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IN SEARCH OF EFFICIENCY: IMPROVING HEALTH CARE IN HUNGARY

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by
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ABSTRACT/RÉSUMÉ

IN SEARCH OF EFFICIENCY: IMPROVING HEALTH CARE IN HUNGARY

One area where spending discipline will become increasingly important in Hungary is health care. This paper describes the structure of the health care system, highlights outstanding weaknesses and considers ways to make financing more stable and sustainable. The slow progress in modernising the health care system is reflected in the low efficiency of hospitals, excessive recourse to inpatient care and heavy prescription of drugs by doctors. The paper discusses ways to modernise the hospitals, including options for giving them more scope in managing resources and greater incentives to introduce efficiency enhancing improvements. To help reduce unnecessary use of inpatient services, mechanisms are suggested for strengthening the “gatekeeping” function of general practitioners and for reinforcing controls over treatment decisions. The paper also considers ways to contain the cost of subsidies to pharmaceutical companies.

JEL Classification: I1

Keywords: Health; OECD; Hungary; Transition economies

A LA RECHERCHE DE L'EFFICIENCE : AMÉLIORER LE SERVICE DE SANTÉ EN HONGRIE

La santé est l'un des secteurs où la maîtrise des dépenses va devenir de plus en plus importante. Le présent document décrit la structure du système de soins de santé, met en lumière ses principales faiblesses et examine les moyens de stabiliser et de pérenniser son financement. La lenteur des progrès accomplis dans la voie de la modernisation du système de soins de santé se traduit par un manque d'efficacité des hôpitaux, un recours excessif aux soins hospitaliers et une prescription abusive de médicaments. Diverses pistes sont envisagées pour moderniser les hôpitaux, consistant notamment à leur laisser plus de latitude pour gérer leurs ressources et à les inciter davantage à améliorer leur efficacité. Afin d'optimiser l'utilisation des services hospitaliers, des mécanismes sont proposés pour renforcer la fonction de filtrage exercée par les médecins généralistes et pour contrôler plus efficacement les décisions thérapeutiques. Enfin, les moyens d'endiguer le coût des transferts au profit des sociétés pharmaceutiques seront examinés.

Classification JEL : I1

Mots-clef: Santé ; OCDE ; Hongrie ; économies de transition

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IN SEARCH OF EFFICIENCY: IMPROVING HEALTH CARE IN HUNGARY

Alessandro Goglio¹

Introduction and overview of main challenges

1. In view of the importance of effective health care services for future well being, many OECD countries back up economies in public health spending by structural reforms. Without reforms there may be increased risks that the quality, adequacy and effectiveness of services worsen, or that public service providers force a breakdown of spending caps (or find ways around them).

2. For Hungary, problems in the health system have not, as yet, emerged in worryingly high health spending since total spending in Hungary is a little above 7% of GDP, which implies that the country is middle ranking in the OECD context. There are however problems in the way the system is organised and actually operates. Many reforms have been introduced to improve the Hungarian health care system since the early 1990s. These reforms have often endeavoured to bring best practice, for example through the introduction of social insurance principles, mixed public and private ownership, separation of payment and control, increased management autonomy and the rationalisation of primary care services. Nevertheless, due mainly to implementation difficulties, achievements so far have been mixed, and there has long been agreement that significant further improvement in efficiency is required. Problems are particularly acute in hospital care, where the structure of incentives remains inadequate and progress in preventing uneconomic access to hospital services has been slow. Another key problem is high spending on drugs. Although spending on drugs per capita is low in international comparison, it represents a high share of total spending on health and there are inadequate mechanisms to curtail unnecessary prescriptions and insufficient encouragement to use low cost drug treatments.

3. In addition, health care is an area where spending discipline will become increasingly important in perspective. It can be expected that the demand for health care services will rise significantly in the coming decades because, as in many other OECD countries, pressures are set to increase due to population ageing. In the case of Hungary, relatively rapid growth in GDP per capita is also likely to bring strong demand growth through income effects. As elsewhere, both demand and costs in health care are likely to be further fuelled by new drugs and treatment options. In addition, along with other countries in the region Hungary has to deal better with its population's relatively poor overall health status, particularly among men. The OECD's *Health at a Glance* indicators show that this relates to very high mortality in illnesses that require extensive medical treatment, notably cancer and heart disease. Though the incidence of these diseases is falling, and life expectancy is increasing, these additional pressures on health are likely to remain for some time to come.

4. Starting with an examination of the organisational structure and performance of Hungary's health care system this paper looks at the main problems with the system and draws recommendations for reforms. The policy recommendations are summed up in Box 1.

Box 1. Policy recommendations for health care reform

Increasing the efficiency of hospital care

Though substantial reforms have been carried out in hospital care, the results in terms of improved efficiency have been disappointing and further reforms are needed. In particular:

- One problem in the current purchaser-provider system is that it leaves limited scope for the efficient allocation of resources across providers. One important pre-condition to solving this would be to make caps on reimbursements more need-based to take into account local differences in population characteristics. One practical policy option could be to revert to the old system of a capped nationwide inpatient budget, while at the same time distributing the overall budget into regionally defined sub-budgets, which would also be capped. The regional sub-caps could be defined by capitation, i.e. taking into account local health and demographic characteristics. Such initiatives should be complemented by measures to put hospitals under more pressure to co-operate or merge in order to improve cost-effectiveness.
- A complementary measure would be to allow for substitutability between payment systems, for example through the introduction of a payment scale between HDGs (Homogeneous Diseases Groups) performance units, outpatient points and chronic-care points.
- At the same time, individual hospitals could be given more scope in managing resources and greater incentives to make efficiency improvements. Responsibility of owners and managers for deficits and debts needs to be increased and made more congruent with service obligations.
- Matching needs-based treatment choices with more rational equipment structures also requires changing current arrangements on capital spending. One approach would be for new infrastructures to remain under the responsibility of the Ministry of Health or local governments, and depreciation costs and equipment purchases under the control of hospital managers.
- Recent policy initiatives have included the experimental introduction of managed care. However, the experience so far suggests that it would be premature to follow up these steps with a decision to eliminate the point-based system in the near future.

