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Reflexive Governance in the Public Interest

Services of General Interest

HEALTHCARE IN HUNGARY

By Sándor Gallai – Balázs Dobos

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HEALTHCARE IN HUNGARY

Sándor Gallai – Balázs Dobos
Corvinus University of Budapest

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Introduction

This paper presents the main features of the Hungarian health sector. It describes the organisation and the management of the sector, including the main actors and their competences. It also gives a review of the most important reform steps and the privatisation process. Finally, it briefly discusses the possibility of applying the proposed analytical grid and the scope of analysing the role of reflexivity in the making and shaping of health policy.

Utilizing the collaborative relational and democratic experimentalist approaches the paper examines those different institutional arrangements and various other possibilities in Hungary that enable citizens' participation in the processes of political decision-making in order to increase the effectiveness of healthcare management. Within this framework the case study pans out about the role of patient associations in law-making and in the variety of representative bodies at national and regional levels. This part is followed by the description and analysis of the advocates of patients' rights. While pointing out the main features and deficiencies the paper, however, pays particular attention to the possible practices of good governance as well, especially to the role of the Advocate Foundation for Patients' Rights which was founded in 1994 and sets an excellent example of lawyers' and other civic experts' activity in policy-making. It also aims to answer whether there is any serious chance for the adaptation of the fourth 'genetic' approach in Hungary.

Historical background: healthcare under Communism

Main features of the Communist system

The totalitarian but later rather authoritarian Communist regime which had come to and had been in power for the following decades since 1948-1949, caused fundamental changes in the different subsystems of the society. Especially the main element of the special Communist political practice and constitutional law carried extensive consequences which set out from the leading role of the exclusively existing Communist party, so it totally refused the idea of separation and balance of powers and represented the thought of unity of power. The new regime annihilated the autonomies of different social subsystems and only the common public interest could be officially acknowledged. It did not really tolerate the formulation and representation of any kind of separate social interest. This finding could be particularly applied to both physicians' and patients' potential participation. Although the Communist law codified fundamental human and political rights in many rules but most of these could not really prevail for lack of rule of law and constitutionality. Moreover the institutional mechanisms and legal guarantees for the protection of these rights were also not built up and so did the consequences of possible violation of law. From another point of view the priority of laws could not come to reality because the tendencies of actions and particular steps were assigned by exclusive, confidential political decisions, party resolutions and instructions in each policy area. As far as the political system had become even softer and transformed into an authoritarian type, informal rules, attitude patterns and values gained ground among the wider social layers. These had been already existing and working among the members of the ruling elite. These different kinds of behaviours and values lived and mixed with the formal prescriptions and officially expected attitudes in a very special way.

After World War II the political takeover by the Communist Party resulted in extensive nationalisation and centralisation in the Hungarian economy. The new political regime represented the idea of the total public property and redistribution within the framework of the established planned economy. The realization of these fundamental

elements proved to be very considerable changes in comparison with the earlier structures. As part of those changes private elements in health sector were dismantled, and the state obtained an exclusive role in both funding and delivering services.

The Communist Constitution of 1949 declared health to be one of the citizens' fundamental rights and put the state in charge of providing—principally free and universal—services. So the act put the equality before the law down which prevailed in practice in a very limited way. In principle, health services for Hungarian citizens were free of charge at the point of use. In reality, however, the system was very much infected by under-table payments and gratuities. The Constitution expressed the state obligation to protect “the workers’” good health by means of organisation and maintenance of medical treatment.¹ Thus the operation of hospitals and polyclinics were funded and controlled by the Ministry of Health. Private practitioners were replaced by district doctor services; and the newly established system was very much in line with the ideal type of ‘bureaucratic’ public interest governance (albeit the system was not built on democratic, representative government).

In the late period (1970s and 1980s) the regime embodied by total public property, redistribution and planned economy showed and officially tolerated some kind of real market elements and processes as well. After 1978 the Communist leadership lost their ability to keep the economy in balance. Since the legitimacy of the party leaders was built on the steadily increasing standards of living, the political leadership had no other option but to introduce some economic reform measures. Yet, it was not before 1987 that a reform secretariat was set up within the Ministry of Social Affairs and Health. This secretariat got in charge of drawing up policy proposals addressing the weaknesses of the health sector. A year later the financing of the healthcare system was switched from taxation to compulsory social insurance contributions. The Social Insurance Fund was separated from the central budget, and it became the main source of financing the operation of healthcare institutions.² At the same time, restrictions on private provisions were eliminated; already existing private practitioners (dentists, dermatologists, urologists, gynaecologists, etc.) were recognised and full time private entrepreneurship was legalised.

The operation of the system of district physicians

In the Communist regime the relating laws defined that only those persons were able to carry out medical tasks that had graduated in medicine and registered themselves by the Ministry of Health. The legal provisions made a clear distinction among the physicians according to fact whether they did exercise private practice or not. For the private practitioners the conditions of functioning were much restrained contrary to those ones who worked as state personnel in public surgeries.³ The physicians who fulfilled the primary cure and prevention were employed by the newly established local council system. In fact these councils existed and worked as the local organs of the central administration, so they had no real self-governmental features until the 1970s. The physicians attended the population of given districts of which boundaries were determined by superior council organisations. In order to found a new district the previous consent of the Ministry was needed.⁴ Until the early 1970s the superior council organs and later the local councils appointed the doctors to be district physicians. They attended the persons who lived and stayed in the given district. At

¹ Act 20 of 1949 on the Constitution of the Hungarian People's Republic. 47. §.

² While the Fund was to cover the costs of services, responsibility for financing capital costs rested with the central government; thus, for one more year, it continued to be financed from the central budget.

³ See 8/ 1959. Statutory rule and 8/ 1959. (31 Dec.) Health ministerial decree on the medical system.

⁴ 42/1961. (22 Nov.) Governmental decree on the allocation of certain health tasks to competence of lower council organs.

first (in the 1950s and 1960s) the district physicians were obliged to give an account of their activities. On the other hand the local council had to provide for the medical care in the given district(s).⁵ The councils could establish, cease and reorganise health institutions including those which were attached to district physicians but these institutions remained state-owned until 1990. They were just under the supervision and maintenance of the local councils.

In the educational field it proved to be a considerable development when the general medicine was introduced as a different qualification for those who had graduated in medicine. Later the general medicine has become a firstly or secondly attainable university degree. On this developing basis of education, the district physicians' activity could soon become an independent profession in Hungary. Although the institutional background of the education, mainly the independent university departments could be really fulfilled after the changeover. In the 1970s the system of further education evolved and many elements have remained in the new democratic political system. According to these regulations the physicians (male doctors until the age of 60, female doctors until the age of 55) had to take part in centrally organised, two weeks', boarding course in every fourth or fifth year. These further educations were coordinated by the Institution (University since 1987) of Medical Further Education. It was also put down that further education was compulsory after three years' interruption of medical work as well.

