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Macroeconomic overview

The second half of 2008 was of course dominated and determined by the economic crisis that overrode every single economic policy plan previously announced. As Hungary was -and is- in a very vulnerable financial position, a EUR 20 billion IMF, EU and World Bank supported stand-by credit was approved on the 6th of November, 2008. According to the official press release the aim is "to implement a substantial fiscal adjustment to ensure that the government's debt-financing needs will decline; and to maintain adequate liquidity and strong levels of capital in the banking system." After the announcement the previously plummeting Forint stabilized, but on a weaker level.

During November the government tabled three different budget proposals within four weeks. The main reason was that the 2009 GDP growth forecasts were constantly worsening in the subsequent

proposals, namely from 3.0% to -0.9%. Table 1 contains the main figures of the economy. Also in November the Parliament passed the act on fiscal responsibility. On the one hand, the act assures by means of budget planning rules that no proposal can deteriorate the balance and the real debt level that was previously set. On the other hand, the act establishes the Fiscal Council that should exercise independent control over the budgeting process, and will also make methodological recommendations.

Table 1

	2007	2008 estimate	2009 forecast
GDP growth	1.1	1.3	-0.9
General government balance	-5.0	-3.4	-2.6
Primary budget balance	-0.9	0.6	1.9
HICP*	7.9	6.2	4.5
Gross earnings growth	8.0	7.8	2.5
Unemployment rate	7.4	7.7	8.0

* Harmonised Indices of Consumer Prices
Sources: Updated Convergence Program of Hungary, 2008-2011. December, 2008; for gross earnings: Central Statistical Office and GKI forecast

The main economic indicators and the government's plan to reduce the budget deficit in a deteriorating macroeconomic environment are considered risky by independent analysts. They see downward risk in GDP growth, inflation rate and employment rate forecast of the government, all pointing to a lower than predicted state revenue. Just before publishing this report Prime Minister Ferenc Gyurcsány announced that it is most probable that GDP decline will be around 2-3% instead of 0.9% planned before, so the budget needs replanning.

Health financing overview

In 2008 the most important change was the abolition of the visit-fee and the in-patient daily fee in April. Besides that, several medium scale changes were introduced in health financing:

- First GPs, and then from September out- and inpatient providers got HUF 50 compensation for each online eligibility check,
- financing multipliers for in-patient rehabilitation were raised,
- pharmaceutical companies are again obliged to pay a fee after their pharmaceutical or medical appliance promotion activity (see section “Act CVI of 2008.”),
- the Health Insurance Fund Administration is now entitled to abrogate a financing contract in case quality or other criteria are not fulfilled (see section “Act CVI of 2008.”),

- the capacity and catchment area planning process has changed (see section “Act CVI of 2008.”)

Currently there are no final figures for the 2008 Health Insurance Fund budget, but according to estimates there was an approximately HUF 45 billion saving. HUF 22 billion out of this amount have already been paid out to the health care providers (mainly in-patient) in December as additional financing, while the rest will presumably go to the central budget.

The biggest change in the 2009 budget is a strange decision that the central budget gives no compensation whatsoever after “child care fee” expenditures. Until 2008 the compensation was 100% (as this reimbursement is not connected to health care, the reason why it is in the HIF was merely technical), which was then changed to 50% in 2008. Moreover the pension contribution after this amount has now appeared among HIF expenditures. In nominal value this means a HUF 66 billion extra payment compared to 2008, and HUF 100 billion compared to 2007.

Because of the fiscal consequences of the crisis the government decided not to pay the 13th month payment to state employees, so this approximately HUF 30 billion was taken out from the budget of provisions in-kind.

To see the consequences of the above and other fiscal measures take a look at Table 2a and 2b. While contribution revenue is expected to rise by HUF 21 billion nominally in 2009 compared to 2008, the budget appropriation of provisions in-kind declined by HUF 22.8 billion and curative-preventive provisions in-kind by HUF 13.8

billion. The planned balance is HUF -8.8 billion. Without the discretionary changes in child care fee financing the balance would

be around HUF 57 billion on the positive side, making room for some development in the sector.