Preventing uneconomic hospitalisation

Relatively easy access to hospital specialists, along with longer periods of hospitalisation and a relatively large number of acute-care beds compared with many OECD countries suggest hospitals play too big a role in the health care system:

- Strengthening “gatekeeping” by general practitioners would contribute to reducing the dominance of hospital care.
- Mechanisms to prevent avoidable recourses to hospitalisation are not very effective. Although some financial and contractual changes have already been made and others are planned, controls by the National Health Insurance Fund Administration (NHIFA) remain mainly confined to verifying that formal reporting criteria are met. The responsibilities of the NHIFA need to be better defined in ensuring good decisions in choices between hospitalisation and outpatient treatment.
- Keeping down expensive treatment costs over the longer term, as well as improving life expectancy, would be helped by more promotion of healthier lifestyles.

Cutting back drug prescriptions

Despite attempts by successive governments to contain pharmaceutical spending through changes in subsidy arrangements, the level of spending remains an ongoing problem:

- Changing general practitioners and specialists into more cost conscious decision makers could help reduce the relatively heavy prescription of drugs. More effort is needed to develop guidelines for the cost-effective use of drugs and to improve the prescription habits of both general practitioners and specialists. In particular a more effective computer system for identifying excessive prescription making by doctors should be considered. An improved system could also be used to identify and diffuse best practices.
- The authorities also need to maintain the current contract with pharmaceuticals companies, so that pressures to remove caps on government subsidies can be resisted.
- The list of products negotiated in pharmaceutical subsidies should be more effectively scrutinised. In particular, greater use of low cost drugs should be considered.

Key features of the health care system

5. Hungary has a comprehensive insurance-type health care system, based on the principle of social solidarity.² Accordingly, compulsory contributions by employees are paid according to earnings, rather than individuals' health risks. Coverage is close to universal in terms of treatments provided, with virtually all citizens benefiting from the service whether they contribute or not. Within this context, however, the system is now radically different from that in place at the beginning of the 1990s, a reflection of the wide ranging structural reforms introduced (Box 2). In particular, it is no longer as strongly integrated in the state sector and operates under a purchaser-provider approach.³

Box 2. Past reforms in health care

1987:	Experiment on Homogenous Disease Groups (HDG) launched – first in Europe. Hungarian Medical Chamber set up.
1989:	Private practice authorised.
1990:	Switch from tax-based funding to compulsory insurance. Ownership of health facilities transferred to local governments.
1991:	Establishment of the National Public Health Service (responsibility for local hygiene stations transferred from local governments).
1992:	Social insurance fund divided into a Pension Fund and a Health-Insurance Fund. Universal entitlement to health care eliminated by Parliament and conditions for eligibility defined. Family doctor network created, allowing free choice for patients; capitation-based payment introduced.
1993:	Voluntary Mutual Health Insurance Fund (supplementary insurance operated by private non-profit institutions) authorised. Outpatient-care remuneration based partly on a fee-for-service scheme introduced. Hospital-care remuneration on an HDG-type scheme introduced.
1994:	New National Health Promotion Strategy adopted by the Government.
1995:	Hospital capacity reduction programme initiated, with almost 20 000 hospital beds abolished in the period to 1997.
1996:	Restoration of universal entitlement to health care.
1997:	Act on Health Care.
1998:	Abolition of the Health-Insurance Self-Government.
1999:	Pilot projects on managed care launched.
2000:	Privatisation of the practices of general practitioners introduced.
2002:	50% wage increase for health care employees working as civil servants approved (effective in 2003).
2004:	New spending rules set up for hospital and pharmaceutical subsidies to avoid expenditures overruns implemented. 20% of the population covered by managed care.

The publicly funded system provides the majority of medical services

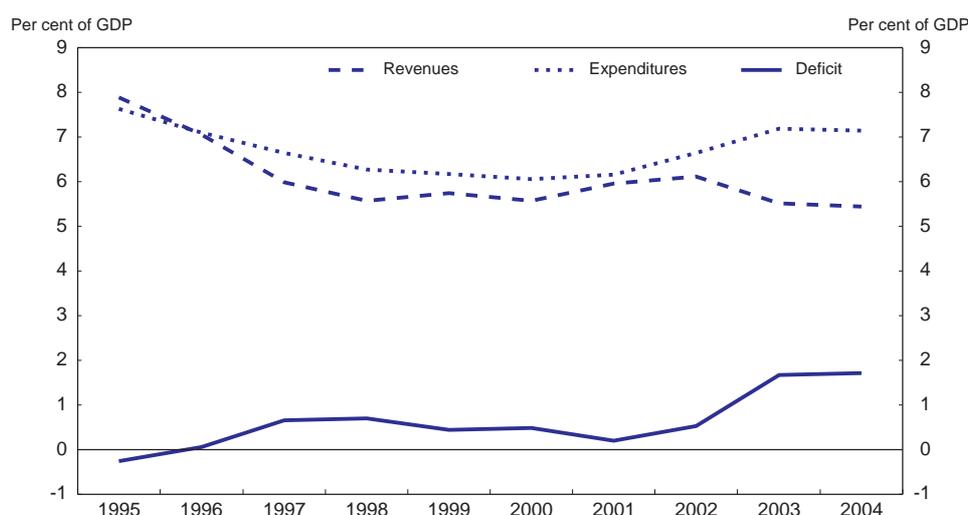
An overview of financing and structure

6. Health services are financed primarily through the Health Insurance Fund (HIF) run by the National Health Insurance Fund Administration (NHIFA).⁴ The Fund receives health care contributions from employers and employees and deficits are covered by transfers from the state budget. The Ministry of Finance prepares the health budget of the HIF in consultation with the NHIFA; subsequently the budget, plus the insurance premium expected to be paid, is voted by Parliament. The fund is used to finance the

majority of current (but not capital) spending on health care services, as well as general subsidies on prescription drugs.

7. Since its creation, the HIF has been almost permanently in deficit (Figure 1). It is not uncommon for health and other social funds to be in deficit and to be topped up by transfers from central government. However, because of the high overall social charges and taxation in Hungary, evasion in paying health care contributions (along with other social commitments) was found to be common. In response to this problem, the collection of health insurance was shifted in 2000 from the NHIFA to the national Tax Office.

