Health Insurance in Hungary

A Brief Presentation of the National Health Insurance Fund and its History

Hungary's Population and its Health Status

The Republic of Hungary has 10.188 million inhabitants of which 1,811 million live in the capital. Almost half of the country's population resides in communities of less than 20,000 inhabitants each.

While life expectancy in Western European countries improved during the 1980's partly due to dropping rates of cardiovascular diseases, this tendency continued to worsen in Hungary as did deaths from cancer, liver cirrhosis and external causes such as accidents and suicide. Hungary has thus far completed an epidemiological transition. However, a special policy of health care for an ageing population is to be implemented. Life expectancy at birth in Hungary in 1997 was 75.1 years for women and 66.1 years for men compared to 80.9 years and 74.6 years in the European Union.

Mortality and morbidity due to unhealthy lifestyle, such as high consumption of alcohol, increasing rate of smoking and high fat and sugar diet are thought to be important causative factors. The factors contributing to the health status of population are complex; however include social and economic factors as well as access to good quality health services.

HUNGARY

Area: 93,030 square km
Population: 10,200,000 (21 percent under 14 and 60 percent between 15-59)
Density of population: 110 (per square km)
Form of government: Republic (parliamentary democracy - 4 year election periods)
Capital: Budapest (1.8 million inhabitants)
Number of counties: 19, **Number of towns:** 169, **Number of villages:** 2,904
Urban population ratio: 60 percent
Population increment: -0.1 percent
Life expectancy: men 66, women 74

Transition in the Hungarian Health Insurance System

Following the introduction of Germany's sickness insurance system effected by Chancellor Bismarck, the first Act on mandatory sickness insurance for Hungary's factory workers was introduced in 1892. Back then, the centralized system of national sickness insurance was laid down for the 20th century. Before and after World War II, both the services provided by the insurance system and the group of the insured had been extended.

In the 1970's and 1980's, Act No. II of 1975, which regulated both the health and pension insurance schemes, defined the health insurance system. In 1991, having returned to the practice of the first decade of this century, the self-governments made up by the representatives of contribution payers became responsible for supervising and managing the social funds. They were the governing bodies of the separated Health Insurance Fund and Pension Insurance Fund.

The health care policy implemented during the 1990's reforms has brought about significant changes to the former fixed annual budget system. The system of payment has become more performance based and payment mechanisms are determined of the type of services. The National Health Insurance Fund introduced the per capita system for family doctors, a fee-for-service system for out-patient health care services. Hospitals are financed through Diagnosis Related Groups (DRG) introduced in the early 1990's. The procedure is managed by both the National Health Insurance Fund and the Information

Center for Health (GYÓGYINFOK). In case of chronic in-patient care the number of days spent in hospital is the underlying basis for payments.

Development of Sickness Insurance in Hungary (1892-1928)

We can find the footsteps of the social insurance even before introduction of the obligatory sickness insurance in Hungary. The early background was developed in the spirit of self-help and taking common risk in the 13th–14th centuries. The increasing danger derived from working conditions and the solidarity made miners form associations. Also industrial workers established voluntary mutual benefit societies based on the principle of collective support.

In chronological order Hungary is the third state in Europe where the insurance obligatory in case of sickness was enacted by law on 1 April 1892. Sick-relief funds provided healthcare services, medicines, medical aids, sick pay, maternity benefit and funeral allowance.

The year of 1907 was the next milestone in the development of sickness insurance, when employers' liability insurance for industrial and commercial workers was introduced.

The Act on sickness and employers' liability insurance enforced in 1928 regulated the services provided by OTI (National Social Insurance Institute) for decades.

Operation of National Social Insurance Institute (1929-1950)

The economic crisis of 1929-1935 rendered the economy of OTI (National Social Insurance Institute) difficult. In 1930 the sick pay equal to 75% of the wage was abolished, in 1933 the sickness benefit, which was 60% of the salary previously, decreased to 50%, and the insured had to pay for the employer's card, etc. On 1 January 1933 the sickness insurance sector was divided into two independent– general and household– branches maintained by their own incomes.

By 1939 the financial balance of sickness insurance had been restored. OTI participated actively in fight against tuberculosis, organised remedial holidays for the young insured, provided healthcare education for the public, laid down rules of prevention of accidents, built blocks of flats, headquarters and surgeries.

During the World War II the social insurance was damaged seriously, too. After the war the first task was to clean up ruins and ensure operation.

Insurance for agricultural workers was introduced in 1945. The obligation of insurance related to the wage level was abated. Improvement of services began. In 1947 members of families became entitled to be treated in hospitals for 60 days a year instead of 42, the amount of sick pay increased and the period of hospital treatment for patients suffering from tuberculosis was extended to 2 years, etc. Merging different insurance institutes started in the sickness insurance sector first.

Operation of Social Insurance (1950-1984)

Unification and amalgamation of social insurance institutes came to an end in 1950.
SZTK (Social Insurance Centre of Trade Unions) was set up.
At the same time, also the county subcentres and sub-offices of SZTK completing local tasks related to the social insurance were established. Funds paying benefits were instituted in companies and offices employing over 100 people.

The obligatory collective insurance for workers at craftsmen's cooperatives was introduced in 1951. KSZKBI (Collective Insurance Institute for Members of Craftsmen's Cooperatives) operated from

1953 to 1964. This institute provided sickness benefit, maternity benefit and funeral allowance for members.

