

Peter Mihalyi

Ownership changes in the Hungarian healthcare sector, 1990–2017

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Tekst jest udostępniony do wykorzystania w ramach dozwolonego użytku.

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The paper's objective is to provide a historical account of the most important changes in two aspects of Hungarian healthcare: financing and provision. It will be shown that after a promising start to the necessary post-communist reforms, a complete reversal took place after 2010. The separation between financing and provision ended. By 2017, the Ministry of the Economy – like the Planning Office under the socialist system – has regained absolute control over the entire healthcare sector, including both financing and provision. Even the Ministry of Health ceased to exist in 2010.

Keywords: Hungary, healthcare, reforms, social security system.

Introduction

“Our healthcare system is in crisis.” This sweeping generalization has been voiced without reservation in Hungary by patients, healthcare workers and government officials alike for three decades. This allegation, however, is a misleading and paralyzing exaggeration. Firstly, the healthcare systems of *all* countries are subject to populist criticism generated by unrealistic expectations. Secondly, the reality is that both exemplary and malfunctioning building blocks can be found in the Hungarian system. This paper will attempt to give an overview in the context of post-communist transition. It will be shown that path dependency explains almost everything that has occurred in the Hungarian healthcare system since 1989, when the Soviet-type, communist rule abruptly disintegrated within a few months.

Hungary is a fortunate country in many ways. Although her overall development level is only about 60 per cent of the advanced Western European countries, when compared to other post-communist countries, she belongs to the upper

second tier. The regime change in 1990 did not bring about border changes and there was no violence. With 10 million inhabitants, Hungary is a middle-size country and has the theoretical possibility to exploit economies of scale in all sectors of the economy, including healthcare.¹ The population is homogenous. Except for the estimated 600–700 thousand Roma minority, there is no other distinct social group which may stand in conflict or in rivalry with the Hungarian ethnic majority.² Although Hungary is a landlocked country, a disadvantage from a growth perspective, this has no direct implications for the health system.

The main objective of the paper is to provide a focused account of the most important institutional changes in the Hungarian healthcare system over the last 25 years, and therefore many other important features of the system are neglected for lack of space. The concept of ownership is interpreted in two dimensions in this paper. International agencies and academic research agree that the separation of health care financing from provision is critical (a purchaser-provider

Peter Mihalyi
Corvinus University of Budapest
Macroeconomics Department
Fővám tér 8
Budapest, H-1093
Hungary
peter@mihalyi.com

¹ For a broader, more detailed system description of the first 10 years, see Orosz, Burns (2000), Gaál et al. (2011) and Mihalyi (2011b, 2012).

² The overall health status of the Roma population is significantly worse than the national average. A 10-year shortfall in life expectancy is a widely quoted, plausible number, although there is no solid demographic research behind it.

split). It has been proven by the practice of many countries that providers make more efficient allocative decisions if they are awarded more managerial freedom, and they work harder if their remunerations are tightly linked to performance.

Thus, the first dimension within the present paper pertains to the ownership and the functioning of health financing funds. Is this the government's responsibility or is the system based legally and financially on independent, competing non-state entities? We will show that during the analysed period, a complete reversal took place. There were several attempts to build independent or at least relatively independent structures, but as of 2017, the entire financing mechanism has been reintegrated into the government budget, as it used to be the case prior to 1990. The same happened in the second dimension pertaining to the ownership of the most important places of therapy: hospitals and outpatient polyclinics. After almost two decades, when ownership of these facilities was in the hands of local governments at different levels, by 2017 the central government has repossessed almost all hospitals and all polyclinics. In 2010, the Ministry of the Economy – like the Planning Office under the socialist system – regained absolute control over the entire healthcare sector: both the financing and the provision aspects. Even the Ministry of Health ceased to exist in 2010. There are two less important areas where private ownership has continued to develop and the process has not been reversed: the ownership of GP practices and pharmacies. The basic facts of these two areas are also presented in this paper.

Continuity and Discontinuity in the Single-Payer System

By the time the Soviet-type, centrally directed economic system collapsed in Hungary, 90 per cent of healthcare provision was funded from the central government's tax revenue. Care at the point of delivery was free except for outpatient drugs in exclusively state-owned pharmacies, where mandatory co-payment always existed. This explained about $\frac{2}{3}$ of the missing 10 per cent. Another private expenditure item was

patients' informal payments to doctors and nurses, although this was more a widespread habit than an obligation. Patients did not receive inferior treatment from the medical staff even if they did not pay the so-called *gratuity* payments. The market was by-and-large in equilibrium: the middle-class and the upper middle class paid these extras almost without exception, while the lower classes got by quite well even though they did not pay the medical staff in about half of the cases.

The new structures started to evolve prior to the regime change. Some elements of social insurance (SI) *de jure* had persisted during the communist era. Payroll-related SI contributions were collected, and cash benefits were administered *via* the National Social Insurance Administration of the National Council of Trade Unions in a fully centralized manner from the 1950s onwards. Then in 1988, to finance pensions, an Act separated the Social Insurance Fund (SIF) from the central government's budget. A year later, but still before the end of the communist era, funding of health services was transferred to the SIF from the central budget. Thus, from 1990 until 1992, the SIF comprised both health and pension insurance, jointly operated by one administration. In 1992, the SIF was divided into two separate funds: the Health Insurance Fund (HIF) and the Pension Insurance Fund. Changes in fund administration followed somewhat later in the middle of 1993, when the apparatus was divided into the National Health Insurance Fund Administration (NHIFA) and the National Pension Insurance Administration (NPIA).

Following the advice of German and French health policy makers, Hungary wanted to revert to the so-called Bismarck model that had existed prior to the communist takeover in 1945, when 52 sickness funds had provided coverage for 22 per cent of employees, or 10 per cent of the total population. The main idea was to make the healthcare financing mechanism legally independent from the state again. Regrettably, the new model evolved with bad compromises being reached from the very beginning, and the 'return to Bismarck' slogan (Marrée, Groenewegen 1997) was only partially implemented.

