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Misplaced priorities and Missing Consistency

Health Policy in Hungary and its Consequences on Health and Health Funding

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- Social and economic inequalities are deepening, which increases avoidable inequalities in health.
- The underfunded health care system is decreasingly able to fulfill its role. Underfunding, inadequate funding, mass emigration of doctors and nurses make the problem more serious.
- The time in office of ministers of health has been on average 2-2.5 years, since 1990. Frequently changing health ministers means too frequent major changes in health policy, and, as a consequence, Hungary in fact has not had a consistent, politically feasible and sustainable health policy throughout the last 27 years. This practical fact has been paired with the lack of adequate funding of the system – therefore the present status of the health care system and the unacceptably bad health status of the population are not surprising at all.
- No real changes can be expected until the political priorities will not change, and the long-lasting underfunding crisis will not be solved in line with a professionally sound, consistent, long-term and politically, administratively feasible and sustainable, comprehensive health policy.

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Content

Introduction

The aim of this paper is to give a brief overview on the main issues of the Hungarian health and health care system.[1] After outlining the health status of the Hungarian population, the funding, the provider structure, provider purchasing methods, financing and subsidization of pharmaceuticals will be discussed. Then we focus on two outstanding challenges: (a) the availability and adequacy of financial resources and (b) the human capacity crisis. Access, equity, quality, efficiency, adequacy, availability and acceptability of the health services, including responsiveness, patient centeredness, financial risk protection, and geographical inequities will also be discussed throughout the paper together with such outcome measures as inequalities in health and inequalities in avoidable diseases & disabilities and avoidable deaths.

Health policy and politics

After the change of regimes in 1990, it was decided that Hungary will turn to a single payer Social Health Insurance System, from the former state run National Health Service model (see below). At the same time, relatively strong interest groups emerged, which have been trying to push through some form of privatization of the Health Insurance System or its provider parts (e.g. hospitals). It is well known that Social Health Insurance and such private insurance schemes are in many ways in a mutually exclusive relationship with each other. This means that whenever such privatization initiatives got political support,[2] the organic development of the social health insurance scheme stopped.

Moreover, almost all of the health ministers since 1990 have been in office for 2-2.5 years on average.[3] Almost each of them has had a comprehensive health reform program, which in many ways differed from his/her predecessors. Some of them wanted to privatize, others wanted to stop privatization. However, in terms of measurable health outcomes of any health reforms, 'the short-term' is 3-5 years, 'the mid-term' is 30-40 years, and 'the longer-term' is 60-70 years. During the last 27 years, no reform program has been successfully implemented. Most of these *so-called reforms* were aimed at reorganizing this or the other part of the system without clarifying any valid aims or objectives. Health policy as such has not existed; instead we had *health care policies*, *"hospital policies"*, politics and political scandals around the health care system – none of them is real health policy.

Health status

Life expectancy and the health status of the Hungarian population is one of the worst among EU member states – often even among the other Central and Eastern European states.[4] Life expectancy *at age 40* among men is only 1.4 years higher than it was 50 years ago – in spite of the improvements in medical technology (Kollányi & Orosz 2016). However, men's life expectancy *at birth* has increased by 4.28 years between 2011 and 2016 (KSH 2017). The better life expectancy of the younger generations offset the far worse health status of the older generations. Women's life expectancies are better than men's (by 5-8 years) but worse than that of other countries (Table 1.)

The level of inequalities in health is particularly worrying. The life expectancy of men is 77.1 years with a tertiary education, 73.9 years with a secondary education, and 65.4 years without a secondary degree. The same social-gradient can be seen in women's life expectancy: 81.5 years with tertiary education, 80.3 years with secondary degree, and 74,8 years without a secondary degree. These data are not only among the worst of the EU countries, but the differences in life expectancies by education (i.e. the social gradient in avoidable inequalities in health) are amongst the largest (Table 1.).