Figure 1. Revenues and expenditures of the Health Insurance Fund

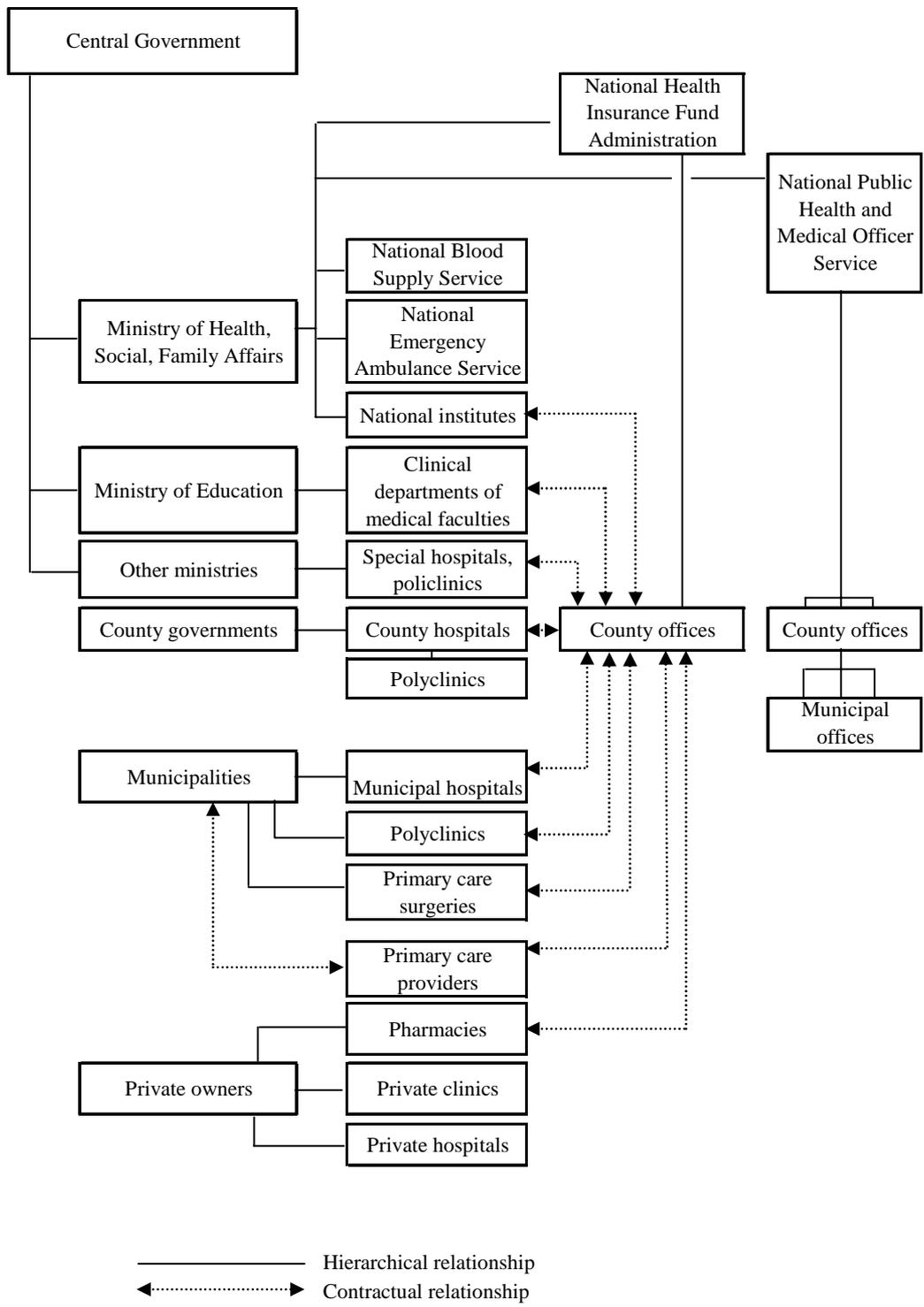


Source: National Institute for Strategic Health Research.

8. Capital spending and a number of other aspects of health care are funded directly by the state. This is the case, for example, with some services (such as ambulance services and high tech interventions) along with education facilities for training health care workers (*e.g.* medical universities). The state also supports the cost of drugs by providing subsidies to those on low-income to help them cover co-payments.

9. The Ministry of Health performs a number of roles in addition to policy formulation, co-ordination and regulation. In 2001 the NHIFA was put under the responsibility of the Ministry. In addition the Ministry oversees a number of bodies that provide services outside the contracting system such as emergency ambulance services and care for elderly and rehabilitation services. One of the most important bodies is the National Public Health and Medical Officer Service (NPHMOS) whose responsibilities notably include control and regulation of health care, including licensing and professional supervision of health care institutions (hospitals and general practitioners' practices). Figure 2 summarises the structure of Hungary's health care system.

Figure 2. Structure of the health care system



Source: Gaal, P. (2004), "Health Care Systems in Transition: Hungary", European Observatory on Health Systems and Policies, Copenhagen.

The purchaser-provider system

10. The purchasing role is performed by the NHIFA which engages in individual contracts across the various groups of providers, namely hospitals, outpatient clinics and independent caregivers. The NHIFA's contracting system is centralised and carried out through a system of sub-funds. There are more than twenty sub-funds (*kassza*), each used for contracts in different types of medical service. For example, there are separate sub-funds for primary care, outpatient specialist care, acute inpatient care, and pharmaceuticals. Health care providers are reimbursed under various payment formulae. Family physicians are paid for primarily by a flat per-patient capitation fee, adjusted for the qualification of the practitioner and the age of the patient. Outpatient treatments are paid through a German-style "*point-system*" and hospital-care is reimbursed according to a Homogeneous Diseases Groups (HDG) system similar to the Diagnosis Related Groups systems seen in the United States (Box 3).

Box 3. Fees in the Hungarian purchaser-provider system

Primary care is run primarily via a "functional privatisation" type system with contract arrangements between family doctors and other providers (e.g. paediatricians) and the NHIFA. About 75% of the revenues received by these practitioners from the NHIFA are paid for from the capitation fees, the remainder coming in the form of a separate fixed maintenance allowance. In order to become eligible for NHIFA funding, family physicians and paediatricians have to service a minimum number of residents. Beyond a certain number of patients, however, capitation payments become regressive so as to discourage excessively large practices and the ensuing provision of poor services.

Outpatient care is funded by a fee-for-service point-scheme, with providers reporting their monthly sum of points to the county office of the NHIFA. Until 2000, performance points were added up nationally, with the related forint value being determined by dividing the national budget by the total number of points earned during the month. This procedure allowed for effective cost containment: as the aggregate number of points increased (fell), the forint value of a point fell (increased), and so total payments for outpatient care remained constant. Since the second half of 2000, however, the forint value of each individual point is fixed in advance and at the beginning of each year a special reserve budget is put aside to offset unexpected additional spending. The forint value of each point is not recalculated until after exhaustion of the reserve fund.