(i) Unlike in the original German model, employers and employees were mandated to pay contributions at very different rates: 19.5 per cent by the former and 4.3 per cent by the latter. Moreover, it was never conceptually decided whether the contribution of employers – the 19.5 per cent – was really theirs, or whether they simply transferred a certain part of the employees' salary to the health and pension funds on behalf of the "insured" workers. In practice, this ambiguity led to complete alienation of both groups from the SI system. The employers felt that they paid payroll taxes to the state³ but they did not receive anything in exchange. Employees looked at the contributions paid by their employers as an insignificant technicality, with which they had nothing to do. What mattered for them was their net salary which they received monthly in a white

envelope. The workers' general perception was that only those contributions which were directly subtracted from their gross salary mattered, i.e. the 4.3 per cent. Neither the employers nor the workers felt any connection between contribution payment on the one hand, and their claim on healthcare and pensions on the other.

(ii) Another important birth-defect of the new system was that the lawmakers did not allow provision for any kind of decentralization of funding, such as industry-based or territory-based, not-for-profit health insurance companies. Competition among the pre-war sickness funds was not re-introduced in order to economize administrative costs. All contributions were channelled directly to the single-payer fund HIF as shown in Figure 1.⁴ Once the system of SI became a government created monopoly, it has become

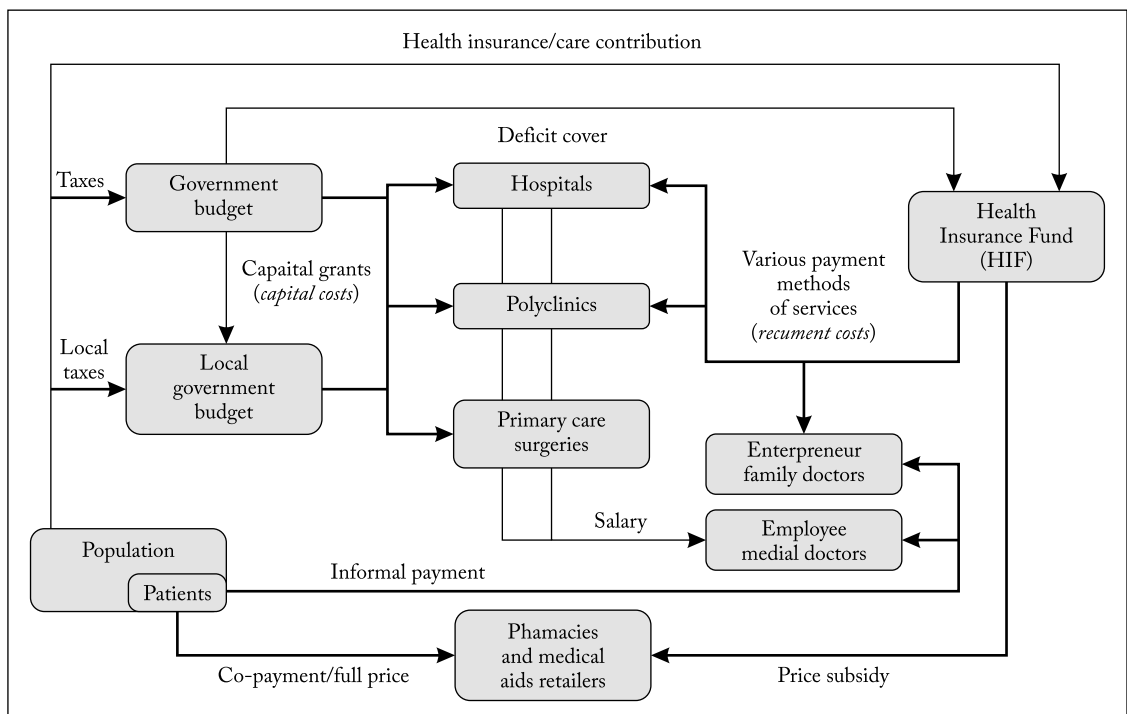


Figure 1: The flow of funds in the Hungarian single-payer social insurance system between 1992 and 2010
Source: Gaál (2004).

³ As a matter of fact, firms paid three types of payroll taxes: pension insurance contribution, health insurance contribution, and unemployment insurance contribution.

⁴ The flow of fund picture in Figure 1 was designed as if all health insurance contributions were paid by the (working) population.

constitutionally difficult to define a basic benefit package (Mihalyi 2011a).

(iii) Opting-out for the wealthy, the highly paid managers of multinational firms, and the independent private entrepreneurs (farmers, artisans, artists, writers, etc.) was not allowed either. It was believed that 100 per cent mandatory membership was the best guarantee for solidarity within the national risk pool.

(iv) The law exempted pensioners from health insurance contribution payments, because they were already exempted from personal income taxation. By a similar logic, children under 18 years of age, those who continued their studies in a tertiary educational institution and the registered unemployed were all exempt. Non-working spouses were also treated in the same way. In this case, the argument was that non-working spouses are likely to be child-raising mothers, which in practice may or may not be the case. As a result, only 38 per cent of the Hungarian citizens (and their employers) were mandated to pay health insurance contributions, and the remaining 62 per cent used the system without directly contributing to it. These rules and proportions remained practically unchanged until 2012.

After a few years of independent operation, the formal elements of NHIFA's independence were abolished step-by-step:

- The HIF's board – comprised of the representatives of the employers' federation and those of the trade unions – was dissolved in 1998;
- The fund's management, some 3200 people working in the NHIA, were put under the direct control of the Ministry of Health (MoH);
- In 2006, the health insurance fund and its pension counter-part became integrated parts of the central government's budget (though the independent legal status of the Fund remained intact for a while).