The circle of the insured was widened gradually. The insurance was extended as far as students, then craftsmen in 1962, and shopkeepers in 1970.

According to the new rules of sickness insurance, from 1 January 1956 two types of services were provided. One of them is the benefit in kind such as medicines, breast-milk, medical aids, hospital treatments, thermal bath treatments; and the other is the financial benefit such as sick pay, maternity benefit, contribution to travel expenses and funeral allowance. After 1 October 1950 the sickness benefit was provided from the first day of being incapable of earning. From 1952 patients suffering from tuberculosis were entitled to get sick pay for 2 years instead of 1 year. The level of the sick pay was either 75% or 65% of the daily average wage; it depended on the length of time since the patient had been insured.

As a result of a long codification, Act II of 1975 on Social Insurance enacted on 1 July 1975 regulated material and legal rules of social insurance on the basis of principles unified. At the same time, healthcare services were separated from social insurance and every citizen became authorized to use them. But this act did not change the sickness and maternity benefits for the insured.

From 1982 both craftsmen and shopkeepers obtained the right to get sick pay.
Actually the insurance had covered the whole population.

The sick pay in case of accident became the total daily average wage from 1 January 1981.

Act II of 1975 on Social Insurance regulated insurance for members of agricultural cooperatives, members of professionals' cooperatives and members of their families on the basis of principles unified. They all were entitled to every benefit except for sick pay and maternity benefit. Instead they were given sick-benefit and maternity grant from the cooperatives.
According to a new legislation, from 1 March 1992 members of cooperatives have worked within the frames of employment or self-employment, and benefits for them are based on these legal relations as well.

From 1 July 1984 the government replaced trade unions in the field of social insurance management. OTF (National Social Insurance Directorate-General) became the central organisation for the social insurance; its regional organisations were county social insurance directorates and their agencies. Both agricultural and craftsmen's cooperatives had to establish funds operating at the places of work if the number of the insured exceeded one hundred.

The amounts spent on social insurance increased from year to year over the incomes from contributions.

Municipal Management of Social Insurance

Local authorities have participated in social insurance since the beginning; however, their roles have changed from time to time.

In 1891 the organisation of funds was built on the principle of self-government. In local authorities employers formed one-third of all the members, and employees formed two-third. From 1907 already both the insured and employers delegated equal numbers of representatives.

In spring of 1919 the Hungarian Soviet Republic invalidated the appointment hold by employers at the local authorities of insurance funds for workers. After the fall of the Hungarian Soviet Republic the

Minister of Public Healthcare suspended the local authority of National Insurance Fund for Workers, and appointed a commissioner to manage the institute.

In 1928 the insurance institute for workers was nationalised, and the local authority with restricted power was restored, whose organs were as follows: general meeting, directorate, presidency and committees.

The local authority was dissolved again in 1944.

After the World War II the Temporary National Government restored local authorities by an order and changed their composition: two-third of the members were delegated by employees and one-third by employers.

From 1 October 1950 trade unions took over the tasks of local authorities; committees of social security were set up in the counties and social security councils were established at the funds.

In 1984 statism replaced the role played by local authorities. The majority of the members of social insurance councils were delegated by trade unions, and room was made for representatives of other interest protecting organizations as well as representatives of some of the state organizations.
OTT (National Social Insurance Council) was set up as a central organisation. In addition, county social insurance councils and social insurance councils at the places of work were established regionally.

In 1991 Health and Pension Insurance Inspection Committee was founded in order to control social insurance. It supervised Social Insurance Funds from 1992.
Ten-ten numbers of the inspection committees were delegated from Members of Parliament, interest protecting organisations and the government.

Health Insurance Authority was set up on 18 June 1993. There were 60 people on the staff of the authority, where employers and employees were represented equally. Each of the representatives was admitted to the Health Insurance Authority by election, and it also served the aim of choosing between trade unions.
The organs of the Health Insurance Authority were as follows: general meeting, presidency, inspection board, sections, committees and local boards.
The Fundamental Rules of Health Insurance Authority – in the sphere of inspection – was approved by Parliament.

The new authorities founded in summer of 1997 were wound up on 23 July 1998 by Parliament, which ordered state control again over social insurance.

Foundation of Social Insurance Fund, Development of Health Insurance

According to a decision made by Parliament, from 1 January 1989 social insurance was separated from the state budget, and started operating as a fund benefited from state guarantee. The contribution to social insurance, state subsidy and other social insurance fees served as its sources.

The Social Insurance Fund covers social insurance expenditures.
Since 1 January 1992 costs of preventive-curative cares have been financed by the Fund.

In 1992 Health and Pension Insurance Fund was established in order to set up independent insurance branches.

Pension and Health Insurance Inspection Board, which was under the supervision of Parliament, exercised authority over the separated social insurance funds and controlled their management.

On 18 June 1993 Health Insurance Authority and Pension Insurance Authority and their central organisations such as National Health Insurance Fund (OEP) and National Pension Insurance Chief-Directorate were founded. At the same time, National Social Insurance Chief-Directorate was wound up.

From 1993 the management boards controlled by National Health Insurance Fund were as follows:

- capital and county health insurance funds and their county offices,
- Social Insurance Directorate for Railway Workers (VTI),
- National Medical Expert Institute (OOSZI),
- Division for Journalists.