Table 2a

HUF millions	2007	2008 (budget estimate)	2009 (budget estimate)
Revenues of Health Insurance Fund	1 676 024	1 437 937	1 408 714
Contribution revenues	1 249 463	1 023 304	1 044 915
Central budget contributions	372 451	353 133	319 141
Other revenues connected with health insurance activities	50 420	60 556	43 698
Revenues for operation	3 680	936	936
Revenues from asset-management	11	8	24

Table 2b

HUF millions	2007	2008 (budget estimate)	2009 (budget estimate)
Expenditure of Health Insurance Fund	1 648 617	1 435 982	1 417 566
Pension provision	288 434	25 022	0
Provisions in cash	217 524	234 509	242 587
Provisions in kind	1 090 160	1 148 821	1 126 020
Curative-preventive provisions in-kind	718 717	741 431	727 583
Primary care	113 413	110 196	119 318
Special nursing at home	3 320	4 011	4 630
Outpatient specialist care (with laboratory fund and dispensaries)	116 185	120 915	133 693
Inpatient care	401 757	425 616	416 458
CT, MRI	12 115	11 709	0
Funds for structural change	22 421	0	0
Pharmaceutical reimbursement - total corrected	323 639	347 940	343 040
Reimbursement of therapeutical appliances	36 626	42 700	42 450
Other provisions in-kind	60 684	85 734	66 431
Health insurance budgetary agencies and centrally managed estimates (administration)	23 300	22 336	23 065
Other Expenditure of Health Insurance Fund	29 199	5 294	25 894

Source: NISHR

Security and Partnership Health care tasks till 2010

The Government drafted the main health care tasks till 2010 in the Security and Partnership Program. In order to improve quality of care and the health status of the population this program contains measures relating to health promotion, the reform of provider system, the reform of health insurance system and the development of human resources.

The major health programs (Public Health Program, and programs for cardiovascular diseases, cancer, youth health, emergency care) will be continued and strengthened. Enhanced intersectoral cooperation is needed at national, regional and local level. Health assessment studies are planned to be introduced as compulsory elements in the governmental decision-making process. The Government will make health consciousness of people stronger through active communication. Another goal is to increase efficiency of screening programs to combat circulatory diseases and cancer.

As far as the provider system is concerned, the most important goal is to improve the implementation of the principle of progressivity. The main elements are the following:

- Enhancing the role of GPs: some outpatient specialist services will be available also at primary level. For these services, GPs remuneration will be supplemented by fee-for-service payments.

- Developing the outpatient care system: building 23 new outpatient centres, improving the outpatient department in 8 hospitals and renovation of further outpatient clinics; new allocation mechanisms: task-, result- and quality-oriented elements in financing based on fee-for-service.
- Improving inpatient care: developing rehabilitation and long-term care, infrastructural development, revision of professional and financing protocols, revision of the strict performance volume limit.

A comprehensive human resources strategy is also needed. The principal objectives are:

- restoring the honour and prestige of the profession,
- regaining public confidence and making the profession attractive for young people (system of scholarship),
- motivating training and re-training of health professionals,
- support working methods beyond civil servant relation (e.g. to work as a freelancer).

A human resources monitoring system is planned to be developed.

The reform of the health insurance system must contain the strict control of eligibility and the strengthening of the role of the National Health Insurance Fund Administration (NHIFA) as a service-purchaser. From 1 January 2009 the NHIFA is divided into 7 regional funds that have to organise health care in their own region by purchasing services selectively from providers.

The central authority of the NHIFA deals with the system-level tasks, namely:

- managing the Health Insurance Fund, monitoring its incomes and expenditures,
- participation in the budget planning of the Health Insurance Fund and in the making of final accounts,
- remittances,
- producing and registering Social Insurance Identifier Numbers and issuing identification cards,
- operating the registration system for individual eligibility,
- inclusion of health technologies into social insurance reimbursement,
- dealing with international cooperative and financial/accounting tasks, managing international accounting, issuing certifications (EU health card).

The 7 regional health funds have to deal with the following tasks under the management of the director-general of NHIFA:

- inclusion and exclusion of health care providers,
- contracting,
- supervision,
- professional contacts with health care providers.

In the future citizens can manage the following affairs in most parts of the country in the agencies nearest to their residence:

- Social Insurance Identifier Number and EU health card,
- Public health care card,
- Sickness benefit,
- Maternity aid/allowance,
- Affairs related to eligibility,
- Complaints.

The main aspects of strengthening the purchaser role:

- Did the insuree get the health care for which he/she is eligible for?
- Did the provider fulfil the duties set in the contract?
- Did the provider not go further than its duties?
- Did the provider report a real, completed performance?