People living in the most disadvantaged small regions die by 13.5 years earlier than those living

1 This paper relies on the first Hungarian Health System Performance Assessment Report on the time period 2013-2015 (ÁEEK, 2016).
2 E.g. in 1997-1998, in 1998-2000, in 2002-2004, in 2006-2008
3 Only two of them was able to remain in office during the whole 4 years long government cycle.
4 »Disability Adjusted Life Years Lost« i.e. avoidable loss in life years within the population due to disease, disability and premature death exceeded 25.700 years-lost in 2014, – the highest within the V4 group, and it is scarcely better than that of Romania, or Bulgaria. (Mérték 2016: 251, 283.)

in the most advantaged ones (Kollányi & Orosz 2016). One should keep in mind that avoidable premature mortality means that due to the avoidable inequalities in distribution of social determinants of health we die years earlier and have shorter lives than it would be necessary, whereas avoidable disease and avoidable disability means that we have to live more years in disease and in disability within our unnecessarily shorter lives. (Wilkinson & Pickett 2009, Marmot 2015). This puts an extra burden of families, especially on women, due to the lack of adequate, acceptable and equitably accessible long-term care.

Though the health status of the population is influenced by several non-health care related factors, an optimally functioning health care system still could have a profound effect on the health status of the population. By better exploiting the potentials of a health care system, the volume of amenable disability and mortality – that is those avoidable disabilities and premature deaths which are attributable to health care – could be significantly reduced. In 2014, 17,677 deaths were classified as amenable, – the 14 percent of all deaths; e.g. in cardiovascular and cancer mortality Hungary is among the worst performers of the EU member states.

The main individual lifestyle related health risks are the high level of alcohol consumption, smoking, unhealthy diet and the low level of physical activities. Several public health interventions have been initiated in order to improve the health behaviour of the population. However, there is a strong social gradient in these unhealthy behaviours as their prevalence strongly correlates with the socio-economic status of the individuals (Marmot 2015). The social determinants of health, their distribution within the population, and even the health effects of these factors strongly correlate with the level of inequality in income and wealth and with the equal opportunities of a given society (Marmot 2004, 2015, Wilkinson 2005, Wilkinson & Pickett 2009). In spite of these facts the official health policies and reforms practically very rarely and very inadequately have addressed the excessive inequalities in the distribution of

Gender	Males	Males	Males	Females	Females	Females
Highest educational attainment	**Less than upper secondary education**	**Upper secondary and post-secondary non-tertiary education**	**Tertiary education**	**Less than upper secondary education**	**Upper secondary and post-secondary non-tertiary education**	**Tertiary education**
Bulgaria	66.6	72.3	74.5	74.8	78.7	80.1
Czech Republic	66.3	76.1	77.4	79.5	81.7	82.5
Denmark	75.4	79.2	81.4	80.1	83.1	84.3
Italy	77.9	82.8	82.8	83.3	86.3	86.3
Hungary	**65.4**	**73.9**	**77.1**	**74.8**	**80.3**	**81.5**
Poland	66.5	73.4	79.2	78.6	81.4	84.0
Romania	66.4	73.0	74.9	76.6	79.7	80.1
Slovenia	74.1	78.1	80.9	82.3	84.2	85.1
Slovakia	62.8	73.6	78.0	75.4	80.7	82.2
Finland	75.6	78.6	81.7	81.9	84.4	85.7
Sweden	77.7	80.5	82.5	82.5	84.0	85.3
Norway	77.3	80.7	82.5	82.1	84.3	85.6

Table 1. Life expectancies by level of education

the social determinants of health. Obviously, this should have needed a multi-sectorial »*health in all policies*« approach, which should have involved such policy areas as education, housing, unemployment insurance and other social policy areas, since the unequal distribution of the most important social determinants of health and thus the improvements in health cannot be effectively tackled by the health care system alone with its 'traditional' narrow *health care policy* approach (WHO CSDH, 2008). Though Hungary has had several health care reforms and individual health risks focused prevention programs so far, in fact it has never had such cross-sectoral health policy which would have effectively and adequately addressed the unacceptably unequal distribution of the social determinants of health within the population.

Approximately 26% of all mortality would be avoidable, and 14% of all deaths is attributable to health care – meaning that a more equal distribution of social determinants of health, and an adequately funded, adequately functioning, more equitable and accessible health care system would stand a good chance to prevent the avoidable diseases and disabilities and premature deaths (Kollányi & Orosz 2016), since avoidable morbidity and premature deaths that are attributable to the health care sector are still much higher than the EU average. This indicates the vast potential in improving the performance of the health care system.