In connection with the above mentioned tendencies the laws of the 1970s could increasingly describe the district physicians' obligatory tasks in a more detailed way. But the institutional framework of the medical supervision did not evolve: the physicians' disciplinary procedures were taken by the disciplinary council of the territorial hospital at first, but later, from the beginning of the 1970s these procedures were dealt by the appointing organ. In the observation of legal regulations and deontology rules the Physicians' and Health Workers' Trade Union had only a small part with very weak rights. In 1972 the National Public Health and Epidemic Supervision came into existence which was responsible for the controlling of execution of the physicians' public health and epidemic tasks. In order to carry out these controlling functions effectively, this Supervision had necessary strong rights such as reflection and passing of resolution.⁶

In addition to the developing medical care the financing of public health sector was backward from desirable degree. The new Communist regime carried out unnatural investments and developments mostly in the sectors of war and heavy industries until the end of the 1960s, so at first it nearly neglected the fields of agriculture, light industry and public services which could have served the people's living standards much better. These sector shares changed later in the Kádár era. At the same time the number of persons initiated into the compulsory social insurance dynamically increased: the system of social insurance entitled to obtain free medical care, hospital treatment and cheap medicines. Although the proportions changed later, but despite of the rising number of physicians and the extension of social insurance expenses, the health expenditures were backward from the relating data of highly developed welfare states. It proved to be also another peculiarity of the Communist system that the Hungarian people's health and mental conditions got even worse because of the relevant extension of suicides, alcohol consumption and mental illnesses in this period.

To sum up the system of district physicians meant a structure of downwards strongly regulated conditions which contained bureaucratic, hierarchic, strict subordinate relations

⁵ See Act 1 of 1971 on the councils and 11/1971. (31 March) Governmental decree on execution of Act of 1971 on the councils.

⁶ 13/ 1972. (12 April) Governmental decree on the National Public Health and Epidemic Supervision. 6/ 1972. (16 May) Health ministerial decree on the execution of 13/ 1972. (12 April) Governmental decree on the National Public Health and Epidemic Supervision.

among the actors. Those district physicians who were state employees could be ordered to elsewhere by the Health minister to execute certain temporary tasks. The local council could also oblige them to do such temporary tasks and to deputize other doctors. After their employment by the local councils came into existence the district physicians were not able to conclude other employments for one year. The strict system of medical districts did not urge the physicians being dependant on the superior organs to improve their accomplishment. The system could be also characterised by the lack of any kind of competition and/ or comparison among them. On the other hand the patients were also dependant on the system because it did not grant the right to freely choose a physician and it made possible wanderings between districts more difficult. The formal legal regulations which had rather symbolic-declarative functions in the period did not really succeed in practice: for a while the free medical care was not ensured for everybody with the extension of social insurance. So it was quite paradoxical that the whole political regime declared itself to be egalitarian and made efforts to realize full employment in Hungary. Parallel to the formally free medical care the informal and soon extended practice of under-table payments could easily gain ground because of the nearly total nationalization. Besides the phenomena of the under-table payments and the all-pervading Communist paternalism the medical paternalism predominated as well. The latter meant a special attitude that the doctor knew better the patients' interests and decided solely the methods of medical attendance. Moreover the regime showed mistrust with the physicians because they did not produce any values according to the ruling Communist ideology. The emerging dual system of values and morality and the featuring political cynicism which was tolerated and sometimes urged by the political elite raised also in the unwarranted utilization of national health insurance in which abuses a part of district physicians contributed so much. The difference between the capital city and the countryside lessened but did not come to an end: in Budapest more physicians worked in comparison with the number of local populations. So in the countryside medical care proved to be still less accessible, especially in small villages where just one doctor could carry out the tasks of several settlements.

Patients' rights under Communism

The laws of that time did not mention the patients' rights and autonomy, the so-called "informed consent" between doctor and patient and they totally missed the expression of ethical issues. In fact greater emphasis on patients' rights and ethical questions could be laid only in the 1980s and mostly at universities in line with the developing international tendencies. But the change of system meant the real breakthrough on this issue that could make way for putting the problem on the political agenda.

The legal and institutional framework of healthcare after the change of system

During the change of political system occurred in 1989-1990 the structures of party state could be broken down and the development of the new system of democracy and rule of law could begin. This complex process was hallmarked by the extension of a competitive multi-party system, the formulation of a new constitutional arrangement instead of the unified power existing earlier, and the codification of fundamental human and political rights and their institutional guarantees. In the totally changed environment the solution of so many issues passed after the 1990 parliamentary elections such as the working out the details of political constellation, the transformation of old institutions, and the establishment of new

ones. The earlier centralised council system became a thing of the past and a democratic but considerably fragmented structure of self-governments has been created.⁷

The economic change of system meant that the former centralised state economy had to be transformed into a capitalist market economy. But this economic transformation was accompanied by very serious social tensions and difficulties. It took a long time for the governments to manage both the economic changes and the emerging questions and crisis.

The major changes in legal framework

These complex political, economic and social processes of the transformation did not leave the public health, its structures and conditions untouched. In the autumn of 1989, when the legal framework was adopted, amendments to the Constitution also included some provisions on healthcare. The general amendment of the Constitution has already put down the principle in 1989 that for those people who live in territory of Hungary have the right to the best possible physical and mental health which is realised by the state mainly through arrangement of public health institutions and medical care.⁸ So the operative Hungarian Constitution recognises the citizens' right to healthy environment, physical and mental health and income maintenance. It assigned responsibility for (public) social welfare and health care provisions to the national government. Besides this the health care ceased to be state monopoly. Since 1989 medical activity can be carried out in the national health service, in the armed forces, in private practice likewise in the past. In addition to these forms the personal and collective enterprises have also been possible in Hungary since 1989. In 1990 it was also put down that whoever natural and legal subject who has appropriate personal and material conditions can pursue health activity and can establish and maintain health institutions.

After the democratic elections of 1990, the first four years were devoted to the restructuring of the centralised healthcare system. As a result, the remnants of the command and control mechanism were mostly eliminated and a more decentralised system was created. In the new system purchaser and providers are clearly separated and their relations are typically settled by laws and contracts. After the elections the first major changes to the healthcare system were brought about by the act on municipal and county governments.⁹ The former local council system ceased to operate and new forms of local and territorial governments have been established. With regard to their functions the political decision-makers have ordered the performance of compulsory tasks for them on one hand, but on the other hand they have ensured the possibility to undertake freely and voluntarily other tasks. The new legal regulation has ranked the local provision for health care among the compulsory tasks of local governments regarding to the local demands and financial possibilities. So the act put municipal governments in charge of organising basic healthcare services in their territory. In return, they became the owners of—formerly state-run—primary care surgeries, polyclinics and hospitals. Gaining ownership also meant becoming responsible for capital (investment and maintenance) costs. However, the central government did not withdraw entirely: it created a system of earmarked subsidies for the local governments. In addition, some clinics and national institutes remained under the control of the Ministry of Health or one of the other sectoral ministries. As the main rule, county governments run county hospitals and they also became responsible for services that municipal governments had been unable to carry out.