Ten Years of Health Insurance (1993-2003)

In the first part of the 1990s during the economic changes entailed by the change of regime the circle of employers was rearranged. Employers occupying small numbers of people replaced large companies and cooperatives employing huge numbers of workers. The number of private companies and enterprises rose by leaps and bounds. It had effects on the system of funds of companies operating for decades. The number of funds was not reduced significantly, but the proportions of workers insured by them were nearly halved. Thus the number of people benefited directly by the health insurance management boards increased.

On 1 January 1997 contribution to the health insurance was introduced, which is paid by employers to supplement the funds for healthcare services.

Decrease in the proportion of those paying contribution, the relatively high number of unemployed people and the spread of the "black market" contributed to the deficit of the Fund significantly.
The ability and willingness of paying contribution declined, and they have resulted in total outstanding claims of HUF 251.3bn for the Funds by the end of 1998.

On 1 January 1999 Tax Control Office (APEH) took over collection and executive tasks connected with the contribution to social insurance that had approximately 2 million current accounts. Since that time APEH has been responsible for collecting and administrating contributions.

The health insurance provides benefits for the insured, those entitled to healthcare services in terms of the law, their dependents and Hungarian citizens paying contribution to health insurance. Health insurance finances cares provided for foreigners who entered into an agreement with it.

A milestone of the reform process of the social insurance was 1990, when within the framework of dividing tasks between social insurance and the state budget, financing healthcare services became the task of social insurance and later the task of health insurance.

In 1992 Sickness Insurance Card was introduced. It links the use of healthcare services with being benefited by social insurance, in other words, the title to insurance. Introduction of the card made choosing physicians possible for patients.
In 1995 Social Insurance Number (TAJ) was initiated. It identifies people entitled to services provided by health insurance, and ensures healthcare services for them this way. The owner of the database of social insurance numbers is the National Health Insurance Fund (OEP).

Foundation of an independent health insurance sector did not have an impact on the system of fixing and paying out benefits.
The system of sick pay was not changed, however, a couple of small modifications were made, and a vast majority of them were depended on the bearing capacity of the economy. Since 1996 employers have covered one-third of the sickness benefit, and the sick leave increased up to 15 days a year. The level of sick pay has become 60% or 70% of the daily average salary. Averagely 117 thousand people a

day receive sick-allowance, and 4 thousand of them are given child-nursing allowance. The total amount of the sickness benefits paid in 2001 was over HUF 64 billion.

On 1 January 1998, Act on compulsory healthcare benefits entered into force. Its fundamental principles are as follows:

- Healthcare services can be used to the extent justified by the patient's medical condition, and users are entitled to equal treatments.
- Financial benefits are in proportion to the contribution to health insurance paid by the claimant.
- The state guarantees benefits.
- The health insurance management board is obliged to inform the insured about their rights and obligations, and provide them with help to enforce their rights.

According to Act on compulsory healthcare benefits, cares related to accidents such as healthcare services provided due to accidents, accident sick pay and accident allowance belong to health insurance services. At the moment the pension insurance division fixes and pays out the accident allowance.
Medicines taken and medical aids used by the insured due to deteriorated health caused either by occupation disease or works accident are free. The calculation of the accident sick pay is not based on general rules, it is equal to the daily average wage.

The tasks of National Medical Expert Institute (OOSZI) are to give professional opinions about the partial disability to work and the degree of disability necessary for qualifying deficiency; fixing social insurance benefits, social and family allowances.
In addition, OOSZI has given opinions about suitability, since rules commissioned OOSZI to work in this field.
Medical committees of first and second instance examine approximately 350 thousand people every year.
In 2001-2002 medical committees examined 140 thousand disabled people as an extra task.

The vast majority of benefits covered by the health insurance are so-called preventive-curative treatments. In 2002 Health Insurance Fund spent total HUF 503 billion on them. Family doctors, health visitors, mother-, child- and youth protecting services, dentists, nursing institutes, ambulance services, services carrying corpse for medical purposes, out-patient services, CT and MRI diagnostic services, kidney machine treatments, professional home-nursing and in-patient services provide cares through Health Insurance Fund within the scope of preventive-curative treatments.

In 2002 HUF 45.5 billion were spent by health insurance on financing **services provided by family doctors and paediatricians.** 6861 family doctors have been contracted with the National Health Insurance Fund (OEP) by the end of 2002. In 2002 the average number of the insured per family doctor was 1429.

Health insurance spends nearly HUF 10 billion a year on **health visitor services** and **mother-, child- and youth protecting services.** Within their frames 4969 health visitor services are paid.

The total remuneration to **dental services** was approximately HUF 16 billion in 2002. That year dental services provided 25 million dental treatments. It means that the number of services provided was 247 per 100 inhabitants. The remuneration paid by OEP was HUF 677 per treatments.

Health insurance finances cures of venereal diseases, tuberculosis, neurosis, oncological diseases, alcoholism and drug addiction in nursing institutes. In 2002 health insurance spent HUF 8.6 billion on remuneration of these institutes.

The Act on compulsory healthcare benefits made **ambulance services** and **services carrying corpse** for medical purposes the tasks for health insurance. Now OEP is contracted with 35 alternative ambulance services using 1242 vehicles to provide services.