Funding of the System

In 1991, as part of the change of the system the first democratic government turned the former National Health Service into a single payer social insurance system; established a separated Health Insurance Fund (HIF), and the National Health Insurance Fund Administration (NHIFA) to administer the HIF. Thus, the funding of the health care system changed from general taxation[5], to an income contingent social insurance contribution (earmarked tax) based system. It is a lump-sum contribution in case of non-employed and government financed groups (e.g. unemployed or disabled people). In this term universal coverage remained in place.

5 In this context 'general tax' refers to all forms of taxes (e.g. income tax, V.A.T.), which are not earmarked taxes, i.e. not social insurance contributions.

Originally, the NHIFA had collected all social insurance contributions. The general view was then that this way the real revenues from the social insurance contributions would become more transparent, and the separated collection paired with the earmarked tax nature of the contribution would ensure a more transparent and secure, predictable funding than it would be the case with a general tax based funding system. This arrangement structurally provided a rather significant independence for the Health Fund from the government and particularly from the annual fiscal policy of the Ministry of Finance. The perception was that a general taxation based funding system would be more dependent on the daily politics around the state budgeting processes, would bring in hardly tolerable uncertainties and instability into the Health Insurance System. Under the 1998-2002 government, the collection of social insurance contribution of the NHIFA was abolished and taken over by the Tax Authority.

During the last decades, social insurance contributions have represented an ever-decreasing proportion of the financial resources handled by the NHIFA. By now, the general tax based revenues became dominant. Social insurance contributions had two main elements: individual and employer contribution. The latter is perceived and called as the »*costs of workforce*« and allegedly it has an antagonist effect on employment, as the higher »*costs of workforce*« would result in a lower employment rate, whereas the lower »*costs of workforce*« would allegedly result in an increased employment rate – according to this argumentation of trickle-down theory based supply-side economics. Based on this argument, employer contributions have been gradually decreased and replaced by general taxation. However, the employment rate – apart from some slight and temporary changes – has remained around 60-62% during the last 20 years, in spite of the fact that the employers share in the HIF's revenues has decreased from 75% (1998) to 15% (from 2010) (Table 2.), and the employers' contribution rate has had a ten-fold decrease between 1994 and 2010 (Table 3.).

Though the arguments for cutting the fair share of contributions of employers and corporations have always been about improving the employment

Breakdown of HIF revenues (in %)	By 1998	By 2006	From 2010 until now
By Employers/Corporations	75%	50%	15%
By Individuals/Employees	12%	30%	35%
General Taxation (taxpayers)	13%	20%	55%
Employment Rates	59%	62%	60,4%

Table 2. Revenues of The Health Insurance Fund, by its main contributors

Social Health Insurance Contribution Rates (%)	1994	1998	2006	2009	2010
Employers/Corporations	19,5%	15%	11%	5%	2%
Employees/Individuals	4%	3%	6%	6%	6%

Table 3. Changes in the Social Insurance Contribution Rates of the different Contributors

rate, in fact it has never changed during the last 20 years, i.e. the promises of the tax cut induced increase in employment by the trickle-down theory proved to be false – despite the five-fold decrease in share of contribution and the ten-fold decrease in contribution rates (Table 3.). By now, employers and firms pay ten times less than in 1994, individuals pay twice as much as in 1998. The revenue losses resulting from the fact that employers do not pay their fair share of social insurance contributions, are paid by the taxpayers in two ways, partly as increased individual social insurance contribution and through general taxes.

In the meantime, NIHF lost its independency by abolishing its self-governing bodies, it lost its independent social insurance contribution mechanism and thus the control over its own funding, lost its political power in negotiating the health care budget. In one word, its political weight and its financial stability have been seriously undermined and it has become fully exposed to the politics and uncertainties around the government's annual budget planning processes. The uncertainties, unpredictability and instability around the Health Budget and the related planning processes have increased significantly during the last 10-15 years; this negative process began with the so called "Bokros-package" in 1996, and has continued since the abolishment of the independent self-government by the first FIDESZ government in 1998. It would be a mistake to overlook the implications of these changes – in fact these do have profound and far-reaching negative consequences both on the stability, security and functioning of the health care system and on the health status of the population.

Levels of health care providers and their financing

The main layers of the Hungarian Health Care System are: primary care with general practitioners; secondary care with outpatient specialist care; acute inpatient specialist care and chronic or recovery inpatient care which includes rehabilitation, nursing and recovery wards.

Primary Care, General Practitioners (GPs) and Their Capitated Finance by a Weighted Capitation Formula.

