

# HEALTH FINANCING IN HUNGARY: TAKING STOCK

by Éva Orosz\*

Paper presented to the 2nd International Research Conference on Social Security  
International Social Security Association  
Jerusalem, 25-28 January 1998

Important changes have taken place since 1989 in the Hungarian health care system, particularly in the health financing: the switch from tax-based funding to *funding through compulsory insurance* and the introduction of *performance-based remuneration*. By the mid-1990, however, reforms implemented have started to exert their side-effects and new problems created by economic transition have been on the increase. The question of "whither the health reform?" is still open. The following basic questions of the health care reform are yet to be answered: How much (public money) should Hungary spend on health care? How to distribute the burden of funding the health care system? What principles of access (for what services) should be applied? How to improve efficiency? What kind of public/private mix (in financing and service provision) should be developed? How to define the responsibility and scope of authority of Ministry of Welfare, health insurance and local governments? *The main purpose of the paper is to give an overview of and assess - from the perspective of the above questions - the main processes of the transition of the health financing system in Hungary*

## INTRODUCTION

Fundamental social, economic and political changes form the general driving forces behind the transformation in the health sector, while different concepts and endeavours of the major interest groups effect the government policy and particular decisions. The differentiation, polarisation of society, the increase of differences in income, on the one hand, have produced well-off groups in society with considerable purchasing power for private provision of health services. On the other hand, the increase of unemployment, the development of regional crisis areas, inflation, and the suspension of former consumer subsidies, increasing poverty affect the increasing inequalities in conditions of healthy life and access to care. The strengthening of a consumer attitude in society started well before the political changes. In the last two or three decades the market of consumer products has been characterised by a broadening variety, and society's differentiation of consumption. The discontent of higher-income strata was increased by the fact that, as opposed to consumer products, in health care there was no "official" way to spend their income on better services (e.g. they were not officially allowed single-bed rooms, a personal nurse, etc.). In a broader interpretation: the effects of commercialisation developing in other fields influence expectations of health care, too; they effect the patients' demand, the behaviour and attitude of doctors which increases the population's expectations.

Transformation to market economy accompanied by a deep economic recession in the early 1990s effected in many ways the health sector. Dramatic decrease in GDP between 1990-94 limited the financial resources of health care, and the priority of reducing the budget deficit, brushing all other objectives aside, has brought to the fore the aspects of reducing welfare expenses. Also, lack of additional resources hinders the modernisation of the service structure.

And last but not least the development of health care is fundamentally influenced by long-term processes of international scale, the *ageing of population*, *the development of medical technology* (the rise of treatment costs), the need to develop technology both on the part of doctors and the population. These processes greatly influence the increase of health care expenses, in turn a pressure on the government to transfer the financial burden to the population.

Transition of the Hungarian health care system is connected to basic elements of the political and economic transformation such as changing role of the State, decreasing redistribution by the state budget, privatisation, competition and individual freedom. A well-functioning health care system meeting the requirements of equity, efficiency and quality should be developed under a situation of transition when economy, society and political system are undergoing dramatic changes and are fraught with uncertainty and instability. It makes difficult to reconcile long-term visions with short run exigencies. In fact, the grave economic situation set the agenda for the health reform rather than internal problems of the health system - forcing and at the same time hindering the changes.

---

\* Éva Orosz, PhD, Associate Professor, Department of Social Policy, Eötvös Loránd University, H-1088 Budapest, Múzeum krt. 4-C Tel/Fax: (36-1) 266 1008, E-mail: oroszeva@mail.matav.hu

Transformation of the Hungarian health care system is an intricate multi-dimensional process, of which main facets are:

- *health policy debates and formation of reform programs and measures to implement them*
- *struggle for redistribution of the power within the health care sector*, changing role of the State. Conflicts between the Ministry of Finance, Ministry of Welfare and Health Insurance can be understood as manifestation of this.
- *spontaneous, market-driven processes*. Aggressive market behaviour of the pharmaceutical and equipment-making companies, furthermore wide-spread corruption influences the distribution of public resources to a great extent.

### **Major problems of the health care system**

Present crisis of the health system is a complex one consisting of three intertwining factors: long-lasting problems inherited from the state-socialism, new problems created by economic transformation, and side-effects of the ongoing health care reform.