During the tenure of the first democratically elected Hungarian government (1990-1994), there were important innovations in the financing mechanisms which have proved to be long-lasting. **Family doctors** (GPs) were allowed and even incentivized to become private entrepreneurs. At the same time, the law required that GPs enter into a tripartite contractual relationship with the respective local governments and the

NHIA. It was the local government's prerogative to decide how many doctors they needed in the town, the village, etc. The payment mechanism between the GPs and the NHIA was based on a risk-adjusted capitation formula, essentially the same as the British National Health Service used in the 1980s.⁵ One GP took care of 1000-1200 patients, and a well-calibrated risk adjustment mechanism incentive ensured that GPs could go neither below nor above this range. Hungarian **hospitals** were among the first in Europe where the American DRG (Diagnosis Related Groups) system was introduced in 1993. Since 1998, **outpatient specialists**, working individually, in stand-alone polyclinics, or in semi-autonomous units of a hospital, were paid according to a floating point system copied from Germany. Every intervention had a point value, but the HUF (Hungarian forint) equivalent of a 'point' was determined year after year.

Experience showed that all the three above-described financing mechanisms served the interests of the main stakeholders reasonably well. The Ministry of Finance (MoF) and the Ministry of Health (MoH) were satisfied, because the expenditures of the HIF were contained within the limits set by the central budget. The providers also accepted these schemes, because they were relatively simple and predictable for both the individual entrepreneurs (e.g. GPs, paediatricians, dentists) and the managers of large publicly owned institutions (hospitals, teaching hospitals, clinics, etc.).

As explained above, GPs became private entrepreneurs at the very outset. The privatization of formerly state-owned pharmacies happened soon after that (see below). Subsequently, a good number of specialists: obstetricians-gynaecologists, dentists, psychologists etc., set up private individual practices and treated patients in their own offices. Their patients had to pay the full cost of treatment, even if they were entitled to free care within the institutions of the publicly owned healthcare system. It took about a decade, when

⁵ As a matter of fact, the capitation mechanism was "reinvented" by the Hungarian health policy makers. They simply did not know that such a mechanism existed within the UK NHS.

the more capital-intensive forms of diagnostics and specialist care became private to a considerable extent, capturing 30–50 per cent of the market.⁶ Understandably, most of these facilities are owned by foreign investors.

In principle, the so-called Semashko system, inherited from the communist past, has been perfectly capable of coping with insatiable demand, because GPs (or family doctors as they were called prior to 1990) function as gate-keepers. Without a referral, patients could not go to specialists or ask for consultation and/or treatment in inpatient institutions. This rule still holds in 2017. From the point of view of care responsibility, hospitals are organized into pyramid-like networks, following the principle of ‘**progressive care**’. This means that patients with simple medical problems are referred to the nearest town hospitals, while the larger and better equipped regional hospitals and the specialized national institutes (see later) accept only the most complicated cases.

In many ways, however, this strictly regulated mechanism gradually eroded during the last 10–15 years of communist rule. Patients were allowed to use and misuse the system according to their own will. The system of illegal gratuity payments, already mentioned above, encouraged both the patients and the doctors to break the written rules. People who were capable and willing to pay went to specialists without a referral. Patients started to choose hospitals and surgeons within a hospital like connoisseurs choose restaurants for dinner. In case of surgical intervention, the government covered all the documented costs in a hospital, while the ‘private’ patient paid a notional sum – say 10–20 per cent of the actual costs – on top of this money directly into the pocket of the surgeon. Drugs were also used in a wasteful manner. Patients walked into GP offices and requested prescriptions according to their own judgment. Since drugs were largely financed by the state and the doctors’ time to sign a prescription was minimal, there was no constraint to speak of. The habits of patients and providers did not change even after 1990.

⁶ Such as X-ray and CT centres, MRI, diagnostic laboratories.

The only change was deterioration. The misuse of the Semashko system served the interest of the more educated and those with better political and personal connections. Technological developments – the possibility to travel, to read foreign newspapers, the arrival of the internet etc. – further increased the gap between the privileged and the poor. As long as the Hungarian economy was able to finance a growing health budget, these social tensions were kept under control. The middle-class and the upper middle-class got what they wanted: reasonable treatment without queuing or waiting. With the use of gratuity money, the Hungarian upper class received good care, the quality of which was close to what private health insurance policy holders received in Germany or in the UK for quite a lot of money. This is the real reason why private hospitals could not effectively compete on the market with state hospitals.

After 1990, **capital expenditures** (investments) were, at least in theory, paid by the founder/owner, which for the budget-financed organizations was the state budget, for self-governmental facilities – the local self-government, and for private providers – the private owners. Gradually, this mechanism was also distorted. Many local governments did not feel the political obligation or necessity to spend money on healthcare institutions when they knew that ‘their’ polyclinics or hospitals were used not only by their own inhabitants, but the inhabitants of neighbouring settlements, too. Given their huge size, it happened quite often that large county hospital with 600–800 beds had to put investment money aside from the current income they received from the NHIFA in order to pay for replacement of defunct equipment, for smaller reconstructions, additions, etc.

The derailed insurance reforms

In 1998, there was a **short-lived attempt** to take the health insurance system away from state ownership. The reform was modelled on the American managed care concept (HMOs).⁷ Unfortunately, the short time between 1998 and

⁷ For a detailed account of the model, see Mihalyi (2003).

2000 when the health policy experts of ruling parties as well as the experts of the main opposition parties supported this HMO-type reform was not well used. Although a new draft law was elaborated, in 2000 the centre-right conservative Fidesz government put the whole issue aside.

