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The Health System Scan newsletter deals with the most important changes of Hungarian healthcare and health policy, including economic background, healthcare legislation, health reforms and their outcomes. It is cited in the publications of international organizations, and the letters of request for the newsletter from ministries and research institutes of several countries provide us with further incentive to continue the publication. Your questions, opinions or suggestions are greatly appreciated (healthscan@eski.hu):

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Macroeconomic overview

The first half of 2010 was dominated by the tight fiscal policy of the Bajnai government that replaced the Gyurcsány-administration in April 2009 with the explicit aim to reduce the budget deficit.

In April 2010, a new government took power led by centre-right Fidesz. In October they enacted a universal 16% income tax rate effective from 2011. The basis of the tax is the so called “supergross” income, which is the gross income plus employer social insurance contributions that adds an extra 27%. In 2012 the extra reduces to 13.5% and in 2013 it fades out completely according to current legislation. (The “supergross” base was invented by the preceding Bajnai government and it was operative in 2010 with a 17% lower and a 32% upper tax rate.) At the same time, the range of tax credits is considerably narrowed, except for child tax allowance, where a generous scheme is introduced.

The new administration, in order to be able to carry out their economic recovery policy – including the gradual

reduction of the corporate tax rate to 10% from 19% – and at the same time to keep the deficit under 3.8% in 2010 and 3% in 2011, imposed “crisis-taxes” on the banking, telecom, energy and retail sectors. These extra taxes will be in force – at least – until the end of 2012, making an extra HUF 360 billion/year for the budget.

Moreover, the government introduced several measures affecting the private pension-insurance system, which acted as a compulsory second pillar next to state pensions. Firstly, from 2010 November until 2011 December, private pension contributions go to the state budget instead of the private funds.

This is approximately HUF 30 billion/month extra. Secondly, but more importantly the government virtually ends the compulsory private pension system by offering the choice to citizens to either remain in the private system, but with the condition that they lose their right for state pension concerning their revenues after December 2011, or they completely opt-in to the state pension system, resulting in the loss of their private savings.

On the one hand these measures clearly ameliorate the budget position as long as they are in effect, while on the other hand the long-term sustainability is not yet clear. (Table 1)

Table 1: Main macroeconomic figures

| | 2009 | 2010 (forecast) | 2011 (forecast) |
|--|------|-----------------|-----------------|
| Real GDP growth | -6.7 | 1.1 | 2.8 |
| General government balance as % of GDP | -4.0 | -3.8 | -2.3 |
| Primary budget balance as % of GDP | 0.2 | 0.7 | 0.3 |
| CPI | 4.0 | 4.9 | 3.8 |
| Gross earnings growth | 0.6 | 2.3 | 3.5 |
| Unemployment rate | 10.0 | 11.3 | 11.0 |

Sources: Eurostat, Central Statistical Office, The Central Bank, GKI

An additional macroeconomic risk is that crisis taxes are to be examined by the European Union, while the measure on the choice of private or state pension is on the agenda of the Constitutional

Court. Although it is really hard to forecast decisions on these questions as both supporters and opponents have their reasoning, radical changes are unlikely.

Health financing overview

In the first half of 2010 some promising changes took place in health financing: international reference-pricing came into effect for pharmaceuticals and therapeutic appliances, legislation on medical technology assessment – which are neither pharmaceuticals, nor therapeutic appliances – was accepted and 18 financing protocols were published. Although all of these represent good practice, in our opinion, their real value will depend on their appropriate application.

The new government haven't – yet – introduced substantial changes to the revenue collection side of health financing (the employer contribution has dropped to 2% from 5% and the itemized health contribution has been abolished just as planned), while initiated some changes in the allocative side from 2011 on. The tight performance volume limit is somewhat softened by the reintroduction of degressive financing above the limit. In the pharmaceutical field, favourable (efficient) prescription routine by doctors will be rewarded and not punished. Another compensation scheme targets pharmacies that may

alter the doctors' prescriptions to cheaper, but therapeutically equivalent substitutes. The previous administration initiated a GP evaluation scheme based on quality indicators where GPs with good results are financially rewarded. This system is kept with some modifications and the amount for incentivization is elevated.