Sanctions:

- Withdrawal of extra payments,
- Assuring the provision of quality care:
 - professional supervision of the service provider's performance,
 - forcing the service provider to further train its staff,
 - temporary or final exclusion from public financing.

The decision n°109/2008 (Sept. 26.) of the Constitutional Court

The Constitutional Court annulled several provisions of Act CXXXII of 2006 on the development of the health care system, as well as the decree n°54/2006 (Dec.29) of the minister of health, relating to the redistribution of specialized care capacities and the rules of access to specialized care.

According to the Act CXXXII of 2006: the minister made a proposition on the regional redistribution of capacities whereon the Regional Health Councils (RHCs) gave their opinion. The decisions of the RHCs were valid only in case they were approved by the sustainer (owner) of all the state financed inpatient health care providers of the region. These sustainers are primarily local governments, universities and ecclesiastical authorities. Final decision in the issue was taken by the minister.

The Constitutional Court established that the order of procedures laid down by the above reform law and created for the redistribution of specialized inpatient care capacities did not meet the requirements of democracy. The minister of health could take a decision on the redistribution of capacities with legally inadequately defined decision criteria. The Act conveyed too wide-ranging authority for deliberation to the minister of health and therefore his decisions might not have been supervised by legal courts.

In connection with the decisions of the Regional Health Councils the Constitutional Court stated that the regulation had trespassed the principle of democracy as the certification of the validity of the RHC-decisions required approval from bodies (persons) that lacked democratic legitimation to exercise public authority. The regulation offended the basic rights of local governments, because representative bodies were empowered with the right to decide in cases that belong to public administration.

The decision of the minister on the redistribution of capacities has been qualified to be that of a public authority as the minister in his official role took a one-sided decision affecting the rights and obligations of health care providers and sustainers by the definition of their capacities (number of beds) and the area of their services. To all of these issues, the guidelines stipulated by law were too general, and it was the decree of the minister that provided a more detailed guidance. According to the statement of the Constitutional Court, the subject of the decree of the minister could only be regulated in the framework of an Act.

At the same time, the Constitutional Court rejected the propositions for the annulment of the reform law as a whole. The measures already taken according to the decree have been maintained (closures of hospitals, contracts concluded on hospital financing, capacity distributions in the institutions).

Act CVI of 2008 on the amendment of healthcare legislation

In December 2008 the Parliament adopted an act on the amendment of four health reform acts, two of which have been objected by the Constitutional Court (hospital development and pharmaceutical efficiency).

The goal of amending Act CXXXII of 2006 on the development of the healthcare delivery system (hospital act) is to create new procedural rules on the distribution of capacities in place of those annulled by the Constitutional Court.

In 2006 the hospital act was prepared for the purpose of distributing inpatient specialist capacities. Its annex provides a list of the national specialist institutes and the priority hospitals, and determines the inpatient specialist capacities to be financed in these institutions. This means protection for the national specialist institutes and the priority hospitals, since the annual capacity review and modification cannot affect them. The other annex of the hospital act includes inpatient specialist capacities broken down by specialties that can be redistributed once a year within the framework of the annual review.

These are not affected by the present change of legislation. The new act, however, includes an addendum that nationally sets the quantity of outpatient specialist capacity, as well as the outpatient specialties into which the capacities may be distributed.

According to the new rules of capacity distribution, before 30 June in every year the Health Insurance Fund examines the utilisation of healthcare providers' contracted capacities by regions on the basis of the previous year's data, then prepares

recommendation for modifying capacity distribution. This recommendation is sent to the Regional Health Council (RHC) and the competent health administration body according to the geographic location of RHC. Within 45 days of receipt the RHC sends its opinion of the recommendation to the health administration body. If the RHC does not send back an opinion within the deadline, it is considered as an agreement with the recommendation. In every case the regional chief medical officer decides on the annual redistribution. This decision cannot in essence change the total contracted capacity in the given region with respect to inpatient specialist care. As for outpatient specialist care, the decision can dispose with at most 5% above the capacities determined by law. Flexible capacity redistribution among providers belonging to the same owner can also be initiated by the owner itself.

The act includes the procedure to be applied in the case of inadequate quality of health service provision, as well as the circumstances of terminating contract with the service provider that performs inadequately.

The act sets the standards of assessment applied in the course of capacity modification.