*Problems inherited from socialist system are:*

- deterioration of health status and inability of public policy to react to it
- deficiencies of the health care system
  - inefficient resource allocation
  - ineffective, highly-centralised management
  - excess capacity in acute hospital care
  - widening gap between existing capacities and available financial resources
- dual structure of health care system

*Problems created by economic transition are:*

- growing tension between health expenditures and income-producing capacity of economy
- distorted fund-raising
- distorted pharmaceutical market, soaring pharmaceutical expenditures
- growing deficit of health insurance (as a consequence of the above factors)

*Side-effects created by ongoing health reform are:*

- adverse incentives generated by the new financing methods introduced in 1993
- disintegration of financial and professional control
- wide-spread bending of the rules of the financing system (false reporting of performance)

Hungarian state-socialist health care had a dual system: a shadow health care (in form of the gratitude money), similar to the shadow economy functioning according to different rules, and the official state health care. Consequently, it would be misleading to interpret the current process simply as the transformation of an over-centralised state health care into a 'public-private mix' system. It must be seen as the transformation of the previous dual system - official state and shadow private- into a system which is a symbiosis of a public and a 'legal' and shadow private care. It should be stressed that the 'official' system and the shadow system have never been sharply separated. Similarly, there is no clear-cut division between the public and private sectors: public institutions often provide a background or basis for the operation of the private sector.

Fundamental questions arise: How to transform the above described dual system into an institutionalised, regulated 'public-private mix', that is how to eliminate the 'shadow' system (gratitude money)? How relevant is the privatisation as a solution for this problem? What would be the most appropriate public/private mix in financing and service provision? What measurements are needed in order to enhance efficiency and the quality of services, widen freedom of choice and last but not least improve the health status of the population? What are the main impediments to achieving these goals.

To cope with these problems would be a demanding task even if Hungary had a well-considered health care reform program, capable health care administration and public support for the implementation of reforms. In reality, there is no consensus even within the government and the ruling political parties as to the basic issues of the reform, health care administration is rather weak and support of the population and health professionals are missing.

### **Process of health care reform**

Important changes have taken place since 1989, particularly in the health financing system. Major measures include:

- switch from tax-based funding to funding through compulsory insurance, establishment of an autonomous purchaser of health services: the Health Insurance Fund,

- greater emphasis on primary care, introduction of the Family Physician Service,
- decentralisation and privatisation mainly in service provision
- performance-based remuneration has begun while maintaining a cap on health expenditures
- a start on reduction of excess hospital capacities

In 1990-91 the shift to health insurance, reorganisation of primary care and privatisation, then in 1993-94 the introduction of performance-based financing and in 1995-96 restructuring of hospital care were given priority by health policy-makers. Shift to social insurance was expected to provide secure financing (vs earlier weak position in the yearly bargaining over the state budget). The health administration expected the remedy of structural problems from performance-based financing, while doctors expected the improvement their personal income from it. In fact, none of these expectations have been fulfilled. It soon became obvious that reform ideas and implementation, expectations concerning reform measures and actual effects differ. By the mid-1990, reforms implemented have started to exert their side-effects and new problems created by economic transition have been on the increase. As a consequence, health policy has become doubtful about the goals set in 1989-90.

## MAJOR ISSUES OF FINANCING

### Trends in health expenditures

During the socialist era, and especially in the '60s and '70s, the "non-productive" sectors, including health care, were considered low priority. A comparison of trends in health care expenditures in Hungary and in the advanced Western countries highlights fundamental differences. Between the early 1960s and the mid-1970s Western countries experienced an expansionary phase: in the period of economic prosperity, health expenditures increased 40-60 percent faster than the GDP. The Hungarian health care system, however, has never experienced a similar (expansionary) period. (The share of GDP going to public sector health expenditures remained at a very low level, growing very slowly (from 3-3,5% in the 1960-1970s to 4.5% in 1989). The lack of such a modernisation period exerts its effect even nowadays. There is no contradiction between this statement and the fact that there has been great increase in the number of the hospital beds and physicians. The expansion in these inputs took place at the expense of low salary of medical manpower, lagging medical technology and maintenance of the infrastructure.

	1989	1990	1991	1992	1993	1994	1995	1996
<b>HI Fund</b>	<b>3.9</b>	<b>4.6</b>	<b>5.3</b>	<b>5.4</b>	<b>5.4</b>	<b>5.8</b>	<b>5.2</b>	<b>5.3</b>
o/w Personal services	2.8	3.6	3.9	3.9	3.8	3.9	3.5	3.5
o/w Pharmaceutical subsidies	1.1	1	1.4	1.5	1.5	1.6	1.5	1.5
State budget (recurrent)	0.4	0.3	0.5	0.7	0.7	0.8	0.9	0.6
Investment	0.5	0.5	0.6	0.6	0.6	0.6	0.4	0.3
<b>TOTAL PUBLIC EXPENDITURES</b>	<b>4.9</b>	<b>5.4</b>	<b>6.4</b>	<b>6.7</b>	<b>6.7</b>	<b>7.2</b>	<b>6.5</b>	<b>6.2</b>
Private co-payments on drugs	0.2	0.3	0.3	0.3	0.4	0.5	0.7	0.7
Source: calculations based on data by HIF, MoW, MF. (data before 1992 do not contain administrative costs of the HIF.)								