The current version of the HDG system classifies *inpatient care* cases into 736 categories, each category's points being allocated according to the complexity and cost of the medical treatment. The system was set up about fifteen years ago and has been modified several times but problems of over-treatment and excessive payments remain. For part of the 1990s, the overall budget allocated to cover HDG point claims was capped, and, as in the outpatient care financing mechanism, the money value of points fell as the total number of point claims increased. The system was modified in 1998 when a new reserve mechanism was introduced, while at the same time it was decided to change the fixed forint value of points once every 10-12 months, rather than every month as until then. The move to the new system provided hospitals with fewer incentives to improve the efficiency and quality of services. Indeed, hospitals became increasingly focused on quantitative objectives – in order to accumulate point-values – and untenable aggregate spending targets by the NHIFA had to be financed drawing from a special reserve fund. In an attempt to fix these problems a new spending control approach for individual hospitals was introduced in 2004. Under the new mechanism providers are eligible for full reimbursement of up to only 98% of their performance in terms of relative points of the previous year, while for the remaining part they are refunded applying a digressive payment scale. Specifically, each extra-point up to 5% is reimbursed at 60% of its monetary forint value; it is then reimbursed at 30% between 6 and 10%; finally a 10% reimbursement rate applies above that level.

11. As mentioned above, the purchaser-provider contracts are for medical services and do not cover capital expenses. Therefore fees received from NHIFA contracts cover variable costs including notably, the salaries of health care workers and the costs of pharmaceutical products administered by the hospitals. The fees do not cover fixed capital costs imputable to asset depreciation, infrastructure investment and the purchase of medical equipment. These are under the responsibility of the owning institutions (*i.e.* municipalities, counties and ministries), and there is a legal obligation to keep assets in a working order using central budget subsidies.

12. Although the purchaser-provider system changed roles and incentives in the system, municipalities, counties and national government remain key players in health care provision. For instance, municipalities and county governments are responsible for ensuring that all residents have access to the health care services. Moreover, because they own health facilities - such as GP clinics and hospitals - they are responsible for spending on capital and are also involved in the contracting process. Furthermore, one feature of the system is that some government ministries own a hospital, often one of the larger hospitals in Budapest. This is again a reflection of the previous system of health care.

13. In many respects the purchaser-provider system is failing to deliver a fast pace of modernisation of health care provision. There are, in particular, problems in the hospital sector because of limited scope and incentives for making efficiency improvements. Incentives to stimulate competition between suppliers are low, although purchasing activities run by hospitals are regulated in the law on public procurement. In addition, there is only limited room for making adjustments to pay and working conditions.⁵ Most health sector workers are public-sector employees and prior to the 50% public-sector wage increase made between 2001 and 2003 earnings had been falling in real terms. Despite the large wage increase, there are signs of problems in pay that jeopardise motivation and generate supply problems. For instance, even after the recent wage hike doctors appear to be relatively low paid.⁶

14. Problems of recruitment are widely reported. While Hungary has among the highest specialist-to-population ratios, the ratios for both nurses and physicians are relatively low, suggesting a bias towards very high-skill health care workers (Table 1). There is an acute shortage of nurses, a problem exacerbated by the growing demand for nurses in countries which can offer better pay and conditions. In addition, though the total number of specialists is high, there are shortages in some areas, because hospitals do not have the flexibility to adjust pay and conditions appropriately. The shortages are mainly in specialist areas that do not receive under-the-table payments (so called “gratitude money”, which is widespread, albeit illegal): anaesthesiologists, pathologists, radiologists, for example.

15. Problems in hospital care are amplified by weak progress in preventing uneconomic access to hospital services, so that hospital care remains overly dominant in the system. In particular the exploitation of cheaper outpatient alternatives to hospital care has been limited and, reflecting the high number of specialists, patients have relatively easy access to hospital consultations.

16. Moreover, the lack of “light” care facilities, combined with the scarcity of nurses and finally the abundance of some specialists, generates the pernicious effect of long patient stays in hospital. In particular, patients often remain long in hospitals because nursing homes for day-to-day treatments are scarce, a situation that greatly complicates the care for the elderly and their rehabilitation. Although the average length of hospital stays has been brought down somewhat over the years, Hungary still ranks relatively high in this respect. Lengthy hospitalisation means the system is under constant pressure to use a large number of beds (Figure 3). All-in-all, these factors keep the modernisation of hospital care on hold,⁷ even though several measures have been introduced in 2004 to encourage the provision of higher quality rehabilitation services. In particular, the professional certification system has been rationalised and financial incentives to rehabilitation activities have been introduced, together with the launching of an ambitious hospice programme. When allocating surplus resources providers are encouraged to give priority to rehabilitation care and day-to-day treatments.