⁷ It means that the country with around 10 millions of inhabitants has nearly 3200 self-governments.

⁸ Act 31 of 1989 on the amendment of the Constitution.

⁹ Act 65 of 1990 on local governments.

The organisational structure and major actors of the health sector

As opposed to the former Communist system, the current healthcare system divides responsibilities among various institutional actors. As a result of considerable political-legal and institutional changes the formerly existing 'bureaucratic' form of public interest governance have been replaced by a 'hybrid' form of governance. In the current system quasi-market arrangements present the dominant form of governance, but regulated market relations can also be found within the sector, and examples also exist for private services of the ideal-type. Contractual relations between state and social actors are widespread as they form the ground for organising and delivering healthcare services.

Figure 1. shows the chart of the organisational structure of the Hungarian health care system. The first column of stakeholders was grouped along the principle of ownership/management. In the second column we can find the service providers. The third column includes those actors who finance the services. The fourth column consists of the main institutions of public health. As the main rule, health services are mostly paid from the Health Insurance Fund.¹⁰ Service providers unusually contract the Fund's management. The contracts define both the required services and the conditions of funding. Services in primary care are largely delivered by private enterprises of family doctors. Other services are typically provided by public institutions, the majority of which are owned by municipal governments. Private actors have been separated by a square dot box. In line with the hybrid nature of health governance, the relations among the main stakeholders involve both hierarchical and contractual relationships.

By the introduction of each actor the following part of the paper pans out about those functions that regard to primary care and the system of general practitioners, too.

The Hungarian Parliament

According to the 1989 amendment of the Constitution, the main organ of the state authority and representation is the Parliament. It enacts the Constitution, its later amendments, the laws and passes the governmental programmes as well. Through these activities it develops the constitutional order of the society, determines the organisation, directions and necessary conditions of the governance. Because it passes these most important legal regulations and documents that embody both the legal and political frameworks, the Parliament has become one of the most relevant actors of health policy. Both the size and the budget structure of the Health Insurance Fund as well as the annual contribution rate to the Fund are determined by Parliament. These decisions are made by simple majority. In contrast, any decision that would affect the competences of the municipal governments shall be approved by a qualified (2/3rd) majority in Parliament.

By way of introduction it should be mentioned that the Hungarian Parliament can be ranked to the "working parliament" type classified by many factors. Thus it has a legally relatively strong committee system with extended parliamentary rights and several issues can be decided during this part of the political decision-making. The orientation, the working field of these organs corresponds mainly to the governmental institutions and their compositions correspond to the current parliamentary power relations. These committees can be excellent fields for the MPs for representing their interests and special policy thoughts which can cause interesting political situations. For example it can easily occur that a governmental proposal is not supported by MPs from the parliamentary majority, it can be struck from the agenda or

¹⁰ Although there is an expanding circle of voluntary private health insurance funds, their contribution to the financing of the health system remained negligible.

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can be modified to a relevant degree. Coalition cabinets, which have been working since 1990, can make these conditions even more difficult.

In 1990 the Social, Family Protection and Health Committee was founded in place of the earlier existing Social and Health Committee, and worked as a steady parliamentary body. In the following cycles the corporation's tasks extended or decreased and its name sometimes also changed. From 1994 to 2002 it worked again under the name of Social and Health Committee, and it has been working simply as Health Committee since 2002. The role of the committee is usually the formulation of parliamentary decisions, being in connection with the competent governmental apparatus, partner organisations and other experts. It also has to control and follow the governmental activities with attention. To sum up this structure means that the most important policy decisions almost surely go through the committee which offers opportunities to represent and to enforce different conceptual ideas and purposes in the framework of modifications.

The central government and the Ministry of Health

The central government ('cabinet') is the main actor of regulating the sector and formulating health policy. It keeps indirect control over the size and the operation of the Health Insurance Fund. Despite the increased responsibility of municipal governments, the central government continues 1. to support local governments with earmarked and targeted subsidies; 2. to cover the deficit of the Health Insurance Fund; 3. to finance the social health insurance scheme of non-contributing social groups and the co-payment costs of citizens with low income; 4. to finance public health, ambulance and blood supply as well as health education and research; 5. and to offer tax rebates to the members of voluntary health funds. Since 1999 the government has been advised on health policy by the National Health Council, which brings together the representatives of professional organisations, trade unions, patients and local governments.

Within the government the centre of the making of health policy is the Ministry of Health. After the change of system the departmental direction of health policy was ranked among the tasks of ministries with different names. These were the Ministry for Public Welfare between 1990 and 1998, the Ministry of Health between 1998 and 2002, the Ministry of Health, Social and Family Protection between 2002 and 2004, and finally the Ministry of Health since 2004. The minister's main tasks are the formulation of governmental programmes concerning public health, the direction, coordination and organisation of health care, and representation of the government in forums of conciliations. The relevant governmental decrees have been ranked other resorts among the tasks such as the realization of prevention programmes, the determination of the system of professional supervision, the works in connection with the departmental professional training, and the contribution to the formulation of financial regulations. As a consequence of these tasks both the formulation of the most important policy decisions and the conduction of concerning negotiations belong to the ministry.

Regarding to the system of general practitioners it is very important that the ministry deals with the physicians' so-called basic register including personal data from those people who have successfully graduated as doctors. The collection of these data can happen either officially or as a result of personal application. After that the ministry should issue a certification of the registration to the given person which is a stipulation to get an own medical stamp.¹¹

¹¹ See 30/1999. (16 July) Health ministerial decree on the physicians', dentists', pharmacists' and hospital physiologists' basic and operational registers, and on the permission of those people who have registered. The European FP6 – Integrated Project
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The minister for health can rely on the professional assistance of more than 30 advisory bodies dealing with specific medical issues and areas. These bodies consist of leading medical specialists and other professional consultants including the representatives of the Hungarian Medical Chamber and other associations of medical sciences.

Among others the minister shall entrust the members of the *Council for Health Professional Training and Further Education* among the persons proposed by health institutions of higher education, professional chambers, representative professional organisations and colleges. This official body deals with the higher education and further education of health sciences and its tasks are mostly the formulation of decisions, putting proposals, and expression of opinions. Regarding to the system of primary care it plays a great part in the valuation of compulsory further education programmes.¹²

According to the relevant ministerial decree, special professional bodies had to be established with different rights of expression of opinions and putting proposals in each health care field. These organs should support and reinforce the decisions of ministerial leaders and apparatus with considerable professional skill. The *Professional College of General Practitioners* dealing with primary health care also functions as a preparatory and executor of decisions which has a role in controlling as well. The members are elected indirectly, by a special electoral body representing several professional, scientific and educational institutions. Only those persons can be elected for four years who have been graduated as doctors, have been registered themselves in the basic register, are able to show outstanding personal performances, and they are with irreproachable past. The tasks of the college have been extended in the past decade to a considerable degree: at first it used to express its opinion about professional conceptions, educational, financial, supervision questions, and drafts of methodology procedures. Since the end of the 1990s it has got the right to formulate these proposals and drafts. The opportunities of expression professional opinions have also widened which have been already included the issues of professional training, further education, and the foundation and development of health institutions. For a temporary period – between 1999 and 2004 – it became an autonomous professional body because it could mostly get out of the minister's subordination and its operation was ranked among the tasks of the Hungarian Medical Chamber. In 2004 the college was declared to be minister's professional organ again.¹³ The relevant legal regulations have made it possible to establish special working groups within the framework of professional colleges. Nowadays this college works with 23 members and has a special paediatricians' working group. Besides this group the professional body has founded seven other working teams on the following fields: education-training, law, pharmacy, practice, informatics, GPs on the countryside, and quality control.