Just like in 2009, in-patient providers got extra (i.e. not included in budget provisions) funding at the end of 2010, basically to avoid bankruptcy and keep the system running. The amount was HUF 27.5 billion and it mainly had to be spent on the debts of institutions, while the rest went to two specific fields (hemodynamics and open heart surgery; traumatologic and orthopedic prosthetic surgery) in order to shorten waiting lists. By accepting this help, institutions agreed to make a consolidation plan, to participate in a regular debt-monitoring system and to cooperate in territorial capacity restructuring.

Table 2. and 3. contains some information on the development of the Health Insurance Fund.

On the revenue side, contribution revenues drop from 2010 as the rate more than halves and the itemized

contribution disappears, while central budget compensation rises significantly. This means that the tax-contribution financing mix shifts to the tax side.

Expenditures decline by 2.9 and 2.7 percent in real terms in 2010 and 2011 respectively. Or at least that is what budget estimates say. A great part of this drop is achieved on sick-pay in both years as a result of change in the rules, falling employment – and probably ameliorating morale caused by a shaky labour market situation due to the

economic crisis. Another substantial contributor to the downfall is pharmaceutical reimbursement. In 2011 real term increase is foreseen in special nursing at home, ambulance services and chronic in-patient care. There is also a HUF 15 billion surplus reserve that can be spent provided that pharmaceutical expenditures do not exceed their time-proportionate value during 2011. The deficit of the Fund is planned to be HUF -69.4 billion in 2010 and -88.7 billion in 2011.

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

| | 2009 (final account) | 2010 (budget estimate) | 2011 (budget estimate) |
|---|-------------------------|---------------------------|---------------------------|
| Revenues of Health Insurance Fund | 1 269 366 | 1 376 095 | 1 370 937 |
| Contribution revenues | 898 597 | 689 480 | 676 782 |
| Central budget compensations | 319 142 | 617 271 | 642 370 |
| Other revenues connected with health insurance activities | 49 932 | 68 364 | 51 345 |
| Revenues for operation | 1 681 | 936 | 425 |
| Revenues from asset-management | 15 | 44 | 15 |

Source: NISHR, http://www.eski.hu/alaptabla/English/Ealapbe_e.xls

Table 3: Expenditures of the Health Insurance Fund, HUF millions

| | 2009 (final account) | 2010 (budget estimate) | 2011 (budget estimate) |
|---|-------------------------|------------------------------|------------------------------|
| Expenditure of Health Insurance Fund | 1 418 832 | 1 445 503 | 1 459 614 |
| Provisions in cash of the Health Insurance Fund | 247 287 | 237 657 | 232 518 |
| Provisions in kind | 1 123 197 | 1 161 471 | 1 188 795 |
| Curative-preventive provisions in kind | 719 031 | 757 632 | 770 120 |
| Primary care | 118 818 | 118 146 | 122 553 |
| Service of dispensaries | 4 595 | 2 300 | 2 300 |
| Special nursing at home | 3 818 | 3 678 | 4 405 |
| Outpatient specialist care+CT, MRI (with laboratory fund) | 129 282 | 137 230 | 139 441 |
| Inpatient care | 410 432 | 440 671 | 445 164 |
| Other curative-preventive provisions in-kind | 52 086 | 55 607 | 56 257 |
| Expenditures on pharmaceuticals | 343 175 | 345 374 | 343 544 |
| Pharmaceutical reimbursement | 328 511 | 300 040 | 296 244 |
| Reimbursement of therapeutical appliances | 46 352 | 45 400 | 44 772 |
| Other provisions in-kind | 14 639 | 13 064 | 15 358 |
| Health insurance budgetary agencies and centrally managed estimates | 23 038 | 20 952 | 10 964 |
| Other expenditure | 25 319 | 25 424 | 27 337 |

Source: NISHR, http://www.eski.hu/alaptabla/English/Ealapki_e.xls

Elections, government

The parliamentary elections held on April 11 and 25 in Hungary resulted in the victory of the centre-right alliance of the Fidesz–Hungarian Civic Union and the Christian Democratic People's Party (KDNP). The alliance won 263 seats in the 386-seat parliament and thus gained a two-thirds majority in the legislation. The former governing party, the Socialists won 59 seats, the far-right Jobbik 47 seats and the eco-centric LMP (Politics Can Be Different) 16 seats.

The Fidesz–Christian Democratic alliance also had an overwhelming victory in the October municipal elections. As a result, they provide mayors for 22 out of 23 major cities in the country and for 19 out of 23 districts in Budapest, as well as control all 19 county assemblies.