Table 1. **Health-sector employment in the OECD**
Per 1 000 population

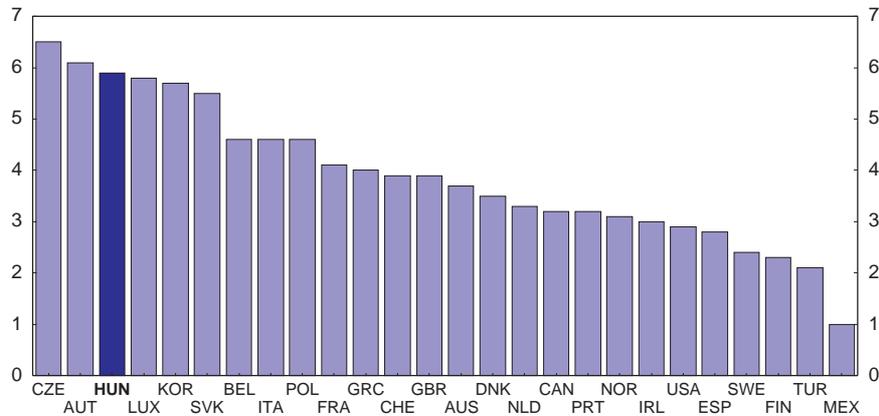
	Physicians	General practitioners	Specialists	Nurses
1	Greece 4.5	Belgium 2.1	Greece 3.0	Ireland 15.3
2	Italy 4.4	Finland 1.7	Czech Republic 2.5	Iceland 14.0
3	Belgium 3.9	France 1.6	Hungary 2.5	Netherlands 12.8
4	Iceland 3.6	Australia 1.4	Germany 2.3	Luxembourg 10.8
5	Slovak Republic 3.6	Austria 1.4	Portugal 2.3	Switzerland 10.7
6	Switzerland 3.6	Germany 1.1	Denmark 2.2	Norway 10.4
7	Czech Republic 3.5	Canada 1.0	Sweden 2.2	Australia 10.4
8	Austria 3.3	Italy 0.9	Switzerland 2.2	Germany 9.9
9	Denmark 3.3	Luxembourg 0.9	Norway 2.1	Denmark 9.7
10	France 3.3	Norway 0.9	Austria 1.9	New Zealand 9.4
11	Germany 3.3	United States 0.8	Poland 1.9	Czech Republic 9.4
12	Hungary 3.2	Czech Republic 0.7	Belgium 1.8	Canada 9.4
13	Portugal 3.2	Denmark 0.7	Spain 1.8	Austria 9.3
14	Finland 3.1	Hungary 0.7	France 1.7	United Kingdom 9.2
15	Netherlands 3.1	Iceland 0.7	Luxembourg 1.7	Finland 9.0
16	Norway 3.0	New Zealand 0.7	United States 1.6	Sweden 8.8
17	Sweden 3.0	Turkey 0.7	Finland 1.5	Hungary 8.5
18	Spain 2.9	Ireland 0.6	Slovak Republic 1.5	Japan 8.2
19	Luxembourg 2.6	Mexico 0.6	United Kingdom 1.5	United States 7.9
20	Australia 2.5	United Kingdom 0.6	Australia 1.2	France 7.2
21	Ireland 2.4	Netherlands 0.5	Canada 1.1	Spain 7.1
22	United States 2.4	Portugal 0.5	Netherlands 1.0	Slovak Republic 7.1
23	Poland 2.3	Sweden 0.5	Mexico 0.9	Belgium 5.6
24	Canada 2.1	Slovak Republic 0.4	New Zealand 0.7	Italy 5.4
25	New Zealand 2.1	Switzerland 0.4	Turkey 0.6	Poland 4.8
26	United Kingdom 2.1	Poland 0.1	Iceland ..	Greece 4.0
27	Japan 2.0	Greece ..	Ireland ..	Portugal 3.8
28	Korea 1.5	Japan ..	Italy ..	Mexico 2.2
29	Mexico 1.5	Korea ..	Japan ..	Turkey 1.7
30	Turkey 1.3	Spain ..	Korea ..	Korea 1.7

Source: OECD Health Data 2004, 3rd edition. The Sources and Methods Section of the OECD Health Data points to certain limits in the comparability between countries of the data referred to in this table.

17. Furthermore, the Hungarian health care system suffers problems of resource misallocation. This is signalled by Figure 4 which shows that there are wide gaps across regions in the supply of coronary artery bypass surgery, which is a key indicator of service levels.⁸ In effect, hospitals in certain regions attract a disproportionate share of resources as well as patients. The size of the gap is particularly marked relative to Budapest, whose residents have the highest health status but also access to most hospital facilities. This is partly because residents of other regions are often treated in Budapest and in other major centres but it is widely thought that there are nevertheless underlying problems in resource allocation. Getting resource allocation right in Hungary is complicated by strong disparities in health status within regions, a phenomenon particularly marked in areas characterised by a high density of Roma inhabitants who usually have a worse than average health status.

Figure 3. **Acute care beds**

Per 1 000 population, 2002¹

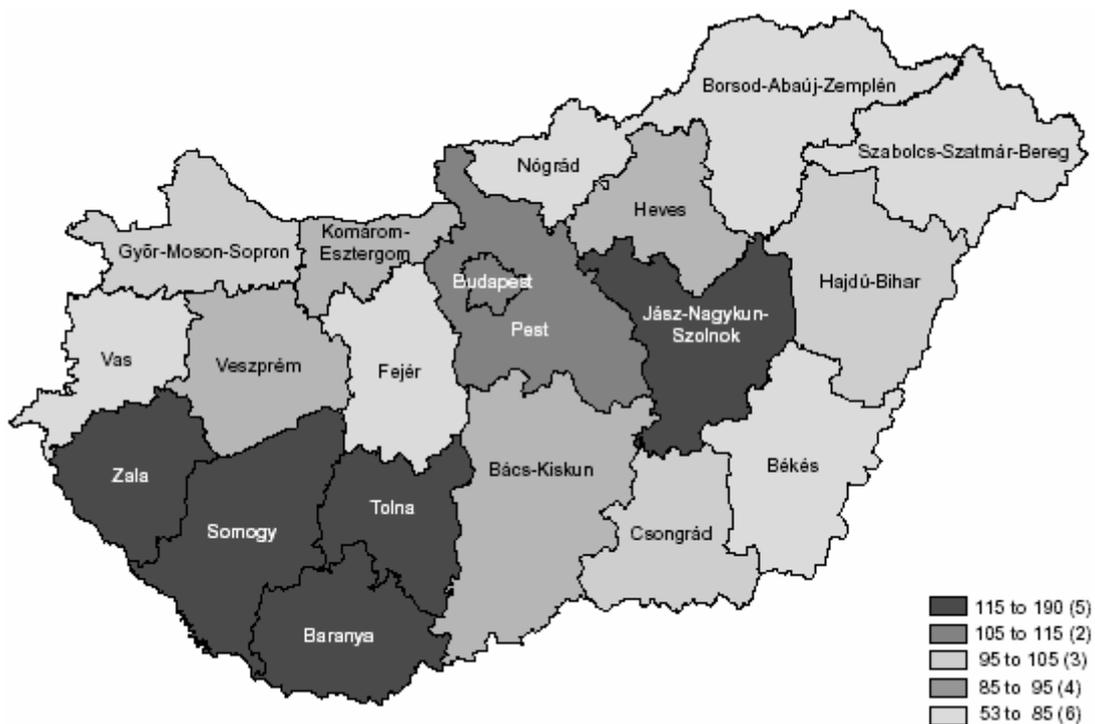


1. 1997 for Belgium, 2000 for Denmark, France, Greece, Spain and Sweden, 2001 for Australia, Canada, Italy, Netherlands and Portugal.

Source: OECD, Health database 2004, 3rd edition.

Figure 4. **Coronary artery bypass grafts by region¹**

Percentage of national average



1. 2003 figures.

Source: Ministry of Health (2004), "Public Health Report".