Besides the dominant position of the Ministry of Health in health policy domain the Prime Minister's Office, the Ministry of Finance, the Ministry of Education, the Ministry of Interior, the Ministry of Defence and the Ministry of Economy and Transport, however, also take part in formulating and/or implementing health policy.¹⁴ The Prime Minister's Office

existence of the medical stamp is very important because it authorizes the physician to order medicines and therapeutic tools. See 20/1991. (5 Nov.) Public Welfare ministerial decree on the medical stamps.

¹² 10/1998. (11 Nov.) Health ministerial decree on the organisation and operation of the Council for Health Professional Training and Further Education.

¹³ See 53/1996. (27 Dec.) Public Welfare ministerial decree on the medical professional colleges. 52/1999. (12 Nov.) Health ministerial decree on the medical professional colleges. 20/2004. (31 March) ministerial decree for Health, Social and Family on the medical professional colleges.

¹⁴ The Ministry of Defence and the Ministry of Interior run their own health care institutions the accessibility of which still remains somewhat limited for the general public. Just like in the case of the six hospitals that operate under the control of the Ministry of Health, their operational costs are financed from the National Health Insurance Fund, while their capital costs shall be covered by the respective ministries. The Ministry of Economic
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coordinates secondary legislation. In 1998 it became responsible for the supervision of the Health Insurance Fund. The area was led by a political state secretary, who proposed to replace the state-run health insurance fund with competing funds. The proposal did not win support within the government, and a year later control over the Fund was transferred from the Prime Minister's Office to the Ministry of Finance. In 2001 the Ministry of Health re-established its supervision rights over the Health Insurance Fund. Moreover, the Ministry is in charge of the management of the entire health sector. Its role includes the formulation, regulation and coordination of health policy. On the other hand, in financial and capacity¹⁵ issues the Ministry of Health shares responsibility with the Ministry of Finance and the Ministry of Interior, while in health education and training it collaborates with the Ministry of Education.¹⁶

Non-departmental public bodies

The Ministry delegated some of its administrative powers to organs of national competences. Thus, the registration and the licensing of pharmaceuticals belongs to the *National Institute of Pharmacy*; the licensing of medical equipments is the competence of the *Authority for Medical Devices*; while the assessment of the service providers' performance is carried out by the *Information Centre for Health Care*.

The *National Public Health and Officer Service* (NPHOS) was set up in 1991. It operates under the supervision of the Ministry of Health; and its head (the 'national chief medical officer') is appointed by the minister for health. Generally it is in charge of public health services, including health care licensing, disease prevention and disease control, health promotion and public hygiene. This organ directs, supervises and coordinates the administrative activities of public health care, so among others it supervises the primary care, prevention, and consultation, including the operation of services and institutions. It registers health care providers and monitors the quality of their services. Since 1994 any kind of health service should be licensed by the NPHOS which registers the granted permissions. Furthermore a 1996 law has ordered that every health care service shall have an operational licence that is issued by the NPHOS after application.¹⁷ The preconditions for issuing this operational licence (or temporary operational licence if necessary) are the suitable personal and objective conditions that are controlled in the surgeries by inspectors both before and after publishing. The issued operational licences are registered by the *National Officer's Office*, one of the leading bodies of NPHOS.¹⁸ To its professional supervising-controlling functions effective rights have been attached by the legal regulations because for example the NPHOS has the right to fulfil on-the-spot investigations and to pass official resolutions. It can call upon the physicians producing failures and deficiencies to fill these gaps but it is able to restrict or even suspend certain doctor's activity, too. It also has an important role in capacity-

Affairs and Transport offers the workers of the state-run Hungarian Railways Company (and their dependants) access to a closed insurance fund and its health services. Health services for prisoners belong to the Ministry of Justice, but they are organised outside the national health insurance system.

¹⁵ Local governments may only decide to expand healthcare capacities if their decision also wins the support of both the finance minister and the minister for health.

¹⁶ While health policy is the responsibility of the Ministry of Health, the macroeconomic implications concern the Ministry of Finance. The deficit of the National Health Insurance Office shall be covered from the central government budget. This gives the Ministry of Finance an important weight in determining health care financing. The Ministry of Education is responsible for medical higher education, while control over clinics as well as the coordination and supervision of health R&D and professional training rest with the Ministry of Health.

¹⁷ Act 63 of 1996 on the territorial care obligation and on the territorial financial provisions.

¹⁸ 2/2004. (17 Nov.) Health ministerial decree.

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planning: local governments may only decide on reducing capacities if their decisions meet the approval of the local/county chief medical officer.

The NPHOS is organised very hierarchically on town (capital city district) – regional – county (capital city) – national levels. Its medical inspectors being excellent experts and well-informed persons on certain medical fields, work on the basis of a determined, every year refreshed working plan. In the framework of their investigations they shall control the observation of legal regulations and other directing documents, and the existence of the expected personal and objective conditions. They shall also look after the practical realization of the general practitioners' gate-keeper role. The arrangement of preparedness and duty shall be controlled as well. About their experiences they usually inform both the leader and maintainer of the investigated institution and so do they to their superior organs, too. The *National Centre for Inspector Methodology* helps their work which institution being in connection with the professional colleges, grants the methodological direction for the NPHOS inspectors.¹⁹

Summing up the NPHOS plays a great part in the permission of operational licences and in the execution of continuous controlling and supervision regarding to the field of primary care. In connection with the former a 1996 law has ordered that every health service must have an operational licence which is issued by the NPHOS after application.²⁰ The preconditions for issuing this operational licence (or temporary operational licence if necessary) are the suitable personal and objective conditions which are controlled in the surgeries by inspectors both before and after the publishing. These issued operational licences are registered by the National Officer's Office.²¹

The *National Emergency Ambulance Service* also operates under the Ministry of Health. Its activity is financed from the Health Insurance Fund. Due to financial difficulties, an increasing number of ambulance cars and units are operated by private companies, charity or non-profit organisations. They contract the local governments and receive an equal funding with those of the public operators.

Blood supply had originally been provided by the respective units of hospitals. In 1998 these units have been reorganised under the umbrella of the *National Blood Supply Service*. The service is responsible for both blood supply and blood products, the costs of which are paid from the Health Insurance Fund.