National Health Insurance Fund (OEP) spent nearly HUF 773 billion on financing **outpatient cares** and **ambulant treatments** in 2002. Funding these cares is closely connected with the insured's Social Insurance Number (TAJ) based on OENO codes (codes for treatments) and the principle of accomplishment in accordance with the German point system. 475 surgeries and outpatient departments contracted with OEP provided services 383.5 million times in 2002. The amount spent on a service was HUF 215 on the average.

OEP spends HUF 8.5 billion a year on **picture making examinations CT and MRI of high value,** and this amount covered 1.3 million examinations equal to treatments for 394.3 thousand patients in 2002.

In 2002 dialysis services provided 696 thousand **kidney machine treatments**. Within the frameworks of kidney machine treatments in 2002 OEP financed treatments for 5468 patients from HUF 13 billion. In 2002 there were 320 dialysis services, and they provided 884 services per 10 thousand inhabitants. 76% of the annual amount were spent on the population over the age of 61.

The largest amount – HUF 294 billion - from the Health Insurance Fund was spent on **inpatient cares** in 2002. Financing has been based on fixed prices of the Homogenous Disease Group (HBCS) since 1 July 1993.
Within active and chronic inpatient cares 2.4 million patients were cured on 80429 beds of 180 institutes in 2002.

The second largest amount paid by health insurance is the subsidy for **medicines**, which was total HUF 209 billion in 2002. The rate of subsidy can be either 100%, 90%, 70%, 50% or fixed. The range of products subsidised is widened from year to year. In 2002 in Hungary patients paid total HUF 119 billion for medicines on 161.2 million prescriptions in 2057 pharmacies contracted with the National Health Insurance Fund (OEP).
The range of **medical aids** subsidised by social insurance and the rate of subsidy is controlled by a government edict. In 2002 Health Insurance Fund spent HUF 29 billion on subsidising medical aids. One can lay claim to these aids under different titles of the subsidies such as public medical care, 100% subsidy, normative subsidy, and other subsidies related to the use of prescriptions, for example, in case of works accident and for the war invalid. In 2002 the population spent HUF 5.6 billion on medical aids.
Health insurance paid HUF 4.2 billion for subsidising **spa treatments** in 2002. Patients can receive 10 sorts of treatments (thermal pool, thermal bath, mudpack, mud bath, weight-bath, fizzy bath, medical massage, jet massage under water, remedial group gymnastics under water and remedial group swimming) to either preserve their health or to get well again. In 2002 health insurance subsidised 9272 thousand treatments within medical bath services.
According to Act on compulsory healthcare benefits, also **breast milk provision** is subsidised by social insurance.
In 1993, when Health Insurance Fund was established, the social insurance paid HUF 500 for a litre of breast milk to mothers giving milk. Later this price increased up to HUF 900, and since September of 2002 it has been HUF 1800. At the moment babies are entitled to free breast milk provision until the age of eight months. In 2002 OEP paid out HUF 125 million to 10 656 mothers giving 112 882 litres of breast milk.

Health insurance funds have direct and continuous contacts with healthcare service providers. Also client services are at the population's service all over Hungary. Health insurance funds and their agencies operated in 19 county towns settle and pay out benefits provided by health insurance. Modern client service offices give information and helping hands to those using healthcare services.

In 1997 a package of acts have been enacted in order to restructure and redefine the social insurance system. Acts No. LXXX and LXXXIII of 1997 define the scope of citizens eligible to social insurance services, private pension, the financing of the above benefits, and the benefits of mandatory health insurance. In 1999 the newly elected Parliament decided upon the supervision of the social insurance funds by a State Secretary.

Following the election in May of 1998, supervision of the National Health Insurance Fund was assumed by the Prime Minister's Office. In 1999 supervision of the institution was transferred to the Ministry of Finance and in the year 2001 it was taken over by the Ministry of Health. Due to a merger of ministries, the supervision power is exercised on both main branches of Social Security (health and pensions) by the Ministry of Health, Social and Family Affairs.

At the moment Hungary's Health Insurance Fund is a separated monetary fund within the State Budget. The budget of this fund is approved by the Parliament usually for one calendar year. The National Health Insurance Fund (NHIF) is a separate administrative organization as well under the supervision of the competent ministry. The National Health Insurance Fund directs the administrative functions of the health insurance branch and controls the calculation and payment of sickness and maternity benefits.

The collection of contributions, the operation of the contribution accounts and the financial control have been the functions of the National Tax Office, since January 1, 1999.

In 1998, in the framework of the Act No. XCI. of 1998 on the State budget for the year 1999 the Managed Care as pilot project was introduced in Hungary. The practical implementation of the pilot project started at 1st of July in 1999 with 9 health care providers, with 161 076 insured person and also with 104 contracted general practitioners. After the revision of the providers in 2001, 7 health facilities with 493 076 person and with 315 general practitioners remained in the project.

The Benefit Package under the Statutory Health Insurance

Benefits in kind (health services provided by the suppliers financed by NHIF) and **benefits in cash** provided by the NHIF are as follows:

Health services provided free of charge according to the "in natura" (in kind) principle:

- Preventive medical examinations.
- Medical care by family physicians (primary health care services).
- Dental care.
- Out-patient care.
- In-patient care.
- Delivery care.
- Medical rehabilitation.
- Patient transportation.
- Accident health supply .