In the course of decision making concerning inpatient specialist capacities it is necessary to ensure that at least in the basic specialties at least 95% of the population should reach the institute within 60 minutes. As for outpatient specialist capacities, at least in the basic specialties at least 90% of the population should reach the outpatient specialist institute within 30 minutes.

Due to amendment of Act XCVIII of 2006 on the safe and efficient provision of pharmaceuticals and medical appliance, the system of reimbursement and inclusion of pharmaceuticals is changed. According to the amendment, a medicine, an infant formula or a medical appliance is granted reimbursement if:

- the owner of the distribution license of medicine, the distributor of infant formula, or the manufacturer of medical appliance (or its authorised representative) requests reimbursement for the given product within the statutory health insurance;
- for medicine the competent authority has approved its safety and effectiveness and has permitted its distribution;
- the cost-efficiency of the given medicine, an infant formula or a medical appliance is verified; and is available for therapeutic use in an economical and expedient way;
- the requestor of inclusion undertakes to adhere to the rules regarding insurance costs;
- the necessary source of social insurance is available;
- the owner of the distribution license of medicine, the distributor of infant formula, or the manufacturer of medical appliance (or its authorised representative) undertakes the obligation to distribute and stockpile the product with reimbursement.

The health insurer reviews the range of reimbursed medicines on an ongoing basis. A medicine is excluded from reimbursement if:

- in the case of a medicine belonging to a fixed reimbursement group based

on active ingredient, its daily cost of therapy or the price of active ingredient per unit exceeds the daily cost of therapy of the reference product with at least 30%, furthermore

- in the case of a medicine belonging to reimbursement group based on therapeutic fixed principle, its daily cost of therapy exceeds the arithmetic mean of the daily cost of therapy of medicines in the group with at least 60%.

Pursuant to the act, pharmaceutical companies are obliged to pay a fee only after those doctor's visitors who actually perform activities. Earlier the Constitutional Court objected to the act's condition that required payment of fee for all registered doctor's visitors independent of whether such activities were pursued or not.

There has been a change in setting the solidarity fee of pharmacies. Global payment is unchanged, the amendment affects pharmacies (about 50) with the largest income from the margin who must pay higher solidarity fee, while payment for the rest is reduced.

The health insurer evaluates healthcare providers on the basis of the quality and efficiency of pharmaceutical ordering. If a doctor deviates from the rules of efficient pharmaceutical ordering, the health insurer imposes obligatory continuing education.

The act terminates the Managed Care System launched in 1999 as a pilot project. Henceforward no health service can be provided within the framework of the Managed Care System and no such activity is allowed to be pursued.

Hungarian healthcare in international context

In the course of 2008 the Hungarian healthcare system has been evaluated by two international organisations: the Health Consumer Powerhouse and the OECD. The Euro Health Consumer Index 2008 (EHCI) made by the Health Consumer Powerhouse was published in November. The EHCI is the annual ranking of national European healthcare systems from the point of view of consumers and covers 31 countries in 2008. The EHCI groups 34 quality indicators into six categories: Patient rights and information, e-Health, Waiting time for treatment, Outcomes, Range and reach of services provided, Pharmaceuticals. This year the Netherlands' healthcare system was rated the best in Europe. Hungary ranks 14th in the Index, which is a vast improvement compared to last year's placement of 24th. Hungary reached 647 points from the maximum 1000 points. This year's better placement is due to improvement in the field of patient information, introduction of pharmacopoeia, provider catalogue and the Doctor Info health portal, and incorporation of patients' rights in the national legislation. The EHCI cites Hungary as an example that an important improvement can be made without increasing healthcare spending considerably. In terms of outcomes, however, there is much room for improvement (e.g. infant mortality, 5-year cancer survival, potential years of life lost).

The OECD study published in April 2008 (Reforms for Stability and Sustainable Growth: An OECD Perspective on Hungary) looks at ongoing efforts of

Hungary to promote sustainable growth to accelerate the convergence process to EU criteria. It proposes structural reforms to achieve these objectives. The chapter about healthcare ("Healthcare Reform: Improving Efficiency and Quality of Care") compliments Hungary for creating a "momentum for change" after scanty reform action since the mid-1990s. Though the study points out weaknesses in the healthcare system - poor health status of the population, relatively low public health spending, inadequate performance of the healthcare system, narrow fiscal space for health reforms -, it also mentions the success of reform measures taken in 2007. These measures, especially the reform of the pharmaceutical market, made an important contribution to fiscal consolidation and enabled the Health Insurance Fund to close with a surplus. In 2007 the total net budgetary savings of the health sector was 0.4% of GDP. The reform measures also included structural changes to improve the performance of the health system in terms of allocative efficiency and transparency.