The methodological centres of certain medical specialisations are the so-called national health institutes supporting the work of the afore-mentioned professional colleges. They are either fully independent institutions or belong to one of the medical universities. Their operation costs are partly financed from the Health Insurance Fund ('clinical services'), and partly form the central budget ('other costs'). These highly specialised centres are in charge of supporting clinical work, education, research and patient care nationwide. As part of their activities, they issue clinical guidelines and medical protocols. In the case of primary care this centre is the *National Institute of Primary Care* (NIPC). The NIPC plays a considerable part in the coordination of execution, following these processes with attention, and being of assistance to general practitioners' practices. It shall also undertake the relevant evaluating works, expression of professional opinions, and putting forward proposals. Its working plan is determined by the Ministry every year and it should give an account of the fulfilled tasks to the Ministry, too.

¹⁹ See Act 11 of 1991 on the National Public Health and Officer's Service. 8/1993. (31 March) Public Welfare ministerial decree on the professional supervision of institutions and services of primary care and prevention. 15/2005. (2 May) Health ministerial decree on the professional supervision of health services.

²⁰ Act 63 of 1996 on the territorial care obligation and on the territorial financial provisions.

²¹ 2/2004. (17 Nov.) Health ministerial decree.

The key institution of financing healthcare services and sickness allowances is the *Health Insurance Fund* (HIF). The Fund was established in 1992, when the Social Insurance Fund established in 1989 was divided into two separate bodies: the Pension Insurance Fund and the Health Insurance Fund.²² A year later the administration of the two social insurance funds were separated too, and the National Health Insurance Administration was established under the control of a health insurance ‘self-government’. That body consisted of elected representatives of trade unions and the designates of employers. It was given both veto power over governmental decisions on social insurance and important rights concerning the budget of the Fund. In 1993 Parliament passed the Act on Voluntary Insurance Funds that permitted the foundation of non-profit (complementary) private health funds, the membership in which has been later encouraged by tax rebates.²³

The 1998 change in government resulted in further modifications to the previous policy line. In 1997 the social insurance self-governments were renewed. The replacement of the formerly elected (union) representatives by designated members was found unconstitutional, but there was no need for new mechanisms, for the new governing majority had decided to abolish both the Health Insurance Self-government and its pension counterpart as early as before the new cabinet was formed. Indeed, the social insurance self-governments lacked the necessary resources and competences for an effective fund management. However, the reputation of the healthcare self-government was particularly poor as it was considerably deteriorated by a series of corruption scandals. Public support for the institution was undermined to that extent that its elimination did not provoke any serious opposition. Regaining control over the HIF and its Administration allowed the government to control health care expenditures more effectively.

The National Health Insurance Administration has regional offices at county (and capital city) level since 1995.²⁴ They administer both contracts with and financial transfers to local healthcare providers. However, the actual payments to providers still arrive from the central budget of the Fund. With regard to the finance of general practitioners’ system it originally went off in the framework of a contract between a central administrator and the operator of a local GP system but later (since 1995) it has been conducted both by HIF or its lower organs, and by the local medical operator. This latter operator can be local government, an association of local governments, health institution, medical entrepreneurs etc. So the HIF and its organs play a determining part in conduction of finance contracts and in the remittance of amounts granted either by the Parliament or by the cabinet in the past decade.

Local governments

The structure of local governments replaced the Soviet-type council system in 1990. The new laws have codified the conditions of self-governance for local communities, the tasks and competences that try to delegate the locally emerging and solvable issues to the adequate level of self-governments. At the same time these tasks and competences have not been complemented by sufficient resources. It has made the whole situation even worse that the concerning law on self-governments can only be amended with the MP’s two-thirds support.²⁵ The municipal governments (the district governments in Budapest) are one of the most important actors of health policy on local level. These governments were granted very broad competences including infrastructure development, primary and secondary education

²² See Act 21 of 1988 on the Social Insurance Fund. Act 10 of 1992 on the 1992 budget of the Social Insurance Fund and on the amendment of Act 21 of 1988 on the Social Insurance Fund.

²³ Tax rebates were introduced in 1995.

²⁴ Act 72 of 1995 on the 1995 additional budget of Hungary.

²⁵ See Act 65 of 1990 on local governments.

and local social policy services. They are also in charge of local health services. In return, they gained ownership over primary care facilities, hospitals and polyclinics. While organising primary care became their responsibility, it got possible to contract out service providing. Most typically they contract general practitioners who deliver primary care as private entrepreneurs. They usually rent primary care facilities (institutions and equipments) of the municipal governments. Private service providers also contract the respective county office of the National Health Insurance Administration which allows them to receive payments from the HIF. A determinative change happened in this field at the beginning of the 2000s as the local governments have not got the compulsory task of guarantying different conditions for medical care since 2001 and the financial regulations have been urging the general practitioners to undertake the real estate and equipments as well. It means that this time the governments meet their obligation through contracting with whatever health entrepreneurs.

Although bigger municipalities often own municipal hospitals or outpatient clinics, secondary care typically belongs to the competences of county governments which only take over responsibility for local institutions and/or public services if the municipal government in charge cannot undertake its obligations. County governments are also allowed to contract out service delivery, but they rarely take this opportunity.²⁶ Operational costs of both municipal and county institution are paid from the HIF, while capital costs shall be raised by the owners, who may receive some support for that task from the central government budget.

Interest groups and professional organisations

After the political changes of 1989-90, the monopoly position of the Communist trade unions ceased to exist. Numerous new unions were organised at local, sectoral and national level. In the health sector the *Democratic Trade Union of Health Workers* became the largest and most influential association representing the interests of health employees at various bipartite and tripartite forums.

Of the professional associations, the *Federation of Hungarian Medical Societies*, the *Hungarian Hospital Association* and the *Association of Hungarian Pharmacists* can be regarded as the most influential ones. Patient associations also gained importance as their representatives participate in the National Health Council, in hospital supervisory councils and waiting list committees; and they also take part at pharmaceutical price negotiations.

The chambers are quite distinct from the other professional organisations as they also have some regulatory competences delegated by the government. Of the official representation of interests, the *Hungarian Medical Chamber* (HMC) does not play a negligible part in formulation of health policy in Hungary. This organisation was established in 1989²⁷ but its detailed tasks, competences, and structures started to outline only in the middle of the 1990s. According to the relevant 1994 law the HMC is the doctors' professional public body with self-government and representation of interests. Its main feature was the compulsory membership for those who would like to do some kind of activity insisted by medical diploma in the country (physicians and dentists).²⁸ In the past years the member of HMC could be a person who

²⁶ Church hospitals are the few marked exceptions.

²⁷ Act 57 of 1989 on the amendment of Act 2 of 1972 on the health care.

²⁸ This constellation has been changed to some extent because the current government eliminated the obligatory memberships of these professional chambers since April 2007. See act 97 of 2006 on the professional chambers working in healthcare. Since then the physicians' and health care workers' trade unions have been able to gain ground.