The failure to create a financially independent sickness fund (or a network of competing funds) resulted in a deep conflict among the three most important stakeholders: contribution payers, patients, and the medical profession. Contribution payers (employers and employees) demanded a reduction of the contribution rates, while the medical profession insisted on steadily growing outlays. The first group claimed that high labour-related costs led to declining competitiveness of Hungarian firms. The starting rate of contribution (19.5 + 4.3 = 23.8 per cent in 1992) was gradually reduced to 13.5 per cent in 1999 and further to 10.5 by 2009. The medical profession, however, only cared about the outlays. They wanted higher public expenditures and raised the question of growing costs of new medical technology and population ageing. Pensioners, the largest group of claimants, voted for those politicians who supported constantly

growing budget subsidies to counterbalance the declines in contributions, because once somebody retires in Hungary, he or she does not have to pay neither pension nor health insurance contributions. Note that pensions are also exempt from personal income tax – a unique example in the European Union.

As a result of these conflicting interests and the irresponsible compromises made by successive governments, the Health Insurance Fund's financial balance continued to deteriorate. Growing subsidies from the central budget became indispensable (Figure 2). However, once the central budget became an important direct contributor into the system, the MoF started to insist on full control of the expenditure side. By 1998, i.e. six years after the re-creation of the Bismarckian model, the HIF budget was compiled and approved by the MoF. *De facto*, the independent status of the HIF ceased to exist.

In 2006, the newly elected coalition of Socialist and Liberal parties realized and publicly stated that things could not continue unchanged. For reasons which went beyond the problems of healthcare, Hungary produced a twin-deficit of the most dangerous type. The shortfalls of the state

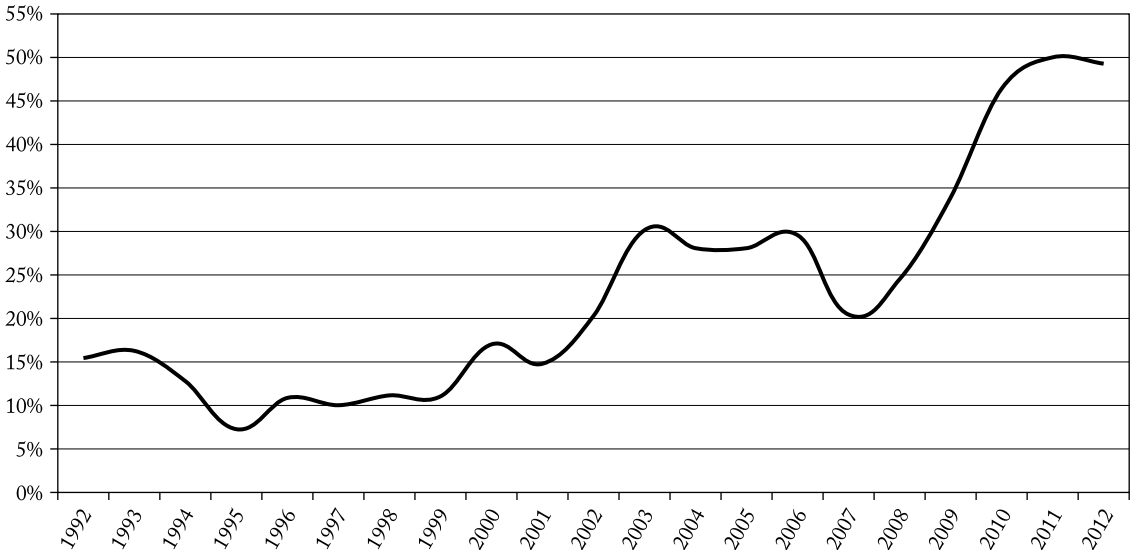


Figure 2: The contribution of the central budget to the annual outlays of the Health Insurance Fund (in percentage)

Source: Author's compilation based on annual budget documents.

budget (caused to a large extent by the healthcare system) and the current account were both close to 10 per cent. Under the pressure of the European Union, whose member Hungary became in 2004, the government accepted an austerity programme with explicit commitments to structural reforms.

With unprecedented speed, **five major health acts** were passed during the Autumn-Winter Session of Parliament.⁸ The opposition parties used every possible move to block this reform, as well as every other restructuring the government had initiated (e.g. higher education, local government, continuation of the pension reforms). On the 23rd of October 2006, precisely on the 50th anniversary of the 1956 Hungarian Revolution, the two largest opposition parties proposed a referendum on cancelling the HUF 300 (less than USD 2) co-payment planned by the Government. The proposal was a ‘visit fee’ paid by patients to doctors and the ‘nursing fee’ paid to hospitals from January 2007 (Baji et al. 2011). The fees aimed to curb the use of state-sponsored medical facilities and subsidized medicine, because Hungary had one of the highest rates of doctor’s visits in Europe. In 2005, the average adult in Hungary made 12.6 visits to the doctor a year, compared with 7.5 by Belgians and 5.4 by the Dutch.

Negotiations on the new health insurance scheme resulted in a compromise: a mixed system which only allowed for partial privatization of the healthcare insurance management funds (49 per cent), but directly endorsed regulated competition among these nominally not-for-profit funds. Thus, the HIF’s responsibilities would have been taken over by 22 non-profit sickness funds: one for each county in Hungary and four for the country’s capital city of Budapest and its surrounding areas. All these funds were subject to **privatization at a later stage of the reform**. Private investors were able to acquire up to 49 per cent of the shares, but the law gave them a good deal of management rights pertaining to financial questions. A mini-

mum price of the shares was planned to be determined prior to the bidding process. The sickness funds’ (or health insurance companies’) task was to guarantee the efficiency of the system by contracting 11 thousand service providers: GPs, specialists, and hospitals. The management funds was given a per-head contribution for each insured person, based on a complex, risk-adjusted capitation formula. According to the provisions of healthcare legislation, all insured persons were entitled to receive health services of the same professional content and standard, without any kind of discrimination. Only those funds which were successful in acquiring at least 500 thousand owner-members within a certain period of time would be able to function. Since the maximum size was set at 2 million, eventually 5–8 funds were expected to remain on the market.