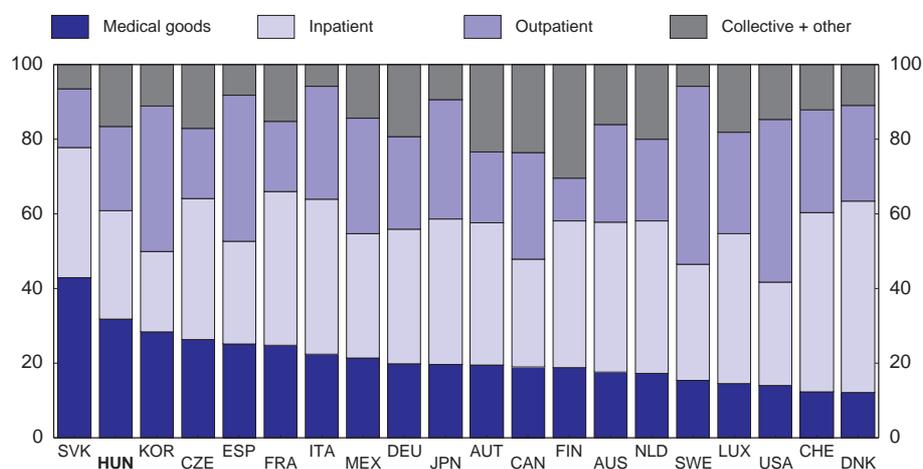
The system of drugs subsidy

18. Overspending of the pharmaceutical sub-budget, linked to a high share of pharmaceutical spending in total health expenditure, remains an ongoing problem in the health system. Hungary spends more than 30% of total health expenditure on medical goods (Figure 5). In this regard, Figure 6 suggests that high and increasing pharmaceuticals expenditure represents a major policy problem. Indeed, such expenditure makes for 31% of total Hungary's spending in health care, with Hungary ranking second in the OECD in terms of consumption of these products as a share of total health spending (from third in 1990).⁹

19. Various attempts have been made by successive governments to contain pharmaceutical spending through changes in subsidy arrangements. The current system dates from 2004 when the government negotiated a two-year agreement with producers. The government initially proposed cutting the administered prices of drugs by 15% across the board but subsequent negotiation with producers resulted in an alternative solution. In the agreement reached, a 5% maximum annual increment in the state budget for financing pharmaceutical expenses was defined for 2005 and 2006. Any medicine expense above the given level is supposed to be paid jointly by the state and the producers according to a risk-sharing scheme involving a regressive government contribution. Specifically, annual pharmaceutical sub-budgets were set at HUF 270, 285 and 296 billion, respectively for 2004 and the following two years. For each HUF 3 billion pharmaceutical spending in excess of budgeted levels, the state subsidy will decrease by 10%, implying that beyond HUF 30 billion no subsidy will be paid. Although the agreement is less restrictive than the government's original proposal, pressure by some producers to revise the subsidy limits upwards continue to be strong.

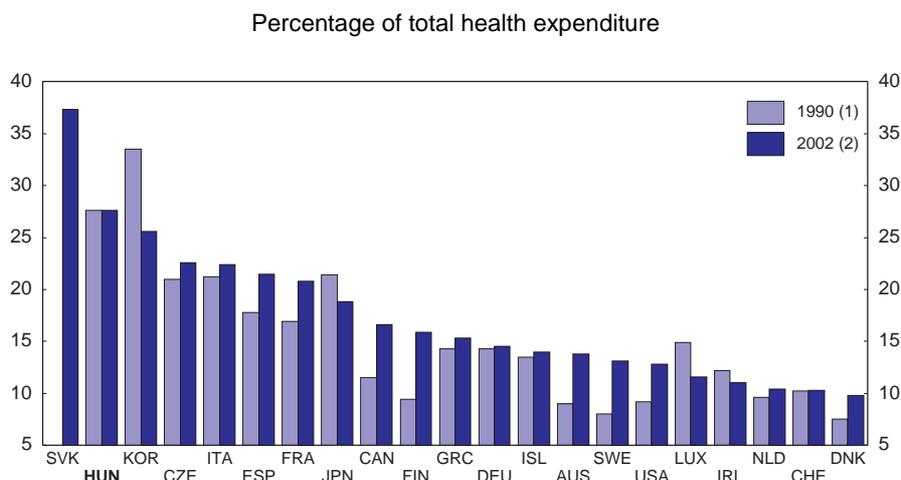
Figure 5. **Health expenditure by type of service**

Percentage of total health expenditure, 2002¹



1. 2001 for Australia and Japan.

Source: OECD, Health database 2004, 3rd edition.

Figure 6. **Pharmaceutical expenditures**

1. 1991 for Hungary.

2. 2001 for Australia, Iceland and Japan.

Source: OECD, Health database 2004, 3rd edition.

Private-sector inpatient services have yet to develop

20. Legal provisions allowing private services to operate have been in place since 1990 and, most notably, private provision is now used in a significant share of outpatient care. Contracts set up by the NHIFA involve a number of private service providers: family doctors; suppliers of outpatient equipment and office spaces; pharmacies; and specialised medical providers, notably providers of magnetic resonance imaging and kidney dialysis. The presence of these private providers has contributed to increases in the amount of non-subsidised private spending on health. Figures for 2002 suggest about half the total outpatient spending was either in this form of health spending or in co-payments for subsidised drugs or “gratitude money”.

21. Outside these services there are only a small number of privately owned clinics, which are typically run by salaried medical professional in the public system. Further expansion appears slowed by the high number of services covered by the NHIFA, although additional private health insurance funds are available and their subscribers benefit from generous tax exemptions. The clinics’ services are in fact mostly used by foreign residents.

How to promote a needs-based and cost-efficient health care system

22. Important structural measures have been introduced over the years to encourage flexibility in the health care system and its responsiveness to market signals. However, as the previous sections have discussed, results thus far have been mixed; they point to the need to tackle a number of specific distortions and outstanding implementation problems. The broad challenge facing Hungary’s policy makers is to adopt a co-ordinated approach to improving the performance of the health care sector, that takes into account the interactions and complementarities between different providers and so increases the overall efficiency of resource allocation. Furthermore, effective identification of both current and future sources of pressure on health care is essential, especially in light of the likely strong demand increases in the future.¹⁰ Within this broad framework, steps announced in May 2005 as part of the Hundred Steps programme indicate the authorities’ intention to move along some of the lines recommended in the following sections (see Annex).