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- had successfully graduated as physician either in a Hungarian university or his foreign diploma had been officially accepted,
- had been registered in the doctors' national and basic registers,
- carried out or wanted to carry out medical activity in Hungary.

Its main task is the representation and protection of the profession's interests and in connection with the HMC also has the right to be consulted on various medical issues. So it has got several additional rights such as agreement, expression of opinion, putting proposal, participation etc. Regarding to the system of general practitioners its main tasks and rights are the followings:

- it deals with a registration of its members (registration was a precondition for medical work in Hungary),
- it has been issuing certification for applicants since 1999 which certifies that the given person is the member of HMC, he has not been punished either ethically or for other reasons, and he has been registered in the doctors' operational registration,
- the HMC grants the 'practice right'.

It has got the right of expression of opinions mostly by the formulation of health legal regulations, the determination of professional training and further education requirements, the investigation of professional suitability in case of employment, and by the development of general contracting conditions between self-governments and general practitioners. By the formulation of contracting conditions among the HIF and physicians the HMC has veto power. In view of its organisation the HMC presents itself on settlement (capital city district) – county (capital city) – national levels. It has established a special section for primary care in order to carry out these tasks more effectively. Its legality supervision is provided by the minister and the court. In case of issuing operational licence and official certificate there is the opportunity to appeal to a court against the decision of the HMC.²⁹ The Chamber issues a code of ethics for medical practices, and has the right to take action against those who do not act accordingly.

Following a similar pattern, the *Hungarian Chamber of Pharmacists* and the *Chamber of Non-medical Health Professionals* were also established.³⁰

Besides the HMC other organisations based on associational law exist in order to represent physicians' interests. In the general practitioners' case several organisations have been founded since the political change of system and these organisations want to contribute in the formulation of health decisions, too. With their demands of representing special medical interests they can register themselves in the ministry where they can be entered in the list of social associations and then they are able to express their opinions about the formulating draft laws. But their formal rights include only the opportunity of expression of opinions, formulation of criticism, and preparation of possible own proposals. In view of these organisations there is the *National Alliance for General Practitioners Practising in Villages and Small Settlements* organised by clear geographical features.

The emergence of patients' choice and preferences

The development and main features of healthcare financing 1990-2006

²⁹ Act 28 of 1994 on the Hungarian Medical Chamber.

³⁰ In 1994 and 2003, respectively.

In primary care the system of general practitioners replaced the former system of district physicians after the change of political system. Since 1992 these family doctors have been the main providers of general primary care services. People are allowed to choose their family doctor regardless of their residence. Family doctors receive per capita payment after their regular patients (corrected by the age of their patients). This is paid from the HIF, and accounts for ca. 75-80% of their income. They also get other revenues from the Fund.³¹ In order to become eligible, they have to contract the respective county office of the National Health Insurance Administration. Most of them operate as private service providers (“entrepreneurs”), so they also contract local governments about service delivery and primary care facilities. In most cases they rent an office and equipments from the municipal government they contracted.

Also in 1992-93 the system of financing healthcare services was revised. The main idea behind the changes was to link payments to outputs. That included the per capita payment to general practitioners. At the same time a (fee-for-service) point system was introduced for services for outpatients. Along the main principles of the German system, it fixes the weight (“share”) of the values of services and pays for the services accordingly. The system also applies a monthly ceiling on funding.³² Services for inpatients also changed, and a system that is quite similar to the American DRG (Diagnosis Related Groups) system was adopted. In the new system (called Homogenous Disease Groups, HDG) funding is paid after the cases. Patients are categorised into diagnosis groups. The weights (“shares”) of different diagnoses are fixed, and money is paid to service providers after the number of their patients (falling in various categories). However, in contrast with the American system, the monetary value of the diagnosis weights was not nationally applied; instead, a different value was set for each individual hospital.³³ As a result, some hospitals could get more—sometimes twice as much—for the same surgeries than others. Absurdly enough, this system favoured the less efficient hospitals, the average costs of which were higher than usual (e.g. hospitals that had had less patients than other institutions with similar capacities).³⁴

Also in 1993 citizens’ access to healthcare services was—in principle—conditioned to contributions to the social insurance (public health) system. However, due to broadly defined exemptions and to services in social health care, services remained virtually universal as less than 1% of the population are not covered.

In the pharmaceutical sector the changes were even more rapid. The liberalisation of the pharmaceutical market was accompanied by large-scale privatisation. National drug producers as well as the wholesale and the retail industry were mostly privatised.³⁵ Increasing drug expenditures have considerably contributed to the deficit of the HIF ever since, and the issue of controlling drug prices has been on the agenda of each successive government.

Also in 1994 a new payment system was introduced within the public sector. Funds for the costs of public employees were allocated to public institutions according their number

³¹ E.g. for the maintenance of their office; ad hoc visits by patients registered with other family doctors; territorial allowances.

³² Should the fund be smaller than required, the number of points would mean proportionally less money in each service category.

³³ The basis of calculation: the hospital’s budget (1992) divided by the performance of the given hospital (1992).

³⁴ Decision makers believed that institutions receiving the same level of funding as a year before would not have to face new challenges and would less likely oppose the new system of financing. As opposed to their expectations, the general economic environment deteriorated and the financial situation of the hospitals got considerably worse. The great differences in the financing of the same operations in different institutions got wide publicity and generated serious tensions and dissatisfaction.

³⁵ The Act on Pharmacies permitted and set the conditions of the privatisation of pharmacies. Nearly 100% of the pharmacies were privatised.

of employees. This meant that those public institutions (including hospitals) which had already rationalised their operation and laid down some of their manpower received less funding than the less efficient ones (i.e. the ones which deliver the same services with more employees).

Austerity measures

Serious budgetary imbalances led the government to seek the possibilities of cutting back state expenditures. In the health sector this policy goal led the central government to reinforce its control over spending on drugs and health services. The austerity measures of 1995 affected the health sector with a particular severity. The sector was regarded as a major source of fiscal imbalances. Consequently, the health budget was cut considerably (reaching the bottom since 1990). In addition, the HIF stopped to finance dental services³⁶ and subsidise spa treatments. Responsibility for work-related health services was shifted to the employers. Co-payment for the transport of patients was introduced, and the number of hospital beds was reduced considerably. In response to these changes, trade unions in the sector were pushing for significant wage increases, while many hospitals demanded (and needed) state participation in their–financial–consolidation. To consolidate health institutions the government decided to draw in additional resources in the sector. However, the distribution of consolidation money was neither conditioned to reforms nor based on performance.

The Constitutional Court found that some elements of the austerity package violated the Constitution. In its decision the Court declared that the way hospital capacities had been reduced³⁷ was against the Constitution. Next year the government opted for a less direct intervention: it invented a need-based formula that was used for determining the necessary healthcare capacities in terms of outpatient consultation hours and hospital beds per county. The outcome was very much in line with the developments of the year before: the formula demanded further cuts in most counties. However, this time the counties were free to decide on the actual way of capacity reductions. Although very few institutions were closed down, the overall reduction was roughly the same as in 1995 (ca. 9000 beds).

