance will be set up, by means of which information will be gathered on the risks and the potential side-effects of the pharmaceuticals.

Introduction of e-prescription will probably take place in 2012, so administrative burden might significantly reduce in this area.

### Public health legislation

In the past year there have been several changes in legislation that aimed at promoting healthier lifestyle.

The Hungarian Parliament passed a law on public health product tax or “chips tax” that came into force in September (modified in November). The goal of the legislation was to reduce the consumption of unhealthy foods, to promote healthy diet and to help the financing of health services, especially public health programmes. The food products to be taxed include soft drinks, energy drinks, pre-packaged sweet goods, salty snacks and seasonings if their sugar, salt or caffeine contents reach a determined level. The amount of tax levied, for example, is 250 HUF/litre for energy drinks or 250 HUF/kilogram for salty snacks.

The new law on the protection of non-smokers became effective on 1 January 2012 (amendment of the 1999 act). The extended legislation makes public places, restaurants, bars and workplaces smoke-free.
It is also prohibited to smoke in bus stops, underpasses used by pedestrians, in playgrounds and within 5 metres of their vicinity. Smoking is banned from schools, child welfare institutes and health service providers, including their courtyard. Rooms or public places affected by smoking restriction or designated for smoking must be visibly marked. Smoking is permitted only at home, on the street and in places not prohibited by law. There are some exceptions that allow smoking in closed places, e.g. in hotels, prisons, psychiatric institutions, as well as workplaces with temperature above 24 °C.

**Creation of Disease Register**

A register will be established, which for each patient will include events of healthcare provision, diagnosed diseases and provided therapies, as well as pharmaceutical and medical appliance prescription data. In the Disease Register a patient cannot be personally identified – the health insurance agency uses a connection code for the data that cannot be decoded to disclose the identity of the patient. The healthcare data may be used for statistical analysis and research purpose as well.

**National Patient Forum**

The National Patient Forum will be established as a forum for maintaining contact with patient organisations with the participation of non-governmental organisations representing patients with specific diseases. The Forum will make recommendations to the minister, provide opinion upon request, prepare analyses and evaluations, pursue representation of interest with respect to disease groups.

**National Institute for Quality- and Organizational Development in Healthcare and Medicines**

Directorate General of IT and Health System Analysis

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