In 1996, the per capita expenditures were around 220 USD - calculated at exchange rate (it would be higher at PPP, while in developed western countries they reached 6 to 10 times as much. (When making this comparison, it has to be taken into account that we purchase medical equipment and medicine at the same prices as they do.)

In the trend of health expenditures the following phases can be discerned:

- the public sector health expenditures increased substantially as a share of GDP between 1989 and 1991, from 4.9% in 1989 to 6.4% in 1991. (Table 1). *There are two factors that justify this: in these two years, real GDP decreased rapidly, and in 1990, during the period of transition from direct financing from the state Budget to a health insurance scheme, funds allocated to the health care sector increased considerably.*
- Between 1991 and 1993 share of the (public sector) health expenditures in GDP remained at the same level. It means that the contraction of health care resources was similar to that of the GDP.

- 1994 is an „outlier“: both real value of health expenditures and their share in the GDP increased. (Presumably it was an effect of „the election year“.)
- In 1995-96 both the share of health expenditures in GDP and their real value decreased. The *real value* of funds allocated for *ambulatory and in-patient care* decreased by 25% between 1990 and 1996. As it is generally known, inflation in health care was above average, therefore the decrease in the real value of expenditures allocated for *ambulatory and in-patient care* between 1990 and 1995 was, in fact, even more significant (about 43%, taking into account the special rate of inflation affecting the health care sector). It contributed to growing debts of great number of hospitals.

The increase of the share of health expenditures in GDP has been determined primarily by the „denominator“ that is the fall of the GDP. (It should be emphasised that the data are based on the registered GDP, while the black economy is estimated about 20-30% of the GDP. Consequently the share of public expenditures is less than these figures show. On the other hand, because of the gratitude money we can only estimate the total expenditures.)

The decrease of the share of health expenditures in GDP has been brought about primarily by the drastic cut of real value of expenditures (a modest increase in GDP also contributed to it). A „paradox“ of the situation is that the *volume of services have been considerably increasing during the period of this drastic cut*. Consequently the „unit price“ (forint value of a performance unit) of both the inpatient and outpatient services decreased.

	Total	Medical services	Pharmaceutical subsidies	Total	Medical services	Pharmaceutical subsidies
	(1)+(2)	(1)	(2)	(1)+(2)	(1)	(2)
	1990=100	1990=100	1990=100	1990=100	1990=100	1990=100
1989	97	91	116	93	87	111
1990	100	100	100	100	100	100
1991	100	94	118	93	88	110
1992	97	91	120	73	68	90
1993	95	86	124	70	64	92
1994	103	94	132	76	69	97
1995	92	83	123	66	59	88
1996	84	75	112	63	56	84

Source: calculations based on data by HIF

The distribution of health insurance fund between *expenditures on personal health care and drug subsidies* has changed considerably: in 1990, their ratio was 76.7% vs. 22.2%, while by 1996, it had reached 70% vs. 30%. It is to be noted that compared to international data, the proportion of drug subsidies was already high back in 1990. The share of drug subsidies in GDP has increased from 1% to 1.5%. Total expenditures including patients' co-payment reached 2.2% of GDP in 1996. The public expenditures on drug in 1996 amount to 4.5 times the nominal value of 1990 expenses, while the relevant figure for patients' co-payment is above 5 times.

In the early 1990s - from a macro-economic point of view - the share of health expenditures in GDP was relatively high for Hungary's level of income. On the other hand, it can not be considered satisfactory in comparison to social needs. This conflict, basically rooted in the low level of our economic development, has been further sharpened by the crisis resulting from the transition to a market economy, by the *dramatic decrease of GDP*. This basic contradiction between a macro-economic viewpoint and the requirements of the health sector cannot be solved in the short run. As a consequence of a modest increase in GDP and a cut (in real terms) in health expenditures the *share of health care in GDP decreased in 1995 and 1996*.

### A shift to compulsory health insurance

The independent Social Insurance Fund was established in 1989 (prior to which the revenues and expenditures of social insurance institutions were not separated from the state budget). The expenses of drug subsidies were transferred from the budget to the fund in 1989. The financing of health care services was transferred to Social Insurance Fund in 1990.