Cost allowances to health care services:

- Drug cost allowance.
- Medical aids cost allowances.
- Travel cost reimbursement.
- International medical cost reimbursement.

Co-payment is charged in the following instances:
- Orthodontic treatment under the age of 18.
- Tooth keeping and replacement above the age of 18.
- Extra meal and accommodation for in-patients.
- Sanatorium treatment.

Benefits in cash delivered by the Fund are:
- Sick pay.
- Pregnancy and confinement benefit.
- Childcare fee.
- Disability benefits.
- Accident benefits.
- Accident pension.

In Hungary the compulsory health insurance operates as an independent branch of the social security system, *based on the principle of solidarity*.

On the basis of Act LXXX of 1997 **the insured are as follows**:
- Employees, civil servants and clerks, employees of the administration of justice professional adoptive parents, members of the armed forces including law enforcement bodies as well as civil national security services, regardless of whether they are employed full-time or part-time.
- Members of co-operatives, excluding full-time student members of school co-operatives if they participate in the activity of the co-operative within the framework of economic enterprises.
- Apprentices on vocational training under a study contract.
- Individuals receiving income supplementing benefits unemployment benefits, pre-pension unemployment benefits.
- Self employed persons whose activity is not to be qualified as supplementary.

Additionally the scope of Act LXXXIII of 1997 on mandatory **health insurance extends to the following groups of individuals**:
- The persons insured by virtue of Act LXXX of 1997 as well as individuals under a special health insurance contract.
- Persons and organizations paying social insurance contributions.
- The providers of health services on the basis of contract.

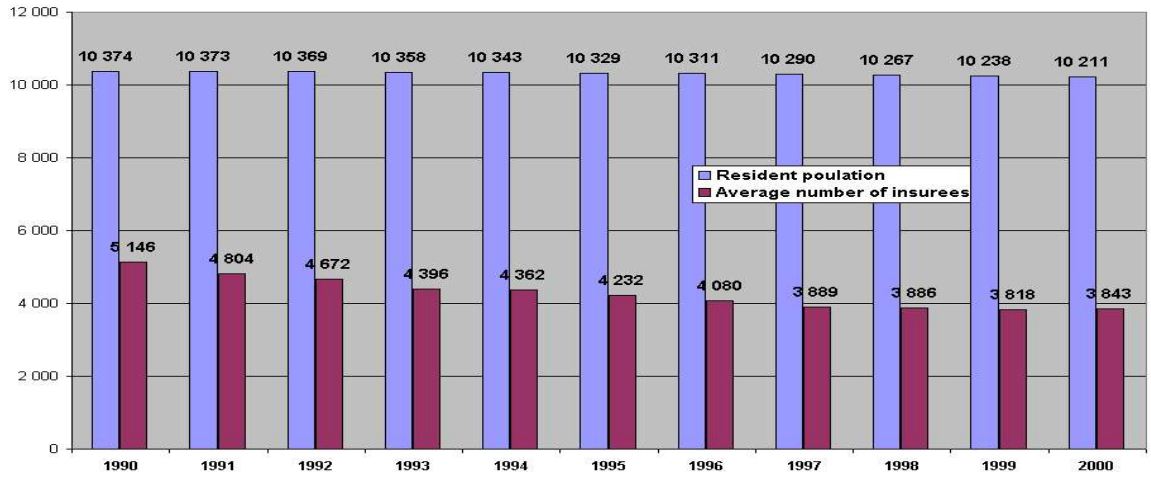
The tasks of National Health Insurance Fund are as follow:
- Purchasing health care services for the insured.
- Directing the regional and other administrative bodies.
- Operating the health insurance branch system.
- Getting involved in preparation of legislation.
- Preparing and implementing the interstate agreements regarding health insurance.
- Developing and operating the data base of the health insurance system.
- Collecting, processing and analyzing the statistical data of the health insurance system.

Health Expenditure, Finance in the Hungarian Health Insurance System

Fast ageing of the population itself puts considerable pressure on financing health care benefits. At the beginning of the 1990s it was probably obvious for analysts that increasing burdens imposed on health care would be taken by a narrowing grade of insurees while their commodity wages were decreasing. In case of either a basic budget or an itemized financing it would have resulted in bankruptcies for the

health providers in sequence. The following two charts below indicate the rapid ageing of the Hungarian society and the continuous decrease in the number of insurees. (Fig 1.)

Fig.1.: Development of resident population and average number of insurees per thousand, 1990- 2001



During the 1990s the number of contributing insurees has been decreased by 1.3 million people, while the number of users has not changed practically. At the same time the ageing index[1] grew 20 per cent, and every year we declare over 40 thousand Hungarian citizens to be disabled, which is equal to the population of a middle-sized Hungarian town. The below shows the sources of the revenues of the health insurance fund in 2001 (Table 1).

