

Background Briefing

Hungary's Healthcare System

By Shannon C. Ferguson and Ben Irvine (2003)

In the aftermath of communist rule, Hungary transformed its healthcare system from centralised Semashko state control to a more pluralistic, decentralised model. Contracts between local governments and providers have replaced direct ownership, and privatisation within healthcare has grown since 1989. Influenced by both the French and German healthcare systems, funding is now predominantly through social insurance.

But has recent decentralisation benefited the health of the Hungarians, who perhaps surprisingly have the lowest life expectancy in Eastern Europe (1)? Is the system designed to serve the interests of the patients? Does the system work for patients? To address these questions, we will briefly examine Hungary's system in the context of visibility of patient's contributions, method of insurance collection and allocation, physician incentives, hospital ownership, and system inequalities.

Financing and Patient Contributions

Hungary's healthcare system is financed through the Health Insurance Fund (HIF), which is primarily responsible for recurrent health care costs. The HIF collects premiums at the national level and allocates funds to 20 county branches, which in turn enter into contracts with health care providers. Although the owners of health care provider organisations (usually local governments) are technically responsible for capital costs, in practice this usually takes the form of grants from the national budget. The HIF is also under-financed, and the state government is obliged to cover

its deficit. So state budgetary assistance is provided for capital costs, and in picking up the slack of under funding. The result is a mix of tax and social insurance-based funds responsible for financing Hungary's system (1).

Coverage is universal and provides access to all ambulatory and secondary hospital health care. All citizens are covered, regardless of employment status, with the government paying contributions for groups such as the unemployed and pensioners. Health insurance contributions are collected from employees, who pay 3% of their total income, and employers who pay 15% of the employee's gross salary plus a lump sum tax or 'healthcare contribution'. The population also pays local and national income tax, which helps to finance the investment costs of health care. Patients make co-payments on certain services, including pharmaceuticals, dental care and rehabilitation (1). These out-of-pocket payments have increased substantially since 1990, and currently contribute 18% to health care financing (4).

The Role of the HIF

The HIF is able to contract freely with providers, and is supervised by the Ministry of Finance. The HIF is also regulated indirectly by the Medical Chamber, which regulates the medical profession and may veto physician's contracts with the HIF (1). Initially an autonomous organisation with self-governing rights, the HIF was moved under direct control of the government in 1998, due to structural administrative problems (3). Within the context of the entire healthcare system, the Ministry of Health is the main regulatory body. National policy framework is drawn up by the government, and Parliament debates bills and proposes amendments, with regulatory responsibilities in the hands of the Ministry of Health (1).

The HIF reimburses providers in various ways. Hospital outpatient clinics are paid fee-for-service, and acute/chronic centres paid according to a Diagnosis Related Group based system and by length of hospital stay. GPs can be paid by the local government, as independent private practitioners, or through the local hospital. However, the majority (77%) of GPs opt for ‘functional privatisation’, a payment scheme in which GPs contract with the HIF and are paid a capitation fee based on a patient list. As a result, the financial incentive is to refer patients on, resulting in a weak gatekeeping system. Therefore, although choice and competition between GPs is theoretically favourable to patients, the current payment system does not encourage GPs to serve their patients (1). Furthermore, in hospitals, the fee-for-service payment scheme discourages treatment as an outpatient and encourages hospitals to treat as an inpatient for financial gain, rather than for the ideal treatment of the patient (2).

Primary Care

In recent years the focus of the system has been shifted to primary care. Patients are encouraged by the government to seek referral from a GP of their choice to limit access to expensive healthcare measures, although in many cases they can go directly to a specialist if they wish. While GPs are meant to be involved in preventative medicine and education, their role continues to be a prescription and referral service (2). A lack of adequate GP training and financial incentives for physicians to retain patients are mainly to blame (1). As a result, though the intention is for a GPs role in primary care to be the patient’s first, and in many cases only, point of contact, this is not often seen in practice.