There are three main sources of funding the health care system: social insurance contributions paid by employers and employees, general revenues (state budget), direct (out-of-pocket) payments. Investments and public health (hygiene and health promotion) activities are financed from the state budget. As to social insurance, in 1993 employers paid 44% and employees paid 10% of which 19.5% and 4% were for health insurance. (Employers' contribution gradually decreased: it was 18% in 1996, while in 1997 employers pay 15% plus 1800 Ft /per month/per capita payments. ) Health insurance covers health care services, pharmaceutical subsidies, sick pay and disability pensions under retirement age. This high contribution rate encourages the black economy, underreporting of earnings, non-payment of assessed contributions, and discourages employment. Two main elements of the direct payments are co-payments on drugs and gratuity money. *Gratuity money goes directly to doctors, distributed extremely unevenly among them, and it distorts the incentives of the official financing methods.* Co-payments on drugs have increased by more than 4 times between 1990 and 1995.

**During the transition period, despite the cost-containment measures, HIF has not been able to balance its budget. The deficit has been - directly or indirectly - due mainly to economic factors outside the health sector.**

	REVENUES	REVENUES	EXPENDITURE	EXPENDITURE	DEFICIT
	in real value 1992=100		in real value 1992=100		in real value 1992=100
	budgeted	actual	budgeted	actual	actual
1992	100	100	100	100	100
1993	92.6	97.1	98.2	97	96.6
1994	96.9	110.7	96.9	106.2	57.3
1995	97.9	96.1	97.9	92.6	54.8
1996	89.1	85.3	89.3	85.4	87.4
	REVENUES	EXPENDITURE	DEFICIT	DEFICIT	
	as % of GDP			as % of revenues	
1992	8	8.8	-0.7	9.2	
1993	7.9	8.6	-0.7	9.2	
1994	8.7	9.1	-0.4	4.8	
1995	7.6	8	-0.4	5.2	
1996	7.1	7.8	-0.7	9.3	
			-		

Source: calculations, based on data by HIF

#### Factors reducing the revenues of the HIF:

- reduction in the number of employees, emergence of mass unemployment (Between 1990 and 1994 the economy lost 28% of the wage-earners)
- Considerable groups are evading the payment of social insurance taxes through:
  - underreporting of earnings in private sector, growing black economy, The most striking disparity is the extent of evasion by the *self-employed*: in 1995, the annual per capita total contribution of the self-employed was one fifth of that of salaried employees
  - non-payment of assessed contributions in both private and public sector (Accumulated arrears of social insurance has amounted to near 24% of the total revenues in 1995. It decreased slightly to 19% in 1996.)
- Contribution on behalf of non-active population groups - pensioners, unemployed, those on social assistance are ill-defined. Until 1997, the National Pension Insurance Fund paid contribution on behalf of the pensioners and the state paid a lump-sum of money as contributions on behalf of certain non-active population groups (receiving social assistance). This amount of money was far below what would be reasonable: calculated on average per capita health expenditures. Consequently the burden on controllable incomes is great, cross-subsidising by contributions paid by employers is unreasonably high. However, in 1997 both the contribution paid by the Pension Fund and the lump-sum payment by the State was eliminated.

Summing up, funding-system of social insurance could not accommodate to the economic processes. **Long-term strategy for funding-system of the health insurance has not been put forward and adequate registration and collecting procedures have not been developed.**

On the expenditure side, problems manifest themselves in different ways:

- curative-preventive services have fixed spending caps - tensions are occurring at the micro-level (e.g. increasing deficit of the hospitals)
- drug-subsidies, sick pay and disability pensions are „open-ended“. Expenditures on these items have exceeded every year the budgeted values contributing to the deficit of the HIF. (The only exception was the spending on sick pay in 1996.)

*Not disregarding the problems of imbalance*, calculations suggest that the Ministry of Finance (and some politicians and the media) exaggerate the extent of the deficit of the HIF. In real terms the deficit decreased considerably between 1992 and 1995. In 1995, when dramatic statements were made about the *increase* of the deficit - in fact, it was 0.4% of the GDP while 0.7% in 1992. The primary cause of the increase of the deficit in 1996 was the cut of the health insurance contribution rate by 1.5% (from 19.5 to 18) and *not* an increase in expenditures (as we seen, real value of the expenditures decreased) If cut of the health insurance contribution rate had not occurred in 1996, the deficit would have been 3.7% of the revenues instead of 9.3%.