Table 1: The revenues of the Health Insurance Fund, 2001, Million HUF and EUR[2]

[1]

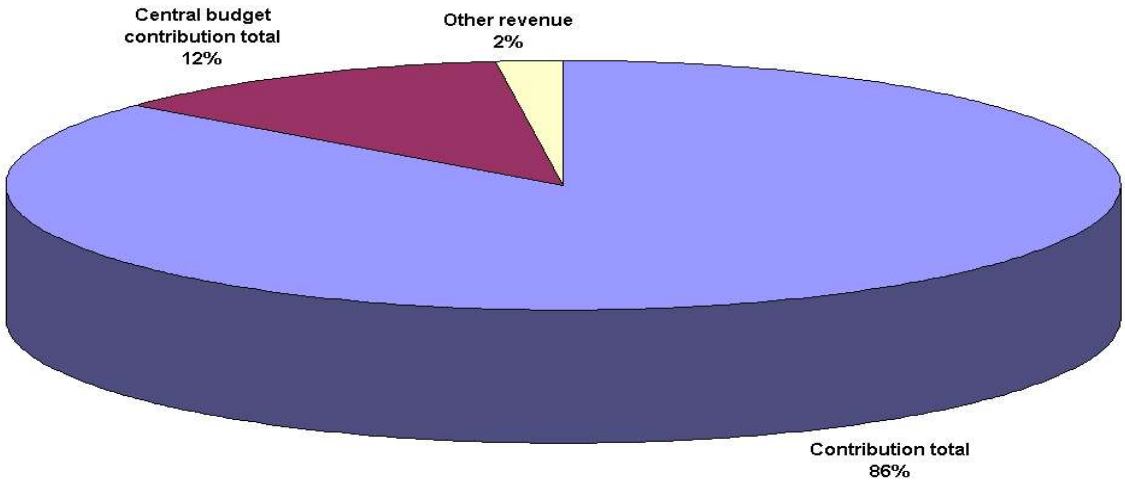
[2] OEP 1.sz.tanúsítvány

	HUF	EUR
Employer's health insurance contribution	439 541	1 816
Insuree's health insurance contribution	105 592	436
Fix health contribution paid by the employee	194 664	804
Charge of overdue payments, fine	3 935	16
Other contributions	18 670	77
of which: health insurance contribution for unemployed provision	3 887	16
accident contribution	1 580	7
employer's contribution to sick-pay	14 625	60
health insurance contribution paid for persons on conscript service	634	3
contribution to the expenses of the preferential pension provision of armed corporations	1 084	4
Contribution total	**762 402**	**3 150**
Central budget contribution	103 928	429
Funds transferred from central budget	70 588	292
Reimbursement of expenses of paying of child-care fee	29 240	121
Central budget contribution total	**103 928**	**429**
Other revenues from the health insurance activity	15 680	65
Revenues from asset management	866	4
Revenues used for operation	1 811	7
Other revenues total	**18 357**	**76**
Revenues total	**884 687**	**3 656**

The National Health Insurance Fund is operating with guarantee of the State. The Fund's principal source of revenue are the health insurance contributions. **Health insurance contribution constitutes 14% of the payroll expenses, 11% paid by the employer, 3% by the employee**. Employers and self-employed persons pay in addition HUF 3450/person/month flat rate health contribution. (This amount has decreased compared with the previous year: HUF 4500 in 2002)

Estimating the overall amount and share of the various sources is difficult. The magnitude of gratuity is unknown. Government revenue is composed of central, local and general sources. The National Health Insurance Fund is the main source of health care financing. The fund defrays the recurring costs of services, while maintenance costs are funded from the central and local governments' budgets. Local governments have their share of responsibility due to ownership, while the country's government provides earmarked and target subsidies. Private health insurance doesn't exist in Hungary. However, there are a limited number of private providers.
The following chart indicates the distribution of revenues in the main groups. 64 per cent of the revenues come from contributions and 34 per cent of them come from either the central budget or taxes labeled (Fig 2).

Fig.2: The main sources of the revenues of the Health Insurance Fund, 2001



The next table includes the structure of the expenditures and the annual balance sheets. The balance shows a deficit of 3-4 percent from year to year. (Some aspects related to the Fund's expenditure have been dealt with in a previous section.)

Beside the Health Insurance Budget, the State Budget plays an important role in the health care financing as well in the following ways:

- Maintains medical universities and professional institutions in the medical field.
- Provides the necessary funds for renovating health care facilities, replacement of equipment and new investment through earmarked subsidies.
- Funds and provides public health and emergency services.
- Covers the co-payment for certain medicines, medical aids and other appliances for the poor.
- Defrays the deficit of the National Health Insurance Fund.
- Subsidizes and provides graduate and postgraduate medical education.
- Funds medical research and development projects.

Significant **co-payment** are required of patients for certain dental treatments, services rendered without referrals, services in addition to those ordered by specialists and extra hotel/accommodation costs. Co-payments are also paid for chronic care and treatment in sanatoriums. Medical services covered neither by the National Health Insurance Fund nor by the State are classified as out-of-pocket expenses. Some out-of-pocket payments are on medicines and medical aids. Finally, informal gratitude payments constitute another category of out-of-pocket expenditure. The latter can be estimated at some 1 to 3 percent of the total health care expenditure.