The other OECD study entitled „Health Status Determinants: Lifestyle, Environment, Health Care Resources and Efficiency” (04-Aug-2008) examines the impact of healthcare and other determinants on the health status of the population and attempts to provide evidence on whether healthcare resources are producing similar value for money across OECD countries. Hungary is among the worst in the 30 countries examined for morbidity indicators, together with Slovakia and

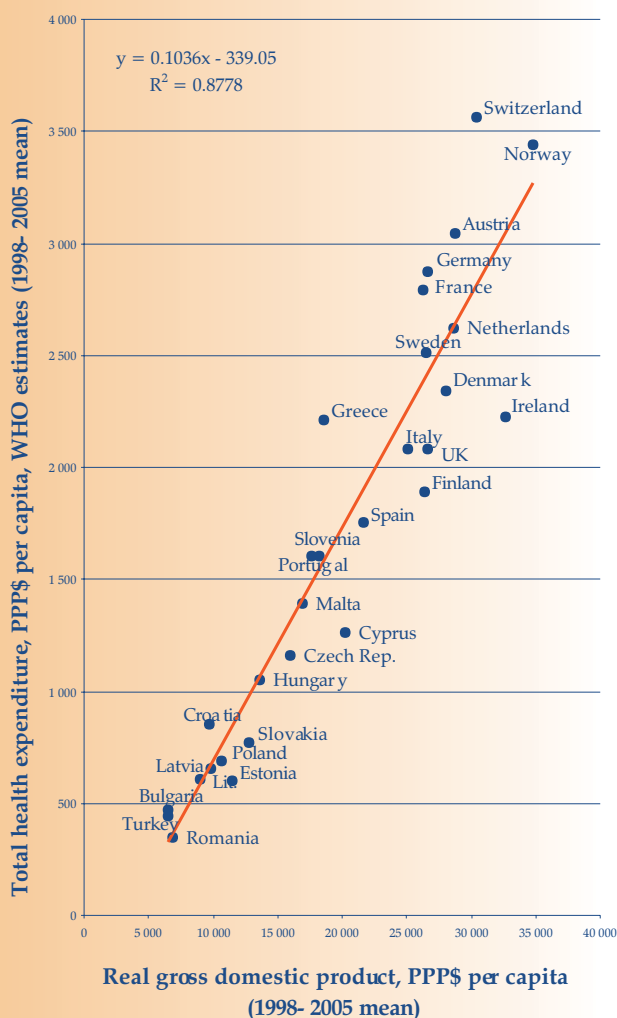
Turkey. Japan ranks the best in all morbidity indicators. According to the results of health status measures, the countries form homogeneous groups and Hungary is in the group with the worst results, together with Poland, the Czech Republic, Slovakia, Turkey and Mexico. In the study the authors make the health status of the population dependent on health care spending per capita, consumption of tobacco, alcohol, fruits and vegetables per capita, level of education, pollution and GDP per capita. Life expectancy at birth in Hungary is 5.6 years shorter than the OECD average. Health-care spending is responsible for -2 years life expectancy at birth in Hungary, but this variable and other country fixed effects can explain only in part the differences found in the health status of the population across countries. The residual variables that account for country-specific effects may reflect efficiency differences. With respect to Hungary, the residual variables are responsible for 3.1 years of falling behind the OECD average of life expectancy at birth out of the 5.6-year lag.

In connection with the above OECD study ESKI¹ has prepared an analysis on the relationship of health expenditure, GDP and life expectancy at birth. According to ESKI's multivariate regression analysis, life expectancy at birth is basically determined by GDP per capita. Beyond this the amount of

¹ Előd Veres, Ph.D.

health expenditure per capita (due to the linear connection of explanatory variables) does not increase the explanatory power of the model. Naturally, the effect of GDP per capita may be modulated by the *relative* weight of health expenditure, though we were unable to prove that this increases the model's explanatory power either with multivariate regression analysis or analysis of variance (ANOVA).