Hospital Provision

In Hungary's current system, most healthcare provision is by the local governments. Municipalities own primary care and outpatient clinics, and municipal hospitals provide secondary care. County governments run county hospitals that provide secondary and tertiary care. Some private, church owned hospitals still exist, but most still operate under HIF financing. Most pharmacies are privatised, but the overall role of the private sector continues to be minimal. The national government owns university and specialist hospitals, but most health care provision comes from local governments (1).

Reforms

In common with many of its former Communist Central and Eastern European neighbours, Hungary's healthcare system has been plagued by overprovision, oversupply of resources (including doctors) and duplication of services. Reforms focused on limiting the number of hospital beds, but failed to cut costs significantly because hospital infrastructure (including personnel and number of facilities) remained unchanged. In contrast to the oversupply of doctors, there is an undersupply of nurses. This results in doctors performing the duties of nurses - an unfortunate misuse of resources (2).

The 'managed care pilot', introduced in 1999, was another recent reform aimed at monitoring and controlling provider performance and influencing clinical behaviour. Under the pilot, a provider is allocated a virtual budget, which is based on capitation payment, and adjusted according to the size and composition of the local population. If the provider spends less than allocated by the virtual budget, the surplus is given to the provider to use to reward staff. Although it is too early to

judge the success of this ‘managed care pilot’, it is promising because it creates real incentives for improvement without altering existing financing and delivery arrangements (4).

System Inequalities

Despite theoretical access to health care for all members of society, there are still gaps in the system that prevent certain socio-economic groups from attaining comparable health status (1). Apart from the abovementioned out-of-pocket payments for pharmaceuticals and dental care, ‘gratitude’ payments by patients, a Communist legacy, continue to play an important role in Hungary. Lower than average salaries in the healthcare sector encourage these ‘gratitude payments’, which are subject to income tax, to guarantee quality or more speedy access to care. They substantially supplement most physicians’ salaries, but their existence clearly puts poorer patients at a disadvantage.

In addition, there are significant variations in health status owing to ethnic origin; the largely poor Roma minority living in Hungary have a life expectancy 10 years lower than the rest of the population (1). There are also geographical inequalities in healthcare provision, with Budapest enjoying the best health status and highest supply of resources by quite a large margin (2).

What lessons can we learn?

Hungary has transformed itself from a centrally controlled tax-based system to decentralised social insurance scheme (supplemented by taxation), with premiums collected by a single insurance fund. In a model more akin to France’s national

'*Caisses*' (CNAMTS, etc.) than to Germany with its competing sickness funds, the HIF operates as a single third party payer supervised by the government.

Contributions to the HIF are linked to employment and may be clearly seen by patients as a percentage of their income, with employers also contributing. The picture is distorted, however, by the continuing importance of under-the-table payments, which contribute substantially to financing health care. This supplementation of low physician salaries creates perverse incentives and, it is argued, hinders the reform process (3). However, it could be also argued that this post-Communist continuation of under-the-table payments might indicate that many Hungarians regard their healthcare as part public good and part consumer good, and to guarantee good service are willing to pay more for their healthcare. They are allowed to do so without contracting out of the national system, as private patients must do in the UK.

Furthermore, practical reform implementation has proven difficult, with the challenge of operating a primary care-based system within the infrastructure of an excessively large hospital system. A weak gatekeeping system and high specialist referral rates have undermined attempts to condense hospital systems and strengthen primary care. These remnants of the former centralised system, plus the relative youth of Hungary's system make it difficult to assess the success of health care reforms. Nevertheless, it is certain that underlying problems will require further organisational and funding reforms if Hungary's healthcare system is to be successful in balancing cost control with the needs and desires of patients.

Shannon C. Ferguson and Ben Irvine

References

- (1) Gaál, P., Rekassy, B., and Healy, J. Health Care Systems in Transition: Hungary. Copenhagen: European Observatory on Healthcare Systems, 1999.
- (2) Orosz, E., and Burns, A. The Healthcare System in Hungary. Paris: Organisation for Economic Co-operation and Development, 2000.
- (3) Orosz, E. and Hollo, I. 'Hospitals in Hungary: The story of stalled reforms,' *Eurohealth*, vol. 7, num. 3, Autumn 2001.
- (4) Gaál, P. Study of the Hungarian Health Care System. Civitas, 2002.