The government also decided to change the system of hospital financing. There remained a diagnosis related system, but by 1998 the differences in the level of payments to various institutions was eliminated, meaning that now each hospitals gets an equal per capita funding after all patients who fall in the same diagnosis group. Retrospective payments to individual hospitals were replaced by a prospective base fee for each diagnosis group; it was nationally uniform and fixed in advance.

Along with expenditure reductions, the government also made efforts to increase revenues to the HIF. Reducing incentives for and the possibilities of evading contribution payments became a key objective. Thus, while the contribution base was broadened and a new lump-sum (hypothecated) tax was introduced, the rate of health insurance contributions paid by the employers was decreased. At the same time, the government also curtailed the rights of both the Health Insurance Self-government and the HIF.

After the abolishment of the self-governments, the supervision of the HIF first belonged to the Prime Minister's Office, then it was transferred to the Ministry of Finance, before landing at the Ministry of Health. The first state secretary who had got in charge of the supervision of the Fund adopted the policy line of the previous government and proposed to introduce a system of competing health insurance funds. The government dropped the idea

³⁶ A year later tooth-preserving treatments and services were again incorporated into the Fund coverage.

³⁷ The minister for welfare instructed the National Health Insurance Administration for what capacities to contract for.

and introduced some other changes instead. It decreased the rate of health insurance contribution, while extended and increased hypothecated health tax. To control the pharmaceutical sub-budget of the HIF, the government assigned the minister for health with the right to approve overspending beforehand and to cover the deficit from other sub-budgets or from the budget of the Ministry of Health. Drug prices came under control a year later: in 2000 the newly established Social Insurance Price and Subsidies Committee negotiated a three-year agreement with stakeholders in the pharmaceutical industry. The agreement envisaged below-inflation price increases and—for expensive medicines—decreasing margins between wholesale and retail prices.

In 1999 the government approved to the introduction of pilot project that combined the American Managed Care system and the British GP Fund-holding model. The so-called managed care model was originally initiated by the previous (Horn) government, but also won the support of Fidesz health politicians. The introduction of the model started with seven pilot projects (“experiments”); and by 2002 it covered some 500,000 people (roughly 1/20th of all insured). The first assessments suggested that the model operated successfully³⁸; yet it has not been expanded to the whole sector (i.e. country).

In 2000 the government invented the concept of “practice right” and introduced it to the general practitioners. The government aimed at restricting the emergence of new service providers by obliging new family doctors to purchase already existing practices. At the same time the government also offered subsidised loans for family doctors, who wished to purchase their facilities from the municipal government. In the same year the ceiling on employee health insurance contributions was removed.

After the change in the position of the minister for health, the new leader of the sector encouraged the public healthcare institutions to transform into non-profit corporations. The status of ‘freelance medical doctors’ was introduced. The minister also wanted to regulate the already ongoing process of ‘spontaneous’ privatisation of medical centres, clinics, hospitals or hospital units.³⁹ The so-called ‘Mikola Act’, named after the minister, was to permit privatisation only for enterprises operating in the form of ‘non-profit corporation’. It excluded the possibility of privatisation by insider investors (i.e. medical enterprises, drug producer etc.), while it did not prevent partial privatisation of healthcare institutions (‘cherry picking’). Changes to the Act on targeted and earmarked subsidies to local governments included a ban on the privatisation of those municipal institutions which had received such subsidies; the ban is to be applied for 10 years after the use of such subsidies.⁴⁰

Delayed reforms

After the change in government in 2002, the new government decided to suspend the implementation of the ‘Mikola Act’.⁴¹ A year later the Act was replaced by a new regulation that did not allow ‘cherry picking’. It only permitted the privatisation of entire healthcare institutions. On the other hand, neither for-profit, nor insider (sectoral) investors were excluded from the privatisation process. It also encouraged privatisation by the management

³⁸ In the districts of the pilot projects doctors earned more, patients experienced more attention and better care, and the consumption of medicines decreased significantly.

³⁹ The process began after 1995. It was primarily encouraged by the lack of sufficient resources. While flow (operational) costs were financed from the National Health Insurance Fund, stock (capital) costs (i.e. investments, equipments, renovation costs) remained to be financed by the owners of the health institutions. Municipal governments, medical universities or ministries have often been unable to allocate funds for such purposes.

⁴⁰ This ban affects roughly half of all hospitals that are owned by county and municipality governments.

⁴¹ The new minister argued that the Ministry would prepare an entirely new law within a few months.

and/or other employees for which subsidised loans were to be offered. However, the Act did not come into effect as the Constitutional Court declared it null and void, for it found that the way the law had been passed was unconstitutional.⁴²

In 2003 the government renegotiated the agreement with the pharmaceutical companies. While a more differentiated price increase was permitted, the companies agreed to cover the subsidies for medicines sold beyond an agreed limit.

The government also revised the managed care model. It was decided that the scope of the project would be extended to a maximum of 2 million people (1/5th of the entire population). As part of the changes for-profit companies were allowed to become medium-level 'patient managers' (care coordinators) operating between the Health Insurance Fund and service providers. Although the prime minister appointed a governmental commissioner to assess the results of the pilot project and to propose a long awaited, comprehensive health reform, his activity is unlikely to bring about major changes to the sector ahead of the April elections.

Privatisation

Since the mid 1990s two main concepts have been formulated and competed within the successive governments. The first has been represented by (monetarist) economists, private insurance companies, liberal politicians, and—particularly under the Socialist governments—the Ministry of Finance. They advocate a considerable reduction in public expenditures on healthcare. In their view the lost resources should be offset by a significant increase in private contributions implying a much bigger role of both private insurance schemes and direct payments by patients for services they receive. In this approach public financing shall be limited to a small circle of basic services and to the very poor.

The other concept has traditionally been represented by the Ministry of Healthcare (formerly Ministry of Welfare) and the HIF. It envisages a dominantly publicly financed system is funded from compulsory health insurance contributions and the tax revenues of the central budget. Services, that are practically free of charge for insured patients, are provided by enterprises of various nature (i.e. private, non-profit, municipal, state-owned). For a limited and well-defined circle of (extra) services co-payment or full payment would be requested from the patients. Private funds, offering supplementary schemes to anyone interested, may operate in this system as well.

In the last fifteen years the involvement of private actors and private capital increased in the health sector. Private participation now involves private practitioners, family doctors, private clinics, factory physicians, diagnostic laboratories, supplementary service providers (e.g. enterprises of washing, cleaning and maintenance), pharmacies, some emergency ambulance operators, and a few big—mostly foreign capital-based—enterprises of artificial kidney centres and other high-tech-based services. Altogether some 10% of all healthcare services are delivered by private service providers. The once state-owned pharmacies have been all privatised. Some 90% of the artificial kidney centres, and around one-third of CTs and MRIs are run by private companies which contract the HIF that pays the same amount for their services as it is paid to public diagnosis centres. Private investors in diagnostic centres often undertake the task of purchasing new medical equipments. Nearly 90% of family doctors and almost 70% of dentists are private entrepreneurs, who deliver primary care

⁴² After Parliament had approved the law, the President used its veto power and sent it back for reconsideration. Parliament decided to overrule the President's veto without discussing his reservations. The Court declared that Parliament did not fulfil its constitutional obligation of "reconsidering" the bill. Although the Court only criticised the formal procedure (i.e. not the contents of the bill), the government did not submit the bill to Parliament again.