Increasing the efficiency of hospital care

23. *One problem in the current purchaser-provider system is that it leaves limited scope for the efficient allocation of resources across providers. The new spending control approach introduced for individual hospitals in 2004 was a step in the right direction (Box 3), even though significant further improvements are required to constrain spending pressures. One important pre-condition to solving this would be to make caps on reimbursements more need-based to take into account local differences in population characteristics. One practical policy option could be to revert to the old system of a capped nationwide inpatient budget, while at the same time distributing the overall budget into regionally defined sub-budgets, which would also be capped. The regional sub-caps could be defined by capitation, i.e. taking into account local health and demographic characteristics. Such initiatives should be complemented by measures to put hospitals under more pressure to co-operate or merge in order to improve cost-effectiveness.*

24. *A complementary measure would be to allow for substitutability between payment systems, for example through the introduction of a payment scale between HDGs performance units, outpatient points and chronic-care points. Making hospitals feel that they can organise their activities more freely in the provision of treatment would be the primary objective of this measure. Such a move would also contribute to allowing hospitals to adjust their workforce according to needs. Moreover, care treatments would be chosen based on the application of economically viable medical parameters and not just as part of the effort to accumulate reimbursement points.*

25. *At the same time, individual hospitals could be given more scope in managing resources and greater incentives to make efficiency improvements. Responsibility of owners and managers for deficits and debts needs to be increased and made more congruent with service obligations. This change would open the way to increasing control over investment decisions, reducing reportedly widespread problems of political interference in capital spending and improving co-ordination between capital spending and service provision. Moreover, it would give more freedom in wage setting and the design of labour contracts, allowing more performance-related contracts to be used. As a consequence, the problems posed by the current imbalances in the structure of hospitals' labour forces would become easier to remedy. For example, it would be easier to shift towards fewer specialists and to increase the number of nurses as part of steps towards shortening the average length of hospital stays and reducing the number of acute-care beds. Furthermore, greater autonomy of hospitals would facilitate the implementation of stricter and more transparent accounting practices. Experience in other OECD countries shows that making the hospitals more accountable also has a positive impact on efficiency because this increases attention by hospital management to the quality of services. Overall, this approach would help towards a more even allocation of hospital services.*

26. *Matching needs-based treatment choices with more rational equipment structures also requires changing current arrangements on capital spending. One approach would be for new infrastructures to remain under the responsibility of the Ministry of Health or local governments, and depreciation costs and equipment purchases under the control of hospital managers. For example, depreciation costs could be included in fee payments under purchaser-provider contracts, accompanied by the requirement that these payments are placed in ad hoc created capital funds that could only be drawn on for equipment purchases. In principle, this measure should also result in hospital managers taking better decisions on the balance between standard and advanced equipment; this aspect of hospital management is regarded as particularly weak at present. Giving the service providers more responsibility in capital-equipment purchases would also help widen the range of suppliers and ensure that equipment is bought at competitive prices.*

27. *Recent policy initiatives have included the experimental introduction of managed care. However, the experience so far suggests that it would be premature to follow up these steps with a decision to*

eliminate the point-based system in the near future. Under managed care schemes, service providers find a strong incentive to improve overall efficiency because they are allowed to share out any surpluses remaining from budget allocations (Box 4). However, the experience so far has shown that key capacities needed to make managed care work well are not yet sufficiently developed in Hungary.¹¹ In particular the IT system for running managed care is already at full capacity and a substantial investment in developing more administrative staff with skills in running managed care systems is needed. Although these costs are difficult to estimate with precision, having managed care implemented on a large scale would presumably push the administrative costs of the NHIFA significantly above the present 2% of total operating costs. Consequently, further expansion of managed care should be gradual to ensure that enough savings are generated to reward providers of managed care services for the efficiency gains they have achieved. These considerations suggest that the government has been right in its 2005 decision to temporarily slowdown the phase in of the managed care system.

28. However, wider implementation of managed care over the long term does not necessarily mean the publicly financed single-purchaser system should be abandoned. A strategy of moving to multiple providers (for example on a regional basis) alongside the introduction of managed care is under consideration. However international experience suggests that efforts should rather be put on trying to enhance the effectiveness of the single purchaser. The latter can use its monopsonistic power to closely monitor service provision and, based on comparisons, pressure caregivers into following best practices. There are *a priori* no reasons to expect that in the future the NHIFA will not perform these functions efficiently, provided that its tasks become clearer (see below), and its employees are encouraged to pursue more goal-oriented objectives. The recent finalisation of a new hospital database by the NHIFA is a step in the right direction; it will improve the capacity of the NHIFA to develop quality indicators, identify best practices and encourage hospitals to converge towards them.

Box 4. Managed care in Hungary

Inspired by the British Fund Holding model and the American managed care system a pilot project in managed care was launched in 1998. Eighteen managed care groups have been created since then and provide health care services to more than 2 million people (around 20% of the population). Similar to arrangements in other countries, the projects give health care providers the opportunity to organise themselves territorially, taking responsibility for the whole spectrum of care over a population group comprising some 200 000 residents. The health care providers potentially eligible to become “care co-ordinator organisation” can be a hospital or a polyclinic, or even a group of family doctors. For example, when the co-ordinator is a hospital or a polyclinic, it has to enter a contract with the general practitioners and their registered residents define the population covered by the co-ordinating organisation.

Financially, the budget of the co-ordinator is defined according to the population covered, rather than the extent of the service provided, as under a classical HDG mechanism. In addition, the co-ordinator has discretion in the use of any surpluses; these, for example, can be used for remuneration or investment purposes, thus providing incentives for efficiencies in the coordinator’s own activities as well as the providers it contracts with. As elsewhere, a key aim in introducing managed care is to induce efficiency gains through better co-ordination between primary and secondary care, notably through better “gatekeeping” by doctors.

Preventing uneconomic hospitalisation

29. Patients have a tendency to visit the hospital specialist directly when in many cases cheaper and more effective care treatments are available at the primary level of the system. *Strengthening “gatekeeping” by general practitioners would contribute to reducing the dominance of hospital care.* Past steps to improve gatekeeping have been welcome, including making visits to some specialists conditional on stricter prior-to-visit referrals provided by the general practitioners. However, the list of exemptions to

these rules is still long and could be reduced along with the introduction of stronger penalties on GPs for non-compliance.

30. *In addition, mechanisms to prevent avoidable recourses to hospitalisation are not very effective. Although some financial and contractual changes have already been made and others are planned, controls by the NHIFA remain mainly confined to verifying that formal reporting criteria are met. The responsibilities of the NHIFA need to be better defined in ensuring good decisions in choices between hospitalisation and outpatient treatment.* One potential source of problems is that, quality-assurance tasks are split between the NHIFA and the NPHMOS, and the division of responsibility is ill defined. In addition, the incentives among staff in these institutions who examine the quality and efficiency of medical decisions are weak and could be strengthened by the use of performance-based pay. More recently, the government has been encouraging the creation of Regional Health Councils but their mandates, as well as the division of responsibilities with the NHIFA, are not well specified. The mandates of the Council could also include promoting new forms of co-operation between neighbouring small hospitals, which has to date been rather weak. Greater co-operation would also facilitate the much needed transformation of small local hospitals into nursing homes.