There are approximately 6,000 GP districts. Presently about 200 of them are permanently vacant and provided for by substitute GPs. The size of an average general practice is about 1,700-1,800 in terms of registered patients. Local authorities are responsible to guarantee the accessibility of general practitioners, and people can freely choose which GP they register to. General practitioners play a gatekeeper role to specialist care and they have to manage the pathway of their patients. GPs are financed on a per-capita basis by a weighted per-capita financing formula.

Though GPs are assumed to have a gate-keeping role, there are numerous specialties where no referral is required for visiting a specialist (e.g. gynecology, dermatology). Because of the inherent incentive effects of capitation finance, because of the lack of adequate quality assurance and due to

some competency issues, the patients are too often referred to specialist care with health problems that could have been definitively treated at the primary care level. Per-capita finance means that the GPs got the same amount of money after each registered patients, irrespective whether they see them, treat them or refer them to specialized care, thus GPs are in a way incentivized in referring patients to the specialized secondary and the more specialized tertiary care level, whereas secondary care level outpatient and inpatient institutions are also incentivized in admitting these patients. As a result, even though one of the main objectives of the official health care policy is always to provide high quality definitive treatment for all patients at the lowest possible provider level, in fact too many patients end up at the highest provider levels, and too often with rather banal health problems.

One of the profound problems of the Hungarian primary care system is that all of the GPs are »*single-handed GPs*«: i.e. one GP is one practice and one business unit. There are many health issues, which could be adequately treated at the primary care level in medical terms, but cannot be run in an economically viable way – for obvious *diseconomies of small scale* reasons; since all of the fixed costs of a practice, including those equipments which could be utilized by more practices, fall into the GPs' practice, whereas in a group-practice such costs could have been shared, which could results in better equipped and financially more viable primary care practices. Recently, EU funded projects are run for designing and developing the organizational, financial and legal framework of such GP group practices.

Outpatient Specialist Care and Its Finance.

About 80% of all outpatient specialist care cases are treated by outpatient clinics integrated to hospitals. The remaining cases are treated by free-standing outpatient centers.

Outpatient care is purchased by the German outpatient finance method. Each medical intervention has its code with its own *"German point."* It is determined which interventions can be reported together, depending on the diagnosis. The HUF value of a German point is revised annually by the NHIFA. Both outpatients and inpatient providers have an annual »*performance volume limit*« (broken down to months) and they are reimbursed for each medical intervention up to that sum.

Inpatient-Hospital Care and Its Finance by a Diagnosis Related Groups (DRGs) Based System.

The number of hospitals providing acute inpatient care varies around 100-140 and the number of acute care hospital beds is approximately 42,000. Additionally, there are 28,000 long-term care beds. By 2012 most of the hospitals were owned by local authorities. As part of the state-centralization in 2012, the state took over the hospitals and most of the outpatient clinics. A public agency – the National Health care Service Center – was set up as the steward of the state-owned hospitals. The idea was that some efficiency gains might be realized by centralizing public procurements, and by the optimization of patient pathways might be easier, which might be resulting in some efficiency gains at system level. However, this issue remained controversial since excessive centralization also might result in massive *diseconomies of large scale & scope*, since the system becomes too large and too non-transparent to be effectively managed and controlled.

Acute inpatient hospital care is financed (by DRGs) up to the *performance volume limit* set for each provider. Long term care is financed on a *patient-care-day basis*.

There are three progressivity levels depending on the hospitals' professional and technical capabilities. In general, town hospitals with basic specialties are categorized as progressivity level one (i.e. the lowest level). County hospitals are typically operating at progressivity level two, whereas national institutions, university clinics, and some wards of the county hospitals form the third level. Each hospital has its own allocated territory, and they must admit and treat *all* patients from these areas. This is called as a »*territorial health care provision obligation*«. The patient is to be transferred to the adequate progressivity level, and the higher-level hospitals must admit these patients. There are

many controversies around this system, since it is not always easy to differentiate between the *real* progressive cases and simple *'patient-shifting for cost-shifting'* practices.