The Prime Minister of the new government is Viktor Orbán, chairman of the Fidesz–Hungarian Civic Union. The government operates with a new structure where „superministries” embrace some formerly separate ministries. Healthcare belongs to the new Ministry of National Resources led by Semmelweis University professor Miklós Réthelyi, who is also in charge of social affairs, sport, education and culture. The different divisions within the Ministry of National Resources are led by state secretaries. Miklós Szócska was appointed to head the Secretariat of State for Health Affairs.

The establishment of government offices

On January 1, government offices – in Budapest and in the 19 counties – were established as the legal successors of the previous public administration authorities. 14 territorially organized administration authorities – among them the Regional Health Insurance Institutions and the regional institutions of the National Public Health and Medical Officer Service – have been integrated into the new governmental bodies. Among others they perform tasks of coordination, supervision, informatics, and harmonisation of specialized public administration functions.

Under the new government offices there are 29 customer service offices (4 new offices in Budapest and 25 around the country), so called “government windows”, which are the first step to a single-window administration system in the official issues related to the state. Full operation is expected to be in place by the end of 2013.

Changes in legislation – 2010

The new Hungarian government – elected in spring 2010 – has brought about several changes in legislation.

From 26 September 2010, the Health Insurance Supervisory Authority, set up in 2006, had been abolished. In the future the tasks of the authority will be taken over by the Hungarian National

Public Health and Medical Officer Service and the National Health Insurance Fund administration: so assessing complaints will be assumed by National Public Health and Medical Officer Service, while collecting reports on waiting lists will fall within the responsibility of National Health Insurance Fund Administration.

By virtue of the new legislation, restrictions have been imposed on the establishment of pharmacies. From July 2010 to January 2011, the establishment of pharmacies in municipalities with an operating public pharmacy has been banned by the Parliament, moreover giving concession to the fusion of pharmacy enterprises has also been prohibited. At the same time the intention to change the rules on establishing and operating pharmacies was announced.

This plan was realized by the law that had been passed in December 2010. In the future, the establishment of a public pharmacy will be allowed only in municipalities:

- where an operating public pharmacy has not yet been put in place,
- where the population served by the public pharmacy (together with the old one) reaches at least 4000, or in greater municipalities 4500,
- and where the distance between the entrance of the public pharmacy already in place and that of the new public pharmacy is 250 meters in

towns with more than 50 000 inhabitants, and at least 300 meters in other municipalities.

New public pharmacies may be established only with the majority ownership of a pharmacist. In case of operating pharmacies, a transition period is stipulated by the law for obtaining majority ownership of a pharmacy by pharmacists. The 50% limit is to be attained by 1 January 2017 (and at least 25% by 1 January 2014). From 1 January 2011, pharmaceutical companies or pharmaceutical wholesalers are not allowed to acquire ownership directly or indirectly in public pharmacies, and after 31 May 2011 off-shore companies may not have ownership in pharmacies. The law restricts the activity of pharmacy chains, too. It is not allowed for more than 4 pharmacies to come under the direction of a given company or group of companies.

Up to 2010, physicians whose prescription practice widely differed from the average were obliged to follow a special training on the subject. From 2011 on, penalties will be replaced by rewarding. According to the changes in legislation, physicians who keep in sight efficiency in the use of the pharmaceutical fund, will be rewarded from the Health Insurance Fund. Prescribing by health care providers is assessed by the health insurance authority from the point of view whether providers prescribe equally favourable products for both the patients

and the Health Insurance Fund, taking into account special therapeutical indications and previously determined requirements for professional adequacy.

Pharmacies are supported by a similar incentive system if the medicine prescribed by the physician is provided by means of changing it – if replaceable – to another product of equal therapeutic value:

- in case of a fix group based on active ingredient, replacement may take place by a reference product or by another product with therapeutic costs equal to or lower than the daily therapeutic costs of the reference product,
- in case a fix group has not been determined, replacement may take place by a product generating lower daily therapeutic costs.