31. *Keeping down expensive treatment costs over the longer term, as well as improving life expectancy, would be helped by more promotion of healthier lifestyles.* There is a need for educational programmes more explicitly targeted to families, the aged and children. International experience suggests that general practitioners and public health professionals could play an important awareness role in this regard.

Cutting back on drug prescriptions

32. *Changing general practitioners and specialists into more cost conscious decision makers could help reduce the relatively heavy prescription of drugs. More effort is needed to develop guidelines for the cost-effective use of drugs and to improve the prescription habits of both general practitioners and specialists. In particular a more effective computer system for identifying excessive prescription making by doctors should be considered. An improved computer system could also be used to identify and diffuse best practices.* More importantly, *the authorities should resist pressures for the removal of caps on the subsidies paid to pharmaceutical companies.* On the contrary, these caps should be extended beyond 2006, and strengthened if spending developments turn out to be stronger than initially expected. In addition, *the authorities also need to maintain their current contract with the pharmaceutical companies, so that pressures to remove caps on government subsidies can be resisted. In particular, greater use of low cost drugs should be considered.*

Notes

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1. This paper was originally prepared for the OECD's 2005 *Economic Survey of Hungary*. Alessandro Goglio is an economist in the OECD's Economics Department. The author is grateful to the experts from Hungarian government and non-government bodies that provided information and comments, as well as to OECD colleagues for their suggestions, in particular Val Koromzay, Andrew Dean, Andreas Wörgötter, Philip Hemmings, Eva Orosz and Márton Szili (now at the Hungarian Ministry of Finance). Thanks are also due to Marie-Christine Bonnefous for technical assistance and to Susan Gascard and Sheila McNally for assistance in preparing the document.
 2. See OECD (2004) for a wider discussion of health care systems in the OECD countries. Building on international experience and grounded in new data on cross-country differences, this study also offers a contemporary roadmap to improving performance.
 3. See also OECD (1999), Orosz and Burns (2000) and Gaál (2004).
 4. See also Boncz, Nagy, Sebestyén and Körösi (2004).
 5. See Rethelyi, Miskovits and Szocska (2002).
 6. See OECD (2005a).
 7. Moreover, this framework exacerbates the donation of "gratitude money", insofar as families feel that they have to give more money away to the specialists in exchange for elderly relatives to spend longer periods in hospital. See Kornai (2000) for a broader discussion of the phenomenon of "gratitude money".
 8. It should be considered, however, that, although Figure 4 captures mainly the capacity of the health care system to supply services, the disparities that it highlights may also reflect differences in demand conditions.
 9. See for a background discussion Gulácsi, Dávid and Dózsa (2002).
 10. In this regard, see Bains and Oxley (2005) and OECD (2005b) for a cross-country comparative discussion of ageing-related sources of pressures.
 11. See Mihályi (2004) for a discussion of Hungary's experience with managed care.

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ANNEX

**MEASURES PROPOSED IN THE HUNDRED STEPS PROGRAMME
ON HEALTH CARE**

In April 2005 as part of the so called Hundred Steps programme, the government began to announce a large number of structural reform measures. This annex presents the measures proposed in the domain of health care, based on available information provided by the Ministry of Finance in mid-June 2005.

Towards faster emergency services

1. Emergency wards and central emergency facilities in areas where such services are in short supply at present will be established.
2. Helicopter depots will be built. Their location will be chosen in such a way to ensure that the whole country becomes accessible to emergency services.
3. 40 Critical Care ambulances and 80 Advanced Life Support ambulances will be purchased. The equipment used in emergency services will be upgraded.

A program to tackle cancer will be initiated

4. A National Anti-Cancer Program will start this year, including widespread use of cancer screening tests.
5. Radiation therapy equipment of regional and county oncology centres will be upgraded and the construction of a central western Hungary oncology centre will begin.
6. All patients affected by cancer will receive treatment in qualified therapeutic institutions, including those living in less accessible areas.

Primary care and specialised outpatient care

7. Financing of the health care system will be made more flexible. Changes include the opening up of a financial channel between the inpatient and outpatient funds, which are separated at present. A unified therapeutic/prophylactic fund will also be established.
8. To improve the standards of primary care, the establishment of practitioners' communities – in which several primary care physicians work in cooperation – will be supported. A uniform system for primary care physicians is to be set up consisting of a central on-call service. A separate practice fund will be established so as to help general practitioners buy the practices of doctors who are approaching retirement. This will help reduce problems of interrupted service provision. While setting capitation rules, greater consideration will be given to differences in the health status of residents in different regions, and to individual physical conditions.

The prescription and consumption of pharmaceuticals

9. Incentives will be offered to doctors who prescribe cheap pharmaceutical products (conditional on the ingredients and the drug are the same).
10. Rules concerning the promotion and advertising of pharmaceuticals are to be tightened. This will allow the reduction of not only avoidable consumption, but also any interest doctors may have in prescribing one specific brand among several that have identical effects.
11. More effort to ensure free medication to the indigent who live in the most difficult circumstances.

Differences in medical treatment and equality of access to health services

12. A system of professional requirements ensuring that the health insurance provider enters into contracts with the service providers that offer the best care is to be established. Continuous monitoring of care services provided will also be ensured.
13. The steps through which patients access different levels of care will be precisely defined.

The health care contribution system

14. A new accounting system enabling the monitoring of individual payments is to be introduced.
15. Entitlement and payments will also be monitored more effectively.
16. The system of collecting contributions and of collecting overdue payments will be improved.
17. As a means of increasing health care contributions, measures to force employers to hire workers on a legal basis are to be reinforced.
18. A “real” contribution payment will be achieved for every single insured person.

Turning the health care system into a fair one

19. A basic package of services for persons who do not have insurance will be designed (emergency care, public health services, mother and infant protection).
20. The package of insured health care services to which every insured party is entitled will be precisely defined.
21. Any extra services will be provided either at full cost or through supplementary or market insurance.

GLOSSARY

GDP	Gross Domestic Product
HDGs	Homogeneous Diseases Groups
HIF	Health Insurance Fund
IT	Information technology
NHIFA	National Health Insurance Fund Administration
NPHMOS	National Public Health and Medical Officer Service

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