In 2012 the regulation of pharmaceutical subsidization was altered to limit central expenditures. Agent based subsidization has promoted the prescription of generics. New procurement methods have facilitated a fiercer price competition. In overall, the reform has been successful as governmental pharmaceutical reimbursement could be reduced from 364 billion HUF (1.16 billion EUR) in 2011 to 283 billion HUF (0.9 billion EUR) in 2012. This was a decrease of more than 22 percent, though expenses slightly rose again in 2013 to 311 billion HUF, there is still a permanent effect. This issue remained controversial: the effects of the budget cuts and the real efficiency gains are not clearly separated. The former might have longer term negative health consequences.

Stewardship

The health care system is supervised by the Secretary of Health which belongs to the Ministry of Human Capacities. Several major reorganizations of the health care system have taken place since 2010, which have substantially redefined the role and responsibilities of all major governmental agencies in the sector. In 2011, five major health care agencies merged into the National Institute for Quality- and Organizational Development in Health Care and Medicines which is responsible for the stewardship of public hospitals since 2012. This massive centralization was followed by more massive centralization. In 2017, several major government agencies were integrated into the ministry, including the Office of the Chief Medical Officer and several tasks and departments of NHIFA. Obviously, these frequent re-organisations can hide the lack of a consistent and professionally sound health policy, but cannot substitute for it. Moreover, by this seemingly technical reorganization, the Social Insurance System as such was abolished without declaring the abolishment of it as a basic institution of social security. This measure surely will have profound, far-reaching longer-term consequences as the stability, security and predictability of the health funding have been seriously undermined.

Financing of the System and the Underfunding Problem

In 2015, – following a decade-long declining tendency – Hungary spent less than 7.2 % of its GDP on health. Two-third of this sum was paid by the taxpayers, 28% by the households and the rest by voluntary health financing vessels. The low level public expenditure, coupled with a high-level household participation, raises serious concerns on equity and access in itself, since it turns access to care more and more dependent on ability to pay.

GDP proportional public funding in Hungary is around 4.7-5%, whereas it is 6.5-7.5% in the relevant benchmark countries (e.g. V4), (and far lower than that of the old Member States or the EU average); thus the volume of public funding of the Health Care system in the other V4 countries is in fact 30-50% larger, than that in Hungary. There is no such macroeconomic reasons which could justify such a difference, since the V4 countries had basically the same inherited problems from the past, and presently their economies are doing neither much worse nor much better due to their higher level of health expenditure. Hungary has no economic advantage from underfunding its health care system by 30-50%, and there is no any *publicly justifiable* reason for doing this.

The annually recurring serious indebtedness of the hospitals is an apparent warning of malfunction and underfunding. Hospitals have to be consolidated each year out of the central budget. The size of the annually recurring indebtedness is estimated at at least 100-140 billion HUF per year (0.32-0.44 billion EUR), whereas the whole health care budget amounts to 780-800 billion HUF (2.5-2.6 billion EUR) per annum.[6]

There is no hard measure for calculating the *exact* amount of the underfunding. However, there are at least two plausible ways for estimating its size.

6 With primary care & without pharmaceuticals

One is a comparison with benchmark countries, as we did it earlier. 1.5-2% GDP proportional difference is about 500-600 billion HUF (1.6-1.9 billion EUR).

The other way for estimating the missing volume of funding is to identify serious dysfunctionalities and problems, and – among many possible explanatory factors –the main reason for them is obviously underfunding.

1. One of these items is the annual recurring hospital indebtedness (100-140 billion HUF per annum). It must be noted that the providers of the hospitals have already priced their expected losses caused by delayed payments of the hospitals. The resulting 20-25% higher prices are excess costs that could be eliminated if the funding of the system would be adequate, predictable and secure.

2. Secondly, the human resource crisis (see below) and the volume of mass full-time employee poverty should be considered. If we compare the extremely low incomes and salaries of the health professionals (doctors, nurses and others) with the salaries and incomes of such public sector branches in which the incomes and salaries are basically acceptable (e.g. the judiciary sector), then we can estimate the volume of the differences, which is the missing finance for abolishing the general *mass full-timer employee poverty* within the health care sector. According to the estimation of the Hungarian Medical Chamber, the size of this missing finance is approximately 250 billion HUF (0.8 billion EUR) (MOK 2017).

3. Finally, one should be aware that the other option for compensating this level of underfunding –besides keeping health professionals in employee-poverty – is a switch to using medical technologies and materials which are cheaper in terms of their actual costs, but are much costlier in the longer run due to the otherwise avoidable complications (which in itself generates avoidable long-term excess costs and avoidable human suffering and deepens the health and health care crisis). Approximately 150-200 billion HUF would be needed to switch back from the cheap technologies to the cost-efficient medical technologies.