As codification work progressed speedily, political tensions mounted inside and outside the Parliament. Key Socialist MPs threatened to vote against the law eliminating the otherwise sufficient majority of the coalition parties. Outside parliamentary politics, various health-related interest groups organized themselves for strike actions and demonstrations. Among the most vociferous opponents, the President of the Hungarian Medical Chamber was perhaps the loudest: “Doctors will block the law wherever they can,” he declared. By Hungarian standards, these efforts brought tangible consequences, even if the few thousand protestors did not represent a large number in absolute terms. In a country with the lowest strike rate in Europe for decades, a few symbolic doctor strikes in several hospitals were enough to gain the attention of the media. After this, various medical associations, trade unions, pharmaceutical companies all turned against the government. But the government and two subsequent healthcare ministers, Dr. Lajos Molnár and Dr. Ágnes Horváth, did not give up.

Having passed many hurdles, the Ministry of Health and the Liberal Party, which gave both ministers, had good reasons to be optimistic in February 2008. After all, the law had been passed, the coalition survived and there were reassuring signals from the business sector that in spite of all reservations, there would be real competition among investors to

⁸ The former Dutch Minister of Health, Mr. Hans Hoogervorst, was brought to Budapest for three months to advise the Ministry of Health and the Health Working Group of the State Reform Committee. The chief architect of the Slovak Reform, Mr. Peter Pazitny, was also invited several times to Hungary for short-term consultations. For more details, see Mihalyi (2007, 2008).

participate in the new multi-payer scheme. Then the nationwide referendum, proposed in October 2006 (mentioned above) took place on the 9th of March 2008. It changed everything. More than 80 per cent of the participants voted for the abolition of the HUF 300 co-payment. What came after this was nothing else but unconditional surrender. In a few days, the Parliament abolished the HUF 300 co-payment as required by the referendum. On the 29th of March, the Prime Minister announced the dismissal of the Liberal health care minister, which in turn led to the fall of the coalition government. On the 26th May 2008, the National Assembly simply repealed the Health Insurance Act by a majority of 348:19.⁹ Only the Liberal Party voted against it.

The general election in April 2010 resulted in a $\frac{2}{3}$ majority of the centre-right Fidesz party, which had been in power already once between 1998–2002.¹⁰ As a result of a secret deal between Prime Minister Viktor Orbán and the CEOs of foreign-owned insurance companies, in 2011 a small amendment was made to the personal income tax law, according to which all firms would be allowed to buy untaxed **private health insurance** for their employees as an optional non-wage benefit.¹¹ Prior to this arrangement, personal income tax law provided tax exemptions only for fees of accident insurance and permanent disability insurance. For a while, it seemed that this new tax-measure would bring a breakthrough and open the way for an American-type private health insurance market, however, this did not happen in the end. The foreign-owned insurance companies hesitated to launch a major PR campaign, and the initial enthusiasm slowly dissipated. As of mid-2017, there are only very few fully-fledged private insurance policies on the market. It seems that demand for such

products is limited to a dozen large, multinational companies which are willing to provide such VIP benefits to the top 1–5 per cent of their employees.

After several failures of the Fidesz to create a supplementary or complementary private health insurance market next to the state-financed SI system, policy makers announced in 2016 that both the state-run pension and health funds would be liquidated, and that their staff will be taken over by the Treasury (directly subordinated to the Ministry of Finance). This decision, not fully implemented yet, is a U-turn. As of 2017, the Hungarian healthcare system is financed entirely from state budgetary funds and controlled by the Ministry of the Economy (the successor of the former Ministry of Finance).

Complete nationalization of hospitals and the system of health financing, 2010–2012

Right after the regime change in 1990, most of the large, **publicly owned hospitals** in Budapest and the countryside were taken over by local governments. Only 8 national centres specializing in oncology, cardio-vascular diseases etc. remained in the hands of the MoH. This appeared to be a lasting solution and an efficient combination of public ownership and decentralized management control. In many cases, the budgets of regional hospitals were comparable with the budget of the city where they were located. In many county centres, the municipal hospital was the largest employer, the largest single buyer of food, electricity, etc. For obvious political reasons, local authorities were strongly incentivized to care for the quality of their hospitals, since their electorate judged their elected leaders' performance *inter alia* on the basis of what they experienced in the local hospital. The authorities were also happy to have the right to hire and fire hospital managers. As a move towards more efficient cost management and more professional administrative control, a few smaller local hospitals were corporatized in the second half of the 1990s, and then subsequently taken over by private, for-profit hospital management companies on a contractual basis, without formally changing

⁹ See Act No. 24 of 2008 on the Revision of Act. No. 1. of 2008 on Health Insurance Management Funds.

¹⁰ The party's full name is: Fidesz – Hungarian Civic Alliance. When the party was founded in 1989 as a youthful, libertarian, anti-communist movement, the word Fidesz was the abbreviation of the words Alliance of Young Democrats (in Hungarian).

¹¹ In exchange, the cash-rich insurance companies promised to buy long-term government bonds to support the central budget.

their ownership status.¹² This arrangement, however, was dismantled by the centre-right Fidesz government after 2010. Within two years, the system was *recentralized* and the corporatized inpatient institutions were *reconverted* into ordinary budgetary units again. By now, all former municipal hospitals are managed directly from the ministerial office in Budapest.¹³

To a great surprise of the outside world, the 2010 election brought a complete reversal in the political and economic reform process in general. Kornai (2015) was right in calling this a U-turn. Within a few months, a new constitution and a large number of new laws were approved by the Parliament in order to systematically remove the classic checks and balances of representative democracies.¹⁴ Most of the new laws tended towards more administrative centralization and created unlimited manoeuvring space for the state authorities, including the right to hide publicly relevant information. The concept of “private ownership” was also removed from the constitution without any public explanation, let alone discussion. Virtually all acts affecting the scope of state power and ownership were treated as “cardinal” laws, requiring a $\frac{2}{3}$ majority to change them. It was mostly symbolic, but nonetheless noteworthy that the word “Republic” was removed from the full official name of Hungary.¹⁵

Prior to the election, the medical profession and many industrial stakeholders (e.g. pharmaceutical companies, medical device suppliers, and patient groups) honestly believed that after the promises made in 2008, health and healthcare would

become top priority for the new government. After all, the Fidesz party had been the chief initiator of the 2008 plebiscite on user charges in healthcare. What really happened was the opposite. After 59 years of existence, the Ministry of Health was abolished, and the highest government commanding post was degraded to State Secretary level (within the Ministry of Human Capacities), which meant, *inter alia*, that the person in charge of healthcare was not present at cabinet meetings.