In June 2009, a decree was passed by the government on the system of higher professional medical training, the so called “resident training”, the rules of which would have come into effect only in 2010. According to the provisions of the law, residents would assume the responsibility that during their studies, as well as during the following 4 years, they would follow the professional activity of their speciality in a contractual relationship with their employer, in return for the state support of the costs of their training. According to the regulation, central interns (who take part in the training of general medicine or scarce professions) are

obligated to perform health care activities in accordance with their special training at a state financed health care provider in Hungary for 4 years after certification. This regulation gave rise to protests by students, who considered it as a binding measure. In summer 2010, the decree of the new government revoked the binding rule.

The act passed in December 2010 brought about changes in the restructuring of health care providers’ capacities, abolished certain categorisation of the health system (for instance hospitals of high priority), and laid the foundation for structural reorganisation. From 2013 on, annual capacity distribution will be done every 3 years, to ensure enough time for the adjustment of the operation of capacities. The tasks of the Regional Health Councils in connection with the distribution of capacities of secondary health care will be taken over by the health care administration agency of the state who takes into account the proposal – based on the utilisation of the hospital bed capacity – of the health insurance authority.

At the end of December, the Ministry of National Resources presented a bill to the Parliament on the reinstatement of the general mandatory membership in the Hungarian Medical Chamber, as well as in all other chambers of health professionals. Mandatory membership that had earlier been in effect was abolished in 2007.

Semmelweis Plan

The Secretary of State for Health Care of the Hungarian Ministry of National Resources has prepared a reform plan under the title „Revived health care, recovering Hungary – Semmelweis Plan to save health care”, and submitted it in the form of a discussion paper for professional consultation. The consultation is still in progress.

The health policy programme aims to establish a sustainable rearrangement of the health system, while maintaining the uniform social insurance model. The action plan attempting to overcome the present crisis includes loosening or abolishing (through deregulation) the regulatory framework that hinders the operability of the system, the financial-economic stabilization of provider institutions, the development of workforce supply system, and the deceleration and prevention of migration of health care professionals.

The new government aims to reach the average of the developed EU member states in the magnitude and structure of health care expenditure: the long-term target is to reach the EU average in public health expenditure, to reduce the proportion of private health expenditure, and to rearrange its structure. (At present, the share of public health expenditure in GDP is 2.1 percent lower than the average of the other three Visegrad countries, and private health expenditure is dominated by out-of-pocket expenditure.)

The main elements of this middle- and long-term sectoral strategy are the following: organization of patient pathways, the restructuring of the health care delivery system, the promotion of the functional integration of provider institutions, the development of technical quality, and the moderation of territorial inequalities in the health care delivery system.

Health policy decision-makers plan to carry out the financial stabilization between November 2010 and December 2011, in two steps: through immediate resource allocation in 2010 and stabilization surplus funding in 2011. They plan to use the surplus resources primarily in three priority areas: to modernize the fleet of the National Ambulance Service, to strengthen primary care and extend its functions (in order to reduce the burden of specialized care), and to reduce the debt of hospitals and health care providers.

To establish **financial sustainability**, effective and transparent resource allocation mechanisms are required that are adjusted to needs. To achieve this, the Semmelweis Plan aims at abolishing the strict performance volume limit in inpatient care. Treatments above the performance volume limit are planned to be reimbursed according to the variable cost of the case.

The government also plans to abolish the strict performance volume limit in outpatient care in order to reduce the provision burden on inpatient care. However, because of the currently used financing method, a significant

performance growth is expected, which makes the change of the financial method also necessary. The present fee-for-service system would be replaced by a system of ambulatory Homogeneous Disease Groups (Hungarian version of DRG).

The action plan aims at creating a career path model for **health care professionals that**, with the changes in the remuneration, education and in the conditions of the employment forms, provides motivation for staying in the field and working in Hungary.

Outlining the framework for the **institutional system for public health care organization** is an important part of the Semmelweis Plan. The basis of the organization of services is the “supraterritorial” level, which is larger than the county, but smaller than the region.

Health care would be delivered on the following progressivity levels:

0. Outpatient care level: health care services in the small hospitals and outpatient offices close to the population, patient pathway management on subregional level

1. In- and outpatient care institution: provides inpatient and associated outpatient care in the basic professions close to the population

2. In- and outpatient care centre on county level: provides county-level specialised care

3. In- and outpatient centre on supraterritorial level: provides full care in the determined area

4. National professional centres and sub-centres: provide costly and specialised care centralized on a national level.

It is to be determined by profession and sub-specialty as to which type of care and on which progressivity level should be provided, and on which professional areas the national centres should be established.