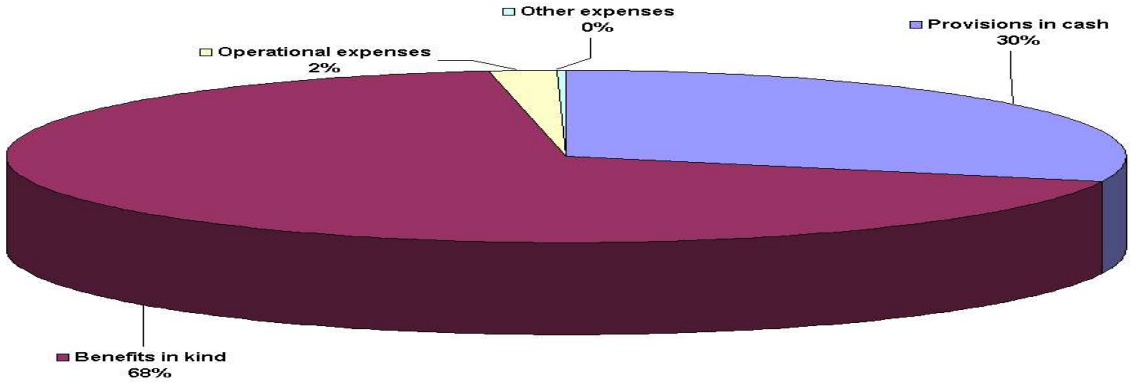
The National Health Insurance Fund finances the recurrent costs in the framework of **contracts** with health care providers. The investment and development costs of the health care institutions do not burden the budget of the Health Insurance Fund. Accordingly, their costs are covered by the owners of the institutions or by the state. In Hungary approximately 98 % of the health institutions are owned by the local governments (communities).

The **Ministry of Health has no longer direct responsibility** concerning financing health care services, except high-cost diagnostic procedures, organ transplants and blood supplies. The Ministry of Finance bears responsibility for fiscal policy and budget planning as well as for the macro-economic implications of health care financing.

The **total health care expenditure** in Hungary is difficult to estimate since it consists of contributions from local governments, voluntary sector and directly from the patients. The total health expenditure as a percentage of the GDP in Hungary (6,5 %) is lower than the European Union's average (8,5 %). The National Health Insurance Fund has a 70 percent share, the largest part of the total health-care expenditure.

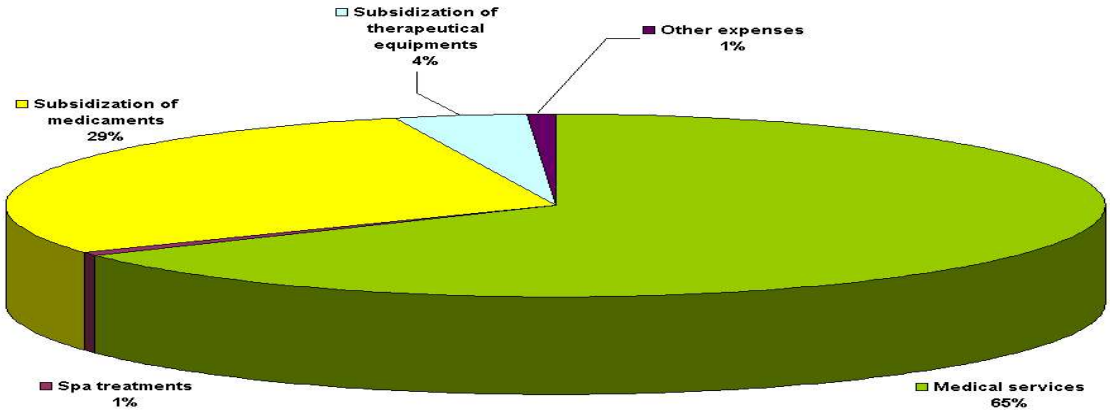
The following chart indicates the proportions of the health insurance fund's revenues spent on medical care and money supplies such as sickness benefit, disability pension, etc. (Fig 3).

Fig.3: Distribution of the expenses of the Health Insurance Fund, 2001



We can see in the figure above that 67 percent of costs were spent on medical cares and 30 percent money supply. It is also important to analyse the proportion of pharmaceuticals to medical treatments within the expenditures of medical cares. The following figure shows these figures (Fig4). It is obvious that the proportion of the pharmaceuticals is extremely high.

Fig 4: Distribution of benefits in kind, 2001



The significant **improvement of efficiency** is unquestionable, while neither the social security nor important hospitals went bankrupt over the reform years. From the cost reduction's point of view the reforms for the financing system introduced in the 1990s did well in the examinations. The deficit of 8-10 percent shown by the social security's balance sheet from year to year is rooted in the different

dynamism between the sides of revenues and expenditures. The deficits higher than expected can clearly be predicted during forward planning, but it is a typical characteristic feature for the national fiscal policy to shifted the deficit shown by the central budget to social security funds.

Considering expenditures over the past decade there has been an important equalization between the territorial and disease categories, which also refers to the decrease in the importance of roles played by political deals in the supply system. Despite positive developments still there are regional inequalities in the system that breaks the horizontal equity. In this case also **allocation efficiency** is damaged. The most typical characteristic feature is concentrating in territories around Budapest and university centers.

European Integration of Health Insurance (1994-2004)
Coordination and Fundamental Principles

On 1 May 2004 Hungary will become a member state of the European Union.