By adding up these items we get approximately the same missing volume of finance (500-600 billion HUF) (1.6-1.9 billion EUR), which we could estimate from the benchmark comparisons. Obviously, these are rough estimations, however, they demonstrate the order of magnitude and the size of the underfunding problem. This clearly shows that even if there are usually loud political-communication around *'giving'* 10-40 billion HUF (0.03-0.12 billion EUR) for this or that – these accidental measures are far less in order of magnitude that the real size of the underfunding problem, and absolutely inadequate, irrelevant from the point of view of solving the health care crisis in a sustainable way for the longer run, which is unimaginable without restoring predictability, security and stability of funding.

A majority of health care capital investment and constructions, and the procurements of high-tech equipment and devices are financed through EU funds. In 2011 the 51% of all such investments (40 billion HUF) (0.12 billion EUR) came from EU sources whereas by 2014 this rose to 77% (65 billion HUF).

Human resources

There are 30,000 physicians and 95,000 health care professionals owning valid license to practice in Hungary (ÁEEK, Mérték, 2016: 585). The physicians per population rate is in accordance with the European average formally. However, all health care professionals who have renewed their license during the last five years are involved in the count, but many of them do not practice their profession or do not practice it in Hungary. Health care professionals' emigration is a serious problem. Recently some data were published on this issue. Annually approximately 7-800 doctors and 7-800 health professionals are leaving the country. The number of newly trained doctors is about 950 per annum (Világgazdaság, 2017). The main destinations are Austria, Germany, Sweden and the

United Kingdom. The main driving force behind emigration is the low pay, the bad working conditions, consciousness related issues due to the applied outdated medical technologies. In 2013 the purchasing power of an average physician salary was more than 3 times higher in Germany and 6 times higher in the UK, than in Hungary (ÁEEK, Mérték, 2016: 615).

Retirement and ageing also decreases the number of doctors. 50% of the GPs are older than 50 years, but there are practicing GPs over age 80 as well (ÁEEK, Mérték, 2016: 629). There is a serious lack of middle aged doctors.

The lack of nurses seems to be the most serious problem: the nurses per population rate is approximately 25 percent below the European average – also affecting the excess tasks and burdens of doctors and the remaining nurses, which further pushes them to consider leaving the country or the profession, which escalates and deepens further the human resource crisis as a *circulus vitiosus*.

To limit emigration some steps have been taken to raise wages. In 2011, a scholarship program was launched for residency training participants. In the first four year 2,500 residents participated, who received a monthly HUF 90,000 (290 EUR) scholarship (ÁEEK, Mérték, 2016., p.47). In 2013, there was a one-time approximately 10% raise of all health professional salaries. In 2016, a '*wage development program*' was launched. However, the size of this problem in terms of annual excess funding is about 200-250 billion HUF. All of those temporary measures, which are far below this volume, are predictably deemed to be inadequate, irrelevant and unsurprisingly unsuccessful.

Until the extremely low salaries and incomes among health professionals and the serious underfunding crisis remain unsolved, one cannot realistically expect any significant changes in this problem. The solution of this underfunding crisis is entirely a matter of political priorities and political will.

Availability and Access

Both the infrastructure and the capacities of the health care system are concentrated in the more densely populated areas. This generates geographical inequities in access to care. Fortunately, General Practitioners are highly accessible and available, there are hardly ever occasions when a patient could not reach a GP within 24 hours.

There are waiting lists in case of specialized inpatient and outpatient surgeries, e.g. hip- and knee-replacement as well as cataract surgery. The average waiting time has been 146, 266 and 88 days respectively in 2015 (ÁEEK, Mérték, 2016: 492). In 2014, the government guaranteed extra funding for the shortening of the waiting lists. Since the reason for a long waiting list in such cases is always restricted finance and a budget cut (and not the lack of technical and physical capacities), it is not surprising at all, that such a once-and-for-all temporary measure led only to a limited and temporary effect in 2015, though a 8 and 6 percent decrease has been achieved in case of hip- and knee-replacement, and further reduction took place in 2016, as a result of provision of some further additional funding above the budget cut for some selected health centres.