The publicly financed institutions that provide specialized care will join the Supraterritorial Health Organization Directorate. (The primary care institutions would be integrated through the outpatient institutions that manage the subregional patient pathways.)

The tasks of the Supraterritorial Health Organization Directorate are the following:

- optimizing the population patient pathways in their area of competence,
- elaborating a model for supraterritorial cooperation,
- creating cooperation agreements, establishing project organizations/companies (e.g. mutual procurement, debt management) on supraterritorial and national levels,
- supporting activities specific to profession (telediagnosics, laboratory, etc.),
- managing economic support activities,
- controlling and supervising,
- organizing education and training for health care professionals.

The specialized treatments that are organized into national centres are coordinated by the State Health Organization Centre, which supervises also the Supraterritorial Directorates.

The Semmelweis Plan devotes special attention to the development of **sectoral informatics**. In order to establish a uniform system of sectoral reports, a sectoral portal would be created, which would serve as legally authentic source of sectoral master data. The health monitoring and needs-based capacity planning system integrates the aggregated data that are generated in the sector, and makes them analyzable through data-mining and GIS applications.

The Plan addresses the issues of the **ownership and management** of health care providers. Inpatient institutions should be kept in public ownership (or in non-profit private operation), and there is room for ownership privatization in the primary and outpatient specialized care. On the basis of the assessment of corporative experiences, it is necessary to broaden the competence of management in the operation of health care institutions. The Plan supports the involvement of doctors and other health care professionals in the management of health care providers and in certain cases in ownership as well. The health care administration supports sector-neutral financing. The costs of capital are planned to be integrated in social insurance financing.

In **emergency care**, the creators of the Plan suggest a single-gate entrance system both in prehospital and hospital emergency care. They support the organization of a uniform dispatcher system centralized in the National Ambulance Service as well as the related out-of-hours service, and the establishment of an adequate emergency unit in every hospital providing acute care.

The Plan regards **primary care** as key element of the health care delivery system. It wants to strengthen the ability and interest of primary care units in definitive care, prevention and health education. It supports the establishment of practice groups and the formation of practice communities. It intends to create a practice fund, which would take over the practices that are on sale (but unmarketable), and would offer opportunity for young doctors to purchase the practice under favourable credit arrangements. Beside the existing financing mechanisms, it would offer opportunity for performance-based funding in certain areas.

Quality and cost-effectiveness stand in the centre of **pharmaceutical policy**. In the pharmaceutical supply system, health policy decision-makers strive for a needs-based supply structure. They will introduce incentives that support the participation of pharmacies in the public health programme and the services offered by pharmacies. They will upgrade the generic programme and wish to motivate cost-effective prescription, dispensation and the rational utilization of pharmaceuticals.

The health care administration attaches special importance to safe, appropriate and timely patient care that serves the satisfaction of patients. For the purpose of **quality development**, it envisages several measures:

- upgrading the indicators in the primary care system (family doctor system), and establishing a feedback system,
- creating an accreditation system in specialized care,
- within the framework of the accreditation system, the establishment and improvement of a reporting system of undesirable events and a pharmacist care services,
- methodological support of the development of professional guidelines,
- the elaboration and application of a uniform patient satisfaction survey, and the introduction of patient reported outcomes after treatment in certain disease groups.

Source: *Semmelweis Plan, October 2010.*



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Hungarian Presidency

Hungary holds the rotating presidency of the Council of the EU in the first half of 2011. With respect to health, the Hungarian Presidency will lay great stress on cooperation in health policy. Though Member States are responsible for their health system, cooperation is necessary in certain areas of public health like communicable diseases, cross-border health services, health hazards, regulation of human tissue use. Creation of a single pharmaceutical market and the consumer protection policy will also be major areas of health policy. Helping to meet future challenges of health care and to achieve sustainable health systems in the EU, the Hungarian Presidency will encourage investments into health systems of the future, support new models to increase efficiency in health care, address issues of human resource in health and support the development of e-health.

Important issues to be addressed constructively during the Hungarian Presidency include the European Commission's Pharmaceutical Package, the EU Influenza Pandemic Preparedness Plan, the cross-border aspects of childhood vaccination, the EU's Public Health Programme, mental health, healthy lifestyle of children and young people. <http://www.eu2011.hu/>

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