The European Union does not aim at introducing unified European law of healthcare replacing the systems of the member states; therefore, there is no legal harmonisation**.**

One of the "principles of four freedom", which is the free movement of people, cannot be realised without healthcare. That is why harmonization and coordination of the system is indispensable. The legal source of coordination is the **EC Regulations 1408/71** and **574/72.**

On the basis of the regulations above

1. our rights obtained at home is also respected by other member states,
2. we do not need to take out insurance again in another member states if we are insured at home, in other words, taking out double insurance is forbidden,
3. we are not discriminated in any member countries on the basis of our nationality, and finally
4. we do not lose our previous insurance, because the duration of being insured is always taken into account in case of providing services.

In Hungary the National Health Insurance Fund (OEP) is responsible for giving effect to orders in the field of healthcare.

Use of Benefits and Settlement of Accounts

The main rule of health insurance regulations is everyone has to be entitled to full service at their abiding-places, and if someone stays in another member country, they have to be given emergency cares at least.
Financial benefits (e.g. sick pay) are always fixed in accordance with rules being in force in the country of insurance. But benefits in kind are regulated by current legislation of the place of temporary stay.
Regulations cover only social security services.

Services can be used with "E" forms issued by the competent health insurance institute.
In other member countries tourists are entitled to emergency cares necessary immediately, however, those moving to another member states have to be given all of the essential cares. Patients travelling to other member state in order to get medical cares can use services only if their national health insurance institutes enter into a written engagement to fund the costs of the cares.

Due to the principle of equal judgement, National Health Insurance Fund (OEP) covers the same healthcare services financed by other insurance institutes for citizens of EU member states, and actually also citizens of the EU pay for these cares, so Hungarian citizens have to pay for them as well. It also applies to citizens of EU visiting Hungary.

Patients do not have to give money for cares beforehand; they are also entitled to free cares for the insured of any member states. This is the reason why patients do not have to cover those parts of expenditures of cares that are financed by insurance companies, national insurance institutes directly settle up with one another.

OEP contributes to costs of treatments provided abroad if beforehand a medical expert's opinion justifies the necessity of cares provided abroad. Depending on the type of medical treatments, the competent national institute issues the medical expert's opinion. If the professional committees of the competent national institutes agree on the necessity of the treatment received abroad, health insurance subsidises the expenditures. It means that resources do not influence the decision, and it will be unchanged even after Hungary joins the European Community

Participation of National Health Insurance Fund (OEP) in Coordination Works

With regard to the coordination for social security, the Act I of 1994 of promulgated the agreement on partnership between Hungary and the European Community disposed over taking account of the duration of insurance acquired by employees in different member countries.

Since 1995 Hungary has been a member of the programme Phare CONSENSUS that supports national initiations of Central and Eastern European countries in the field of coordination of social security.

In 1997 within the frameworks of this programme Phare made a report on the candidate member countries analysing the state of their social security systems. During the programme based on this report, five institutes entered for a competition announced by the programme Phare CONSENSUS III. One of the winners is the National Health Insurance Fund (OEP) that participated in the competition with the project entitled "Social Security for *Migrant Workers"*.

The agreements on social security between Hungary and Germany, and between Hungary and Austria, respectively, which are regulated by orders enforced **in 2000** and **2001**, even before the accession to EU modelled the future situation by a bilateral relation that helped the National Health Insurance Fund (OEP) adjust itself to the new situation in time.
At the same time, the preparation of healthcare administration for application of orders was started by the project "Phare twinning."

In 2002 120 employees of the National Health Insurance Fund (OEP) took part in education on application of the orders regularly. The organisational system to accomplish orders was established with their participation. Since September of 2002 a unified electronic database and a computer programme have helped the National Health Insurance Fund (OEP) check the entitlement, record rights, handle "E" forms and settle accounts with international partners.

In April of **2003** the National Health Insurance Fund (OEP) was invited to represent Hungary in the future in the organisational unit of the European Committee responsible for maintenance of the orders.

Thus, as a result of an approximate half a decade long works, by now the National Health Insurance Fund (OEP) has been well prepared for the access to the European Community, it is ready and able to accomplish the rules of the Regulations.

Summary

The structure and financing of the Hungarian health insurance system have significantly changed in the 1990s. As a result of the changes a considerable development can be observed in the field of efficiency from both the allocation's and the production's points of view. But the supply induced demand is among the factors in improving the production efficiency, which was not accompanied with the overall

improvement of quality. The latter is largely blocked by reduced levels of resources and the lack of amortization expenditures, while the proportion of out-of-pocket payments was increased and the system of gratuity was not vanished. The merit of the changes to date is equity has been damaged neither horizontally nor vertically, in spite of a vast majority of insurees have been lost. The health insurance system keeps providing widespread safety for both insured persons and those who are entitled in another way, but the low level of inputs questions the sustainability of the system. Despite growing burdens imposed on the population, the expenditures of pharmaceuticals represent a disproportionately large part of expenditures spent on medical cares. It is impossible to maintain this proportion from the system's safety's point of view, because this is one of the most important recurring reasons for the yearly negative balance sheet. We do the best to put out-patient cares in the foreground against in-patient cares. We want to strengthen the preventive and screening programs so as to avoid acute and serious conditions. We would like to strengthen purchasing role of the health insurance system by improving our controlling system. Also from the Managed Care experimental models gives important experiences to us.

To sum up, there is still a quality aspect to emphasis more in the health insurance, yet, Hungary's health insurance is ready to fulfill the growing task of coordination conferred to it by the accession to the European Union.