### Reform of the financing methods

The former system was inefficient, but able to control costs. *Since the 1988 reform document, financing according to performance has been a top-priority goal.* The new system has been expected to encourage micro-efficiency, while maintaining cost-control. The shift to new methods of remuneration of providers represents a serious effort to improve efficiency by linking payment to performance. New methods of payment, as implemented to date, are fraught with flaws.

Provider Payment Mechanisms in Hungary	
TYPE OF SERVICE	REMUNERATION METHOD
<u>Family Doctor Service</u>	fixed allowance per doctor + weighted capitation
<u>Inpatient Care</u>	
1. Acute Hospital Care	
- general rule	DRG-type with spending cap
- special services (kidney dialysis, CT, MRI, cardiac surgery, etc.)	fee-for-service
2. Long-term Care	per diem
<u>Outpatient Specialist Care</u>	basic fee + capped fee-for-service (German point system)
<u>Special "Tasks"</u> (school health, public health nurse services, dental care, special dispensaries, etc.)	fixed budget (historical basis)

The capitation system for family physicians does not provide sufficient incentive to improve the content of Family Medicine. As to the specialized care, *performance-related financing was compromised by retaining elements of the old system* in order to avoid mass bankruptcy of health care institutions. The capped fee-for-service method for outpatient specialist care was applied to only 45% of the budget until the end of 1995. This financing method theoretically reduces the incentive to increase services otherwise built into a fixed-tariff fee-for-service system. In practice in Hungary, it does not seem to have generated the desired effect. The result has been an increase in the number of "service points", and a reduction in the money value of a single point.

A hospital can earn HIF revenues from different sub-funds: acute care; long-term care; special services such as kidney dialysis, CT, MRI, heart surgery, etc.; and out-patient care. Acute care and long-term care are financed in different ways, as described below. Special services are remunerated by fee-for-service. Acute care services are financed essentially by a method similar to that of the American Diagnosis Related Groups (DRG). However, the DRG method as applied in Hungary's hospitals rewarded past inefficient performance by assigning higher "cost coefficients" to hospitals that had higher unit costs in 1992. The Forint value of each unit of performance was hospital-specific until the end of 1995, and it was determined on the basis of the given hospital's costs and performance in 1992. Hospitals that had higher unit costs in 1992 received higher weights. (These relative values ranged from 14,000 to 60,000 Forints per DRG unit of performance, i.e., per average case). In October 1995, the hospital-specific Forint values of DRG unit of performance was eliminated and two "coefficients" were introduced: so-called professional (department) coefficient and the "institutional coefficient". Furthermore - according to the government regulation - individual hospitals could not fall outside the range of 90% and 120% of their previous revenues. It was again a compromise between performance-related finance and the old input/previous budget/-related finance - because of the fear of bankruptcy of hospitals. Changes introduced in 1995 further confused even messed the relationship between real performance of an individual hospital and remuneration given for it by the health insurance. Changes introduced in March 1997, eliminated the above mentioned "coefficients" and intends to reach a uniform money value for DRG unit of performance by April 1998.

### **General problems of the financing system**

- Slightly simplifying the matter, we can describe the past few years as the *system of financing having distributed resources, diminishing in real value and "collected" from an ever-shrinking segment of the population, using inadequately developed methods -- in an uncontrolled and "abandoned" service provision system*. And this amid a social environment where the evasion of laws and regulations is a generally accepted behavioural model, and, further, where, amid rapid social polarisation, the revenues of the budgetary sphere (including health care) have broken away from the realm of economic competition at a never previously experienced pace. Gratitude money is fulfilling its earlier "function", providing an adequate income for doctors and ensuring "peace" with respect to health care in the political domain, less and less.

- **Two opposing criteria clashed in the transformation of the funding system.** On the one hand, we have the **efficiency approach**: establishing balance between institutions' activity and their income (normative financing providing identical fee for identical performance). On the other we are looking at the criterion of **political security**, that is, to weathering inevitable changes with the least possible conflict. The principal argument of the latter approach was maintaining the operational viability of health care. The health care administration (both the Ministry and Health Insurance) has always been divided over the issue of performance financing, with respect to employing market-type incentives. The Health Insurance Self-Government (formed in 1993), and the National Health Insurance Fund have inherited the new financing system - then inaugurated - and were not prepared for its likely problems. Thus, from the very outset, its attitude thereto had been divided and ambivalent.

