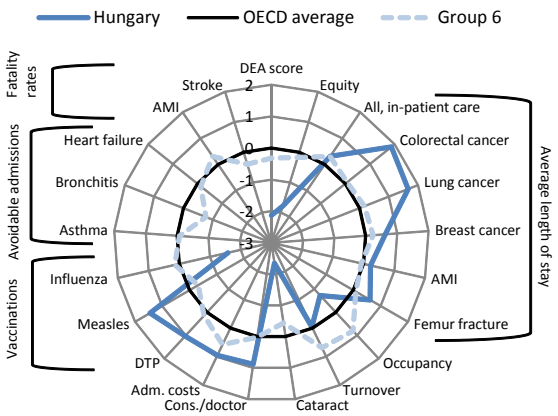
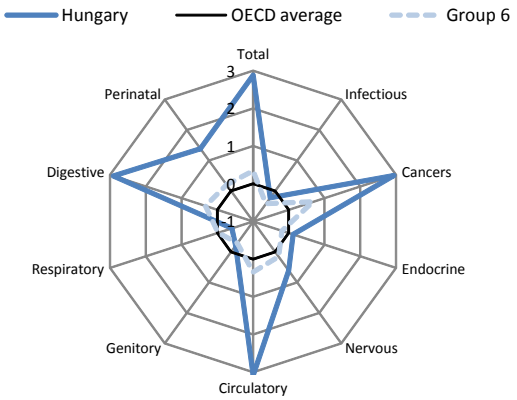
Hungary: health care indicators

Group 6: Hungary, Ireland, Italy, New Zealand, Norway, Poland, United Kingdom

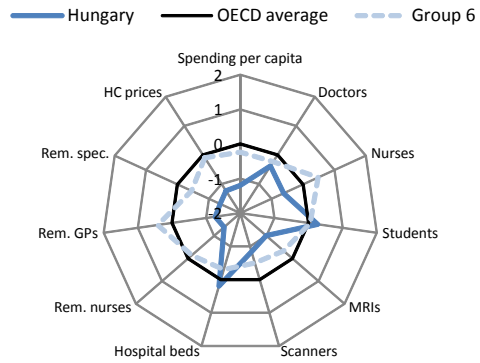
A. Efficiency and quality



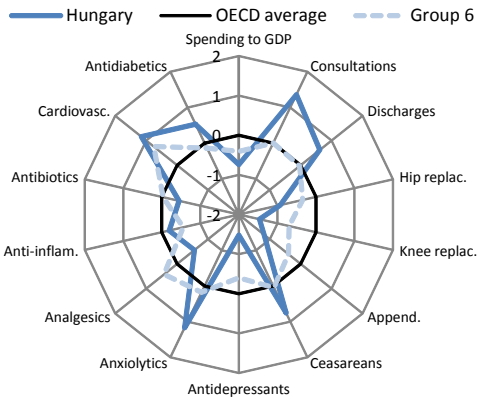
B. Amenable mortality by group of causes



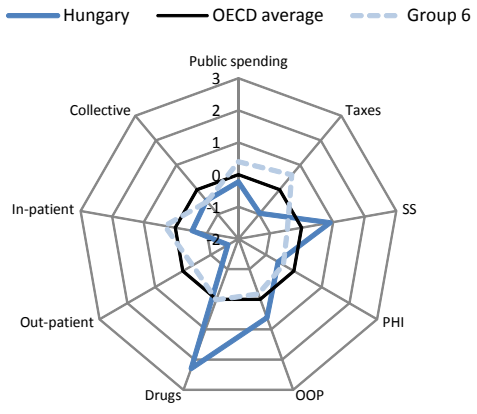
C. Prices and physical resources



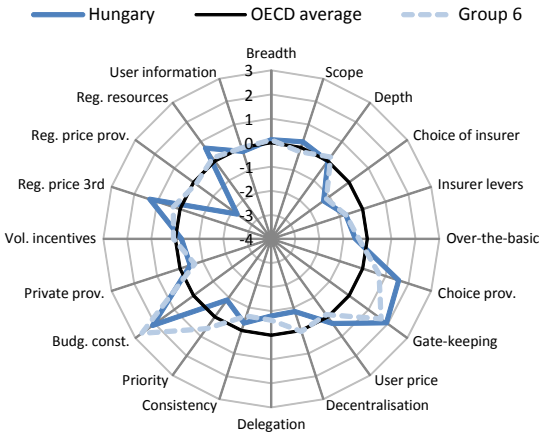
D. Activity and consumption



E. Financing and spending mix



F. Policy and institutions



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.

Source : OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

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GROUP 6: Mostly public insurance. Health care is mainly provided by a heavily regulated public system, with strict gate-keeping, little decentralisation and a tight spending limit imposed *via* the budget process.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
Low DEA score, high rate of amenable mortality, high inequalities in health status	Spending *per capita* and as a share of GDP remain below the OECD average		High share of out-of-pocket payments		Examine the main reasons behind high inequalities in health status, and in particular the role of large (largely unofficial) out-of-pocket payments and regional disparities in access
Rather short durations of stay in the acute care hospitals but low occupancy rate of acute care beds	More acute beds but less high-tech equipment *per capita*	More hospital discharges *per capita*	Very low out-patient share	More choice of providers, combined with tight gate-keeping arrangements. Little incentives to increase volumes of care	Consider increasing the role of preventive and out-patient care, which would contribute to reducing drug consumption and in-patient care. Adjusting the level and mode of physician compensation (currently capitation for GPs and salary for specialists) may be warranted. This would in turn allow strengthening the gate-keeping role of GPs.
A high rate of cataract surgery performed in the in-patient care sector which may signal a mis-allocation of resources across sectors	Less doctors and nurses but more medical students	More doctor consultations *per capita*		Less binding regulation on provider prices but more regulation on health care resources. Less priority setting	Improve internationally comparable data on health care quality
Low administrative costs	Very low relative compensation level of health care professionals		High drug share	Little decentralisation but still some overlapping in responsibility assignment across levels of government	Reinforcing priority setting may also contribute to a better balance of health care spending between out-patient, preventive and in-patient care