For the purposes of this paper, two formal constitutional changes are of utmost importance. Firstly, the legal basis of SI was removed from the text. As noted above, the independence of the health insurance mechanism was *de facto* annulled already in 1998, now the change became reality *de jure*. Secondly, the rights and responsibilities of local governments were also curtailed, which in practice meant that virtually all hitherto locally managed hospitals and polyclinics were earmarked for state takeover.

After the central government took over all the provincial hospitals from the local governments in 2012–2013, the flow of money from local governments to hospitals stopped immediately. The system survived this shock with little difficulties, because after 2010, EU structural funds arrived into the Hungarian hospital sector in unprecedented magnitude and proportions. Between 2010 and 2015, dozens of provincial hospitals and ambulatory institutions were modernized, expanded or even newly built. This happened at such a scale that it is now widely held that the inpatient institutions of the capital city of Budapest are on average in a worse state than large countryside hospitals.¹⁶

To the surprise of many health experts, the threat of renationalization did not induce the top management of hospitals to change ownership form entirely in order to escape direct state control. Except for a few small hospitals owned by religious orders, there are no private hospitals with more than 20 beds. The first private hospital with substantive capacities (150 beds and 9 operating

¹² All such companies were domestically owned. Foreign investors did not have the courage to get involved in such long-term management contracts.

¹³ To be more precise, this power is vested in the State Secretariat responsible for healthcare within the Ministry of Human Capacities. As already noted, the health care sector does not have a ministerial representative in the Government since 2010 – which is a problem in itself.

¹⁴ For independent assessment of these changes, see Fukuyama (2012), Kornai (2011, 2012, 2015), Scheppele (2012), Müller (2014), Bugarcic (2014) and Brodsky (2015).

¹⁵ See Article A. The official English version of the current Hungarian constitution can be downloaded from: <http://www.kormany.hu/download/e/02/00000/The%20New%20Fundamental%20Law%20of%20Hungary.pdf>.

¹⁶ In a way this was hardly avoidable, because according to the rules of the EU Structural Fund, Budapest was not eligible to such development grants due to its relatively high GDP/capita level.

theatres) is currently being built. Earlier, there had been half a dozen aborted attempts by foreign investors (including American, British, and Israeli developers) to build brand new “joint venture hospitals”, in which a large part of the medical staff would have come from prestigious foreign institutions. But none of these efforts bore fruit. It seems that in the current circumstances only small private clinics, with a limited medical treatment portfolio and the maximum of 10-20 hospital beds, are financially viable.

At the same time, large state-owned hospitals accumulated debt in the form of delayed payments to suppliers and, to a smaller extent, to their own employees as well. This process repeated itself year after year, because the management knew that the state would eventually bail them out. Until 2010, the bail outs usually took place in the last quarter of the year, after 2010 the injection of government support arrived 2–3 times in a calendar year. In any case, at the beginning of the year all hospitals’ debts are cleared. As a result of financial troubles, not a single hospital has been closed since 1990, although debts and financial irregularities have often been quoted as a reason for administrative mergers of a good hospital with a loss-making one.

The renationalization of hospitals and outpatient (ambulatory) care institutions previously

owned by municipalities was planned to take place in two steps in 2013: first the hospitals, than the outpatient institutions. This intention, however, did not materialize due to strong political resistance of local municipal governments, and so stand-alone (hospital independent) outpatient care facilities remained under local control. In line with the same legislative effort, the Fidesz government established 8 “health regions” in the country in order to rationalize the hospital bed structure and surgical capacities. According to the plan, simpler services that could be provided in bulk should be available close to the patients’ place of residence, whereas complex, specialized interventions and services should be provided in centres of a high professional level. But these plans were also derailed by the local governments, and the idea of administratively created health regions was quickly forgotten.

In Hungary, **teaching hospitals** were always owned by medical universities, while the universities themselves were under dual control (Ministry of Health, Ministry of Education). This system also worked reasonably well, although some teaching hospitals occasionally felt they were lost between the two ministries. Quite recently, in October 2016, the government announced new plans to integrate all the 8 clinics of national excellence under the umbrella of the Budapest medical