Graph 1: Gross domestic product, PPP\$ per capita and total health expenditure, PPP\$ per capita



Graph 2: Gross domestic product, PPP\$ per capita and life expectancy at birth

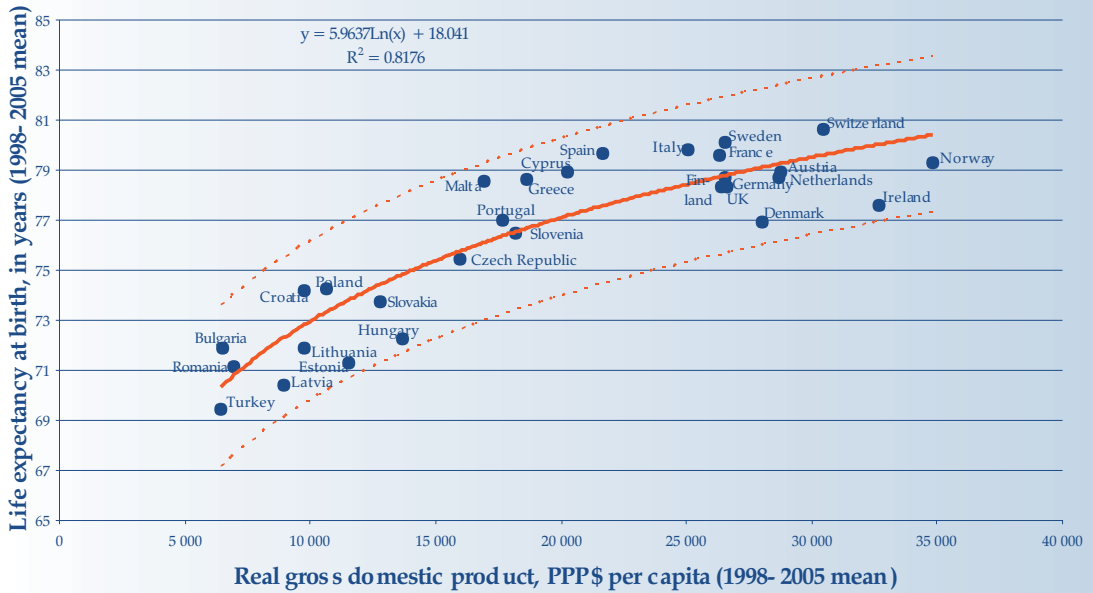


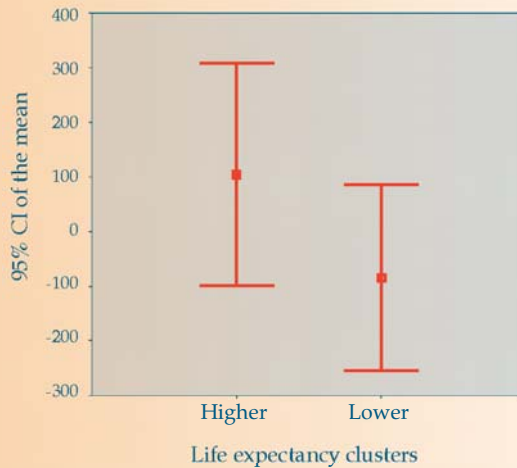
Table 3: Matrix of countries grouped by deviations from expected total health expenditure per capita and deviations from expected life expectancy

1998-2005 average		Life expectancy at birth compared to expected level based on GDP			
		Higher		Lower	
Health expenditure per capita compared to expected level based on GDP	Higher (PPP\$ per capita)	Switzerland	746	Germany	460
		Greece	623	Austria	398
		France	404	Norway	168
		Croatia	183	Turkey	114
		Bulgaria	141	Slovenia	58
		Portugal	112	Latvia	19
		Sweden	102		
		Malta	-24	Netherlands	-7
	Romania	-27	Hungary	-20	
	Poland	-78	Lithuania	-20	
	Spain	-152	Czech Republic	-151	
	Italy	-180	Slovakia	-219	
	Cyprus	-492	Denmark	-222	
			Estonia	-251	
			United Kingdom	-335	
			Finland	-507	
		Ireland	-822		

Mean	104		-84
F=2.38			
Sig.: 0.13			

Source of data: WHO, Health for All database

Graph 3. Confidence Interval of mean deviations from expected total health expenditure per capita in the above two LE clusters



According to our analysis of variance, in those countries where life expectancy at birth is higher than expected based on GDP, the average of the relative weight of health expenditure is not significantly

higher (+\$104/per capita) at the 5% level than in those countries where life expectancy at birth relative to GDP is lower (-\$84/per capita).