- **The drastic fall in 1995-1996 in the real value of expenditures** on treatment and prevention triggered of counter-reactions. Trade unions were pressing for higher wages, hospitals for consolidation. This led to supplementary money being channelled into the system of service provision - this money was not, however, distributed as a function of actual performance. **Ultimately, curtailment of expenditure ran contrary to increased efficiency, to genuine reforms.**

- Hospitals' revenue derives, on the one hand, from their services to out-patients and, on the other, from their services to in-patients, as allocated based on the above methods. Since they are significantly better off if they attend to a patient as an in-patient (rather than as an out-patient), the **financing system is prompting hospitals to adopt a behaviour in total contradistinction with health care policy goals.**

- Fees paid by health insurance and operational costs do not contain cover for amortisation (we shall subject this issue to closer scrutiny later on).

- Performance-based financing has stopped at the door of institutions, and the Act on Public Employees has put in place regulation of a mentality diametrically opposed to performance financing.

- Significant difference appears between the regional distribution of resources and the public's need

### **The special situation of health care institutions**

In the more broadly interpreted sphere of health care several markets with markedly differing characteristics are linked together: the market for capital goods, different types of current assets, the labour market, etc., and, on the other hand, the market for health care services. On the *market for capital goods, assets and medicines, health care institutions appear as buyers*. The conditions of these markets determine the costs of the services. These markets are dominated by uncontrolled prices, unregulated conditions and an aggressive market behaviour, with buyer institutions little able to influence prices. (In addition, in this sector corruption is occasionally a factor greatly influencing actual processes.) A few characteristic figures with respect to price trends: between 1992 and 1996 the price of surgical thread has jumped four-fold, the price of surgical plaster five-fold and that of AGFA film 2.2-fold.

On the other side we have the *market for health services, where the hospital (institution) is the seller, and National Health Insurance Fund (in principle) the buyer of services*. NHIF is a monopoly buyer, who can dictate terms. Financing methods fix price ratios, as well as the maximum with respect to total expenditure. The incentive to step up quantity has proved to be more powerful than the performance-curtailling impact of price reduction.

***Institutions have found themselves in a situation wherein, as buyers, they are faced with an upward trend in prices, while at the same time, as sellers, they are faced with a downward trend in prices.*** This "dual pressure" has elicited various institutional behaviours, one of which is institutional indebtedness and pressure on the Ministry of Public Welfare and HIF for supplementary resources.

Recent years have demonstrated that it is not enough to deal with improving the financing system. The government must address the analysis and the potential for influencing (including investment regulation) the market for medical technology and other material factors.

### **Financing of investments**

Management of capital assets currently lacks the criteria of both economic rationality and those of public policy (equal access to service provision). Even though health care institutions also calculate amortisation and net asset value pursuant to effective financial reporting provisions, these calculations have an exclusively informative role, and do not fulfil any economic function whatsoever. Nowhere and in no form does a development fund accumulate to offset the calculated amortisation.

Capital goods have no real price to the proprietor and to the institutional management, since central subsidy is the largest single item among investment sources. The service-providing institution does not perceive or bear a major element (capital cost) of the actual cost of services. This manifests itself at the level of the "system as a whole" (borne by society, the tax and dues-paying citizen). Collective irresponsibility characteristic of the former system persists: not a single player in the system perceives that superfluous and unused fixed assets significantly mark up the actual cost of services. Superfluous and under-used investment capacities draw resources away from other areas, where the same amount of investment could, given rational resource allocation, ensure provision of far better quality and cost-effectiveness. Similarly to previous decades, investments have been largely influenced (and continue to be influenced) by the individual aspirations of influential doctors, the ability of hospital managers and proprietors to "get things done", the individual interests of central decision makers. (The situation has only deteriorated in tandem with dwindling investment sources and swelling ranks of lobbyists pushing for those resources, with, for instance, Members of Parliament in tow). A misguided investment policy has created the superfluous capacities. Therefore, satisfactory handling of development projects is an extremely topical task, and restructuring is extremely pressing, also with respect to the scaling down of hospital capacities. The present system signifies an disproportionate burden on the local authorities who own the institutions. In a town with a hospital, the burdens of development and maintenance fall exclusively to the local authority, despite the fact that a hospital provides services to the population of several towns and settlements. Hitherto experiments to enter into shared maintenance have not been successful in a single case. A detailed proposal for a solution was hammered out by years ago, whereby the cover for asset replacement (the amortisation ratio) is linked to performance fees, and which includes the mandatory accumulation of an amortisation fund on tied-up assets.

### **Privatization and decentralization in the Hungarian health sector**

In Hungary nationalisation, carried out in the fifties, did not wholly eliminate private practice, though it remained rather limited up to the late 1980s. But only physicians with a full-time employment by the state sector could have a private practice. In the late 1980s there were about five thousand doctors who had private practice, approximately half of them were dentists, the rest were mainly general practitioners, surgeons and gynaecologists. Occasionally - depending upon the general political situation - attempts were made to curb private practice, but characteristically always leaving a "back door" open. The institutions of public health "tacitly" meant a background to private practice in many ways. For instance, the physicians arranged the diagnostic tests of their private patients usually in the state hospital where they were employed as if they were public patients.