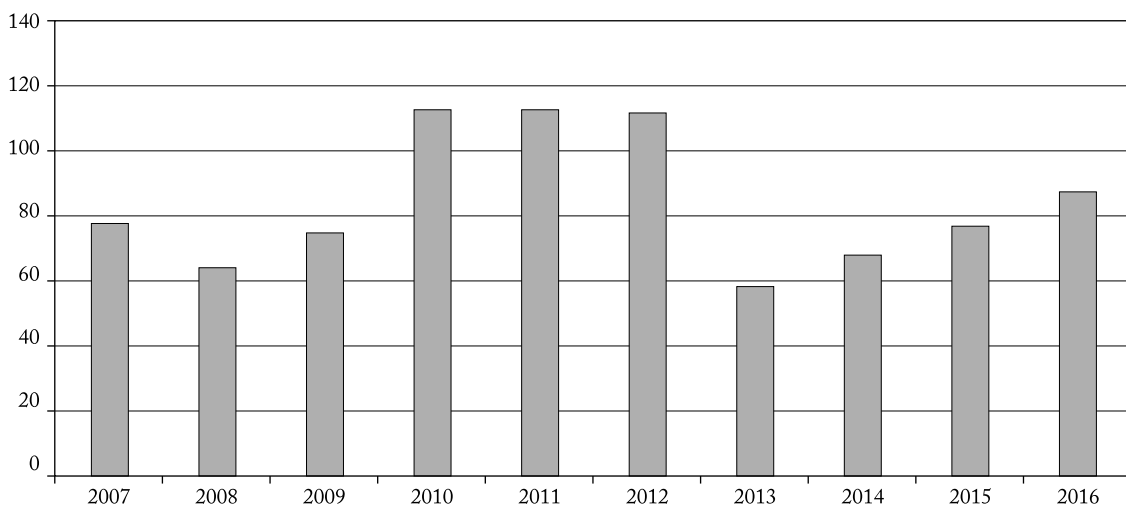


Figure 3: End-year debt of Hungarian public hospitals (HUF bn, without outstanding interests)

Source: Author’s compilation on the basis of newspaper reports and official documents. There is no systematic collection of data; the coverage of hospitals is not fully comparable between the years.

university and thereby to create a decentralized giga-hospital network with 8 thousand hospital beds. But these are still plans at the time of writing this paper.

Smooth Transition to Private Ownership in the Pharmaceutical Sector

Prior to the regime change, Hungary had a relatively well-developed pharmaceutical industry concentrated in seven large firms (Chinoin, Human, Richter, Egis, Biogal, Alkaloida, and Reanal). All these companies were reasonably successful in the production of generic drugs using reverse engineering techniques. In a relatively short time, all these firms were privatized: some sold directly to Western strategic partners, in some other cases through IPOs. As of 2016, there is only one “independent” Hungarian pharma company, meaning that all top managers are Hungarian. Richter is listed on the Budapest stock exchange, and the Hungarian state has a 25 per cent + 1 vote stake in it. All the other drug companies are now operating as subsidiaries of Western multinationals.

After a slow start, when different state bodies could not agree for five years who would privatize the pharmacies, the privatization of the pharmaceutical retail sector was relatively quick, non-turbulent and almost completes (ca. 100%). If newly opened pharmacies were taken into account, the total number of retail outlets increased from 1479 in 1990 to 2541 in 2010 (72%). Since in 1995 Hungary was not a member of the EU, the government had no legal problem with excluding foreigners from privatization tenders. Moreover, sales auctions were designed in a way to guarantee that the new owners of the previously state-owned pharmacies were going to be licensed pharmacists only. Later measures also prohibited the establishment of chains, i.e. several pharmacies being owned by the same entity. This market pattern and the relevant legislation have remained unchanged even after the country’s accession. Therefore, it is not surprising that Brussels launched an infringement procedure against Hungary

for discrimination of citizens and firms of other EU member countries.¹⁷

Conclusions: Patient Assessment and the Main Challenges of the Future

According to the public opinion survey carried out by Gallup World Poll on behalf of the OECD, the Hungarian public shows increasing confidence in the country’s health care system after the implemented changes.

These data, however, are to a certain extent misleading. As the OECD Secretariat noted, 60 per cent of Hungarians were satisfied with health care services in 2014, compared to an average of 71 per cent in OECD countries. For intra-country comparison, it is interesting to point out that among the Hungarians only 56 per cent are satisfied with the education system and 44 per cent express confidence in the judicial system. At the same time, confidence in the government in general stood at 33 per cent in 2014. It is very likely that measured improvement in consumer satisfaction regarding the healthcare system is an artefact, reflecting that between the two periods overall popularity of the government increased (in 2007, it stood at 25 per cent only) and this overall increase in the popularity of the government is reflected in the improved health sector assessment.

As already noted at the beginning of this paper, one of the important features of the Hungarian healthcare system is the relatively high share of private funding within the total national healthcare budget. According to the latest data, the share of out-of-pocket payments (OOP) amounted to 29.0 per cent in 2015 – a very high figure if compared to the OECD average (20.3%). This is directly caused by the high share of patient co-payments in outpatient provision of medication through pharmacies. The average Hungarian patient has to expect a 33 per cent co-payment.

¹⁷ Before sending this paper to the press in August 2017, the European Commission dropped the charge against Hungary, acknowledging that the regulation of the healthcare market is a national prerogative.