Quality

A ministerial decree from 2003 sets the minimal requirements – regarding equipment, human resource and volume of interventions – for each specialization at each progressivity level to operate in order to guarantee the adequate care being provided. Another ministerial decree from 2013 regulates the process of developing and introducing national treatment protocols. However, only a very limited number of national treatment protocols or clinical guidelines are in effect.

Some mortality data warn that the quality of care is to be further strengthened. For example, the 61% five-year survival rate of cancer is a serious problem, particularly because it is slightly worsening due to a negative tendency in the timely diagnosis of malignant tumors. Also, an analysis of mortality following hip-replacement indicates that

there is vast heterogeneity in the applied methods and their outcome, which results in serious inequities in terms of the avoidable diseases.

Similarly, a high and constantly rising level of caesarean sections and the practice variations among different hospitals imply that the decision on the applied medical intervention is not always based on medical reasons. For example, mothers from the less advantaged settlements had substantially lower ratio of caesarean sections – which is actually closer to the optimal value –, nevertheless this phenomenon raises the suspicion that under-the-table payments may distort the medical decisions on cesarean section, and due to their inability to pay they may have much restricted options, i.e. their opportunities in having enough control over their own treatment is denied from them.

Financial risk protection

Health care coverage in Hungary is universal, however, the proportion of out-of-pocket payments is high: in 2014, an average household spent 5.5% of its income on such expenses, and out-of-pocket expenditures represented 28.3% of the total health care expenditure. Part of these out-of-pocket payments are legal: e.g. out-of-pocket payments have been the main sources of pharmaceutical expenses since 2013, which is another aspect of the reform in 2012 aiming to limit the government subsidy outflow in this area (ÁEEK, Mérték, 2016:781.).

However, the above figure also contains the estimated value of »*under-the-table payments*«, which is still widespread in Hungary, though it is officially illegal. The widespread »*under-the-table payment*« system distorts in many ways the functioning of the system. There is a danger that, in parallel with the financial and organizational destabilization of the health insurance system (see above), the health care system will increasingly become dependent on *under-the-table payments*, whereas access to care increasingly turns from a health needs based system into a system where equal opportunity to access to adequate care will not be based on the equal health needs of the patient but instead access will depend on the ability to pay, and on under-the-table payments.

Poor households spent a smaller proportion of their income (4.3%) on out-of-pocket health expenses than households above the poverty line (5.3%) (ÁEEK, Mérték, 2016:803). However, it is a well-established fact that there is a very strong social gradient in the occurrence of the different health problems (Marmot, 2004, 2015). That is, the lower the socio-economic status of a given group the higher is the risk of diseases. The fact that the poorer households make less out-of-pocket payments – in a system in which such payments play a significant role – indicates that precisely those people have the less access to adequate care who are in the largest need for it. A recent study showed that, on average, availability of care has been improved in general, but at the same time the inequalities in access have increased (Kollányi & Orosz 2016). In a publicly funded public service, such inequities are also simultaneously inefficiencies, since those people systematically receive less adequate treatment who are in the largest need and who are supposed to receive more care on the basis of their health needs.

Concluding remarks

Hungary has never had any real and sound health policy. The establishment of a modern Social Health Insurance System was decided in 1991, after changing the state socialist system, however the building up of such a Social Insurance System has never been accomplished. The health system is chronically underfunded, which results in poverty among the medical professionals, emigration of the health professionals and a human resource and underfunding crises. In the meantime, the health status of the Hungarian population is by any reasonable measures among the worst in the EU.

The frequent reorganizations of the key institution cannot substitute for the lack of health policy. There are many technicalities around the different changes and around the different so-called health programs, reforms, however, serious macro-level underfunding of the system will not be resolved until the political priorities will be changed, and until the efficient and adequate funding at the macro level is ensured, no significant change can be realistically expected despite any well-sounding

technical level, so called health policy initiatives or reform programs. This is why we avoided in this paper the detailing of the different, controversial, short-lived, technical level reforms, which have taken place during the last 25 years, as an intended but seemingly inadequate substitute for a real and professionally sound, politically and administratively implementable and sustainable health policy program. Moreover, the manifold dysfunctionalities of the system could and should be changed through a sound health policy and manifold technical level interventions and regulations, however we are not going to go into the details of this substantially technical level details and proposals, since we cannot realistically expect any significant improvement until the underfunding crisis of the system is solved, and until the stability of the Health Found is restored.

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