Since the late 1980s privatisation of health care has been taking place in all three major fields: regulation, finance and services. Some of the processes are mainly state-driven, while others market-driven. But this has not affected public sector dominance so far. It should be emphasised that there is no clear-cut division between the public and private sectors - public institutions often provide a background or basis for the operation of the private sector.

The most important components of privatisation in health care are:

- privatisation of production and trade of medical equipment and pharmaceuticals
- emergence of private insurance
- an increase in direct payment (for prescriptions, private doctors etc.)
- reorganisation of primary care (introduction of family doctor system)
- privatisation of pharmacies
- development of private medical companies
- privatisation of (part of) hospitals and out-patient clinics owned by the local governments

*Privatisation have been far more important in provision than is finance.*

### **State-driven privatisation**

In 1989 and 1990, the main intention in politics was to provide proper ground for and to support private businesses, and therefore ensure unbiased (so-called „sector-neutral“) financing. That was hoped to lead to the improvement of efficiency and quality, as well as to a better response to market demands. However, in the early 1990s, health policy - mainly through proclaiming sector-neutral financing as a major goal - encouraged for the establishment of new private enterprises in a period of time, when the financial resources were insufficient even to cover the expenses of existing capacities. However the reality has proven to be much more complicated than theory. Privatisation did not start in the health care in 1990. By 1992, even political goals were reduced to the so called “functional privatisation” of family doctor services and support of new private institutions - the privatisation of the existing stock of public institutions (especially hospitals) were opposed by the government.

Functional privatization has meant that a family doctor has become self-employed (or established a private firm) having contract with the local government and the health insurance - while the local government remained the owner of the health care facilities. 4933 (73%) of the total 6802 family doctor services functioned as private practices or enterprises in early 1995.

Since 1994 the law gives possibility for similar way of “functional privatisation” (special form of “opting out”) for specialists too. However, it has happened only in very few cases so far. Another form of privatisation is the “contracting out” of the management of the hospitals. Many plans under preparation and one case that failed could be mentioned.

### **Market-driven privatisation**

Despite the uncertainty of health policy, privatisation has evolved in several ways in Hungarian health care since 1989. Private enterprises are extremely heterogeneous, ranging from physicians working individually to foreign companies striving for an international presence. The majority of private medical provision is financed by the consumers' direct payments. An important minority are those enterprises which have contract with the Health Insurance Fund - these foreign and Hungarian firms are playing an increasing part in the establishment of diagnostic centers and the realization of high-tech developments. In 1996, about 50% of kidney dialysis and about 70% of the MRI examinations was provided by private centers having contract with the Health Insurance Fund. One of the main causes for the expansion of the private sector lies with that - in lack of capital - the resources of the state and local governments are insufficient to answer the medical and citizens' demands for modern medical technological developments.

It should be stressed that those private enterprises could expand which has been financed by the HIF. The relationships between health care businesses and the Health Insurance Fund is, however, rather delicate. The 1991 budget entitled the Health Insurance Fund to conclude contracts with private providers, but no detailed concept had been worked out as to what aspects should be considered when signing the contracts and how prices should be defined. There is a danger that, in some time, having strong market positions private enterprises will be able to dictate the prices in some case of high-tech services. The privatisation of dialysis treatment has indeed led to higher standards, but increased costs for an increasing number of patients have led to resources being diverted from other areas of health care. We do not know whether it is improved or not the allocative efficiency.

## **MAJOR ALTERNATIVES OF THE REFORM - WHAT KIND OF PUBLIC / PRIVATE MIX?**

During 1995-96 policy debates sharpened as to the main direction of the reform. We must emphasize that, explicitly or implicitly, the two alternatives concerning the main trend of the reform have been present since

the mid-80s in professional and political debates and various programs. One of the possibilities is a health care system based fundamentally on *public financing* (compulsory insurance and tax-financing) and mixed ownership in the service sector (in providing services the non-profit sector takes over, to a great extent, the role of the state sector), in which private health insurance assume a supplementary role. *The main objective of this reform are to contain costs and to increase the efficiency of the health care system.* That is, the objective is the development of a service structure, an institutional-, financing- and information system which guarantees that the money spent on health care contributes to the greatest possible improvement in health status. In short: the main objective here is to increase "value for money". (The modernization program of the Ministry of Welfare, as well as the strategy of the Health Insurance Self-Government follows these principles.)