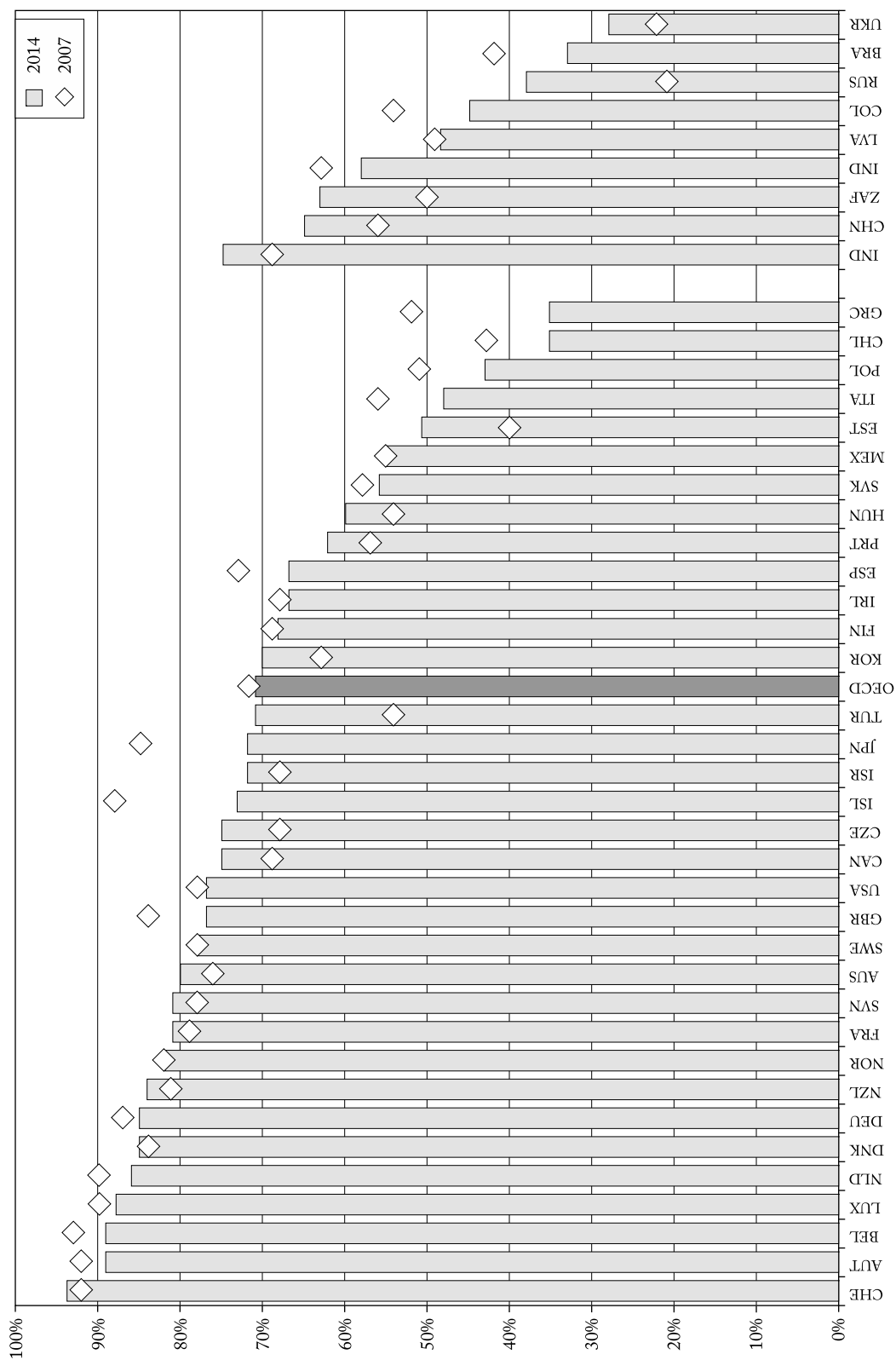


Figure 4: Citizens' satisfaction with the healthcare system, 2007 and 2014
 Source: OECD, <https://www.oecd.org/gov/Hungary.pdf>, accessed on 2nd October 2016.

This is a very high proportion, and it is a well-known fact that low-income families often simply cannot afford to buy their prescribed medication or at least some of it. Although a subsidized scheme to help the financially fragile families to buy their basic medication does exist, the scheme can help only a part of the people in need.¹⁸ Many Hungarians share the opinion that this is perhaps the biggest social challenge facing the healthcare system as such.

Another serious issue is the increased **out-migration** of health workers to the West. Unfortunately, reliable statistical monitoring does not exist yet. Nevertheless, it is widely believed that the probability of doctors' migration has already increased to very dangerous levels. According to the best available research at this point of time – Varga (2016) – EU accession affected out-migration of Hungarian physicians and dentists only after Austria and Germany lifted their temporary restrictions towards workers from the new EU member states in May 2011. In other words, this is a new issue. Varga found that push factors, such as the endless financial tensions in hospitals, the moral burden of the gratuity system etc., have as great a role in Hungarian physicians and dentists' decisions to out-migrate as do pull factors (higher wages, more learning opportunities, etc.). The same author noted, however, that staff shortages are not only due to high outward migration, but also by two other problems: attrition and feminization. Discouraged health workers vote with their legs: nurses go into other service industries; female doctors stay home with their children for many years.

One measurable consequence of this type of healthcare staff shortage is that those who can afford it choose a private provider rather than asking for an appointment within the public sector. The speed of this process appears to be alarming. A recent survey carried out by Synapsis Market Research, a privately owned, business-friendly health research company, found that

between 2014 and 2016, the share of those living in Budapest who went to a private provider at least once in the course of the year jumped from 49 to 60 per cent. Paradoxically, this structural shift helps to improve many voters' perception. After all, they can afford private services and their personal experiences are usually positive. The other side of the coin, of course, is growing inequality. Access to massively consumed, “free” healthcare services (appointments with GPs and outpatient specialists) gets worse and worse for the low-income segment of the population. At this point in time, this problem has not affected the hospital sector, because the share of privately owned hospitals and hospital beds is still insignificant (< 1%) in Hungary.

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¹⁸ At the same time, it is known that the per capita pharmaceutical consumption – measured in daily defined doses (DDD) – in Hungary is high, as high as in Austria, and much higher than in any Scandinavian country or the Netherlands.

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Zmiany własnościowe w węgierskim sektorze opieki zdrowotnej w latach 1990–2017

W artykule zaprezentowano historyczny bilans najważniejszych zmian w dwóch sferach opieki zdrowotnej na Węgrzech: finansowania i świadczenia usług. Wykazano, że po obiecującym starcie reform koniecznych w okresie wychodzenia z komunizmu po 2010 r. nastąpiła całkowita zmiana kierunku działań. Podział na płatnika i świadczeniodawcę zakończył się. W 2017 r. Ministerstwo Gospodarki – podobnie jak Biuro Planowania w systemie socjalistycznym – odzyskało pełną kontrolę nad całym sektorem opieki zdrowotnej, czyli zarówno w sferze finansowania, jak i świadczenia usług. Ministerstwo Zdrowia jako takie przestało istnieć w 2010 r.

Słowa kluczowe: Węgry, opieka zdrowotna, reformy, system zabezpieczenia społecznego