The other approach, sometimes supported by the Ministry of Finance, states that the *main objective of the reform is to reduce public expenditures*, as a result of which the financial resources of health care need to be provided for, to a great extent, from the private sector: a widespread introduction of patient fees, and private health policies. In this case public financing would be limited to rather basic services, and the health care of the poor. Considering short-term, top-priority budget interests, the Ministry of Finance tends to overlook that this trend contradicts long-term socio-economic interests of the country, for it would launch structural changes which are likely to lead to exclusion from adequate health care of great part of the population or/and massive increase of total health expenditures.

The new bills on Health and Health Insurance reflect the approach of the Ministry of Welfare: retaining the dominance of public financing. However, we expect that the debate between the two approach will not come to an end.

## CONCLUSION

Nowadays many are of the view in political and governmental circles alike that the "genuine" reform of health care has not yet taken place, indeed it has not even begun. In our opinion dominant political and media views underestimate the significance of hitherto changes in the macro structure of the health care system, overestimate the negative side-effects of reforms to date, underestimate the time required for transformation, overestimate the potential for government intervention, underestimate (or do not take into consideration) spontaneous processes, overestimate spectacular public reaction (e.g. the demonstrations against hospital closure) and underestimate (or do not take into consideration) the dominant expectations of the public vis-à-vis the state (which are quite unequivocally manifest in public opinion research).

In actual fact, fundamental changes have taken place in the health care system since the Eighties. The transformation of the system is riddled with contradictions partly as the result of conscious reform moves and partly as that of spontaneous processes: fundamental changes have taken place in both the macro structure and the incentives operating in the health care sector. Obviously we are not saying that further significant structural changes are not necessary.

In actual fact, the present framework of the health care system is as follows: public funding, which accounts for 70-80 % of expenditures, mandatory insurance covering almost the entire population, voluntary supplementary insurance (the legal possibility thereof), mixed ownership relations, the separation of the role of purchaser and service provider, and the establishment of the contractual relationship, the new financing methods for institutions are in line, generally speaking, with Western European systems. (At the same time, we emphasize that Western European systems reveal rather different traits by individual country). The general standard of medical expertise also stands up to comparison, with Hungary keeping abreast with medical technology at a comparatively fast pace. Nonetheless, everybody is dissatisfied and advocates the necessity of "the" reform.

The reason for this is that the changes that have taken place in the macro-structure have not brought about a spectacular and rapid solution to the basic problems such as deficit in health insurance, the problems related to the cost-effectiveness and quality of service provision, the doctor-patient relationship and the meeting of consumer demand. Indeed, they could not have. They could not have done so even if in tandem with these changes the real value of expenditures were to have increased rather than decreased. The problems of efficiency and quality are manifold. A majority of incentives impacting the behaviours of institutions and doctors (including gratitude money!) run contrary to the criteria of efficiency and quality. Patients are treated at a higher level of the health care system than is medically required. On the one hand, there is a great deal of superfluous service provision, even as, on the other, some people do not have access even to services they are in need of. Adequate incentives are lacking on all levels of the health care system: hospitals' financial interest conflict with the professional goals of health care policy (the transformation of the structure of service provision). Neither doctors, nor patients have a stake in cost-effective provision, with patients not trusting that they might receive satisfactory service provision even in the absence of gratitude money, there does not exist an infrastructure to satisfy the needs of the affluent, etc. These problems cannot, however, be resolved overnight by any major overhaul of the health care system. In our view, we ought not be thinking in

terms of a one-off "major reform", but, rather, in terms of incremental development, changes and programs aiming at improving efficiency and quality on an ongoing basis. The balance of health insurance fundamentally hinges on economic growth. And general improvement in quality perceivable by the public and by doctors can hardly be imagined without a significant increase in the real value of health care expenditures.

The question of "whither the health reform" is still open. The following basic questions of the health care reform are to be answered: *How much (public money) should Hungary spend on health care? How to distribute the burden of funding the health care system? What principles of access (for what services) should be applied? How to improve efficiency? What kind of public/private mix (in financing and service provision) should be developed? How to define the responsibility and scope of authority of MoW, health insurance and local governments?*

The forthcoming years will show whither privatization is progressing, whether restructuring of health care delivery will be profound or only illusive, toward what model the Hungarian health care system is muddling through. The analysis of the processes involved and the possible effects of different policy options can help decision-making. However, we should not cherish illusion - political ideologies and improvisation under the pressure of economic exigencies might influence the reform more strongly than principles of equity and efficiency.