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services in contractual relationship with the Fund. In secondary outpatient care many specialists have private practices and clients besides their public employment. Yet, in both specialised outpatient and inpatient care the role of private providers remained very limited.⁴³

Thus, privatisation, in its classic meaning (i.e. shift from public to private ownership), remained limited in the Hungarian health sector leaving pharmacies to be the only marked exemptions. On the other hand, functional privatisation is extremely widespread in primary care, and it has also gained ground in secondary care services. The transformation of public institutions into ‘non-profit corporations’ is a rather recent phenomenon. Although the act that had encouraged such a development lost its effect, standing laws do not ban such transformation. Indeed, there are examples for such a transformation, and the number of cases might increase further if spontaneous privatisation were to accelerate.

The current conditions of healthcare financing

This time ca. 8,5% of the Hungarian GDP is spent on healthcare. On the one part this value involves nearly universal coverage with only few inclusions (around 1% of the health care services). On the other hand it means that the role of co-payment was quite limited in Hungary in the past decades. The different forms of co-payment were introduced in the pharmaceuticals’ sector (buying medicines) and for the free choice patients have been obliged to pay, too. The current government also made efforts to increase to role of co-payment but 2008 referendum voted down the newly introduced forms of visiting fee and hospital allowances. On the whole it follows that the HIF has mostly been running a significant deficit since the early 1990s. That is why for each of 20 sub-budget of HIF upper ceilings have been applied and corresponding provider payment mechanism has been designed to protect the predetermined cap on expenditures. For the first time in its history the calculation of the Fund showed balance in the first term of 2007. As mentioned above the HIF finances recurrent expenditures, more precisely the government pays for recurrent expenditures of services of high costs, high technology and public health. With regard to the owners of healthcare facilities which are mostly the local governments are responsible for the investments.

Around 75% of these healthcare expenditures come from public sources which include three main elements. Firstly, both employers and employees are obliged to pay the healthcare contributions embodying one major component of social contributions. Of the population of ten million people around 3,5 million pay these contributions. Here the crucial problem is that almost half of active employees earn minimum wage, partially due to tax loophole. The estimated number of free-riders is 0,5 million. Moreover many people work in the black or grey economy, so these revenues vanish for the calculation.⁴⁴ Secondly, ca. 10-15% of the revenues come from taxation. Finally it should be mentioned that the bulk of private contributions accounting for 25% come mostly from out-of-pocket payment (21%).

With regard to the structure and capping of these expenditures ca. 30% is spent on cash benefits. Of this amount around 97% are in-kind benefits including curative and preventive benefits (2/3rd), medicines subsidy (30%), and medical aids subsidy (5%). The remainder 3% is spent on administration. Ca. 70% of the total expenditures is devoted to health care. It means that the share of primary care is around 15% which includes both dental doctors (1/3rd) and general practitioners (2/3rd). The detailed description and analysis of the latter are in following subchapter.

⁴³ Less than 10 of the ca. 150 public hospitals have been privatised (‘functional privatisation’), and just a few were returned to the Churches.

⁴⁴ Doctors’ salaries are also distorted by under-table payments and gratuities, too.

The outpatient specialist care, diagnostics and dialysis partake around 20% and nearly 2/3rd is spent on inpatient services, especially for acute care. With regard to the former, the payment for outpatient specialised care is based on contracts which shall determine several elements: type of service providers, timing of service providing, and the providers' capacity, so number of services they may be paid for (here the bases are 98% of preceding year). Last but not least the contracts shall determine the financing services provided over the agreed limit (here a kind of degression is applied: up to 5% 60% covered, 5-10%: 30%, above 10%, 10% paid). In the area of outpatient specialist care the payment is based on a fee-for-service (German) point system with monthly ceiling on funding. The point values are determined nationally (ex-ante), and compensations and seasonal variations part of the relevant sub-budget is used for. Service providers are obliged to document all their activities on daily basis and monthly report them. Summing up the system of outpatient services denotes a somewhat limited choice for citizens and comprehends some disadvantages (prisoner dilemma, unnecessary services) as well.

In the sector of financing acute and chronic inpatient services a performance-based payment mechanism has been introduced. Here the already mentioned Homogenous Disease Groups (quasi DRG) system has been applied for acute care and rehabilitation cases with the exception of high-cost interventions which mean rather a case basis. Calculation of HDG is based on category weights (points) and the categorised cases shall be reported. The hospitals' monthly performance is multiplied by the monetary value of 1 point (i.e. "national base fee"). This national base fee is annually set in advance. Similarly to other calculations the sub-budget of acute inpatient care is also capped to avoid cost explosion, and part of it is reserved for compensations and seasonal variations. Just like in outpatient care a special kind of degression has been built in. The chronic cases are paid on basis of patient days adjusted by case complexity. Likewise the primary care and outpatient service the both under- and over-financed system of inpatient service has also got several disadvantages. It offers only a limited choice for patients. But the shortcomings can be caught especially in cheating: patients usually spend very high number of days in hospital. Furthermore they often spend these days with different medical examinations and cares only on paper which phenomenon is the misinformation of the HIF.

The system of managed care originally was launched as a pilot project in 1999. The original initiative involved limited territories and a population of 160,000 people, but later on the involvement peaked in 2004 by more than 950,000 people. The idea of managed care aims at rationalising by better resource allocation. Primarily this means care coordination (including hospitals, polyclinics or group of general practitioners) for the population in the entire spectrum on one part, and as a second basic element it makes reallocation of resources between sub-budgets possible (pharmaceuticals and high-cost interventions not included in the scheme). More precisely, the different care coordinators receive population-bases capitation payment and contribution for prevention and organisation. Here the payment is for those services that are ordered for the patients coordinators manage. The coordinating actors have a "technical" account, but are not allowed to show deficit for more than 3 months. That is why they are able to spare money they receive once a year and establish a joined risk fund (10% of savings). There are two main achievements of the managed care: it shows positive balance in most cases, and has considerable improvements in prevention.

To conclude, besides the limited role of patients' choice the system of healthcare financing has to face several problems in Hungary. The crucial role of informal payments should definitely be mentioned. The avoidance of cost explosion leads to implicit waiting lists and the structures and mechanisms of financing may cause the dilution of services.

The main features of the system of general practitioners

Who and how can become a GP?

The basic structures of the new system were laid down around 1990-1992. In this area the 6/1992. ministerial decree determined firstly, in a very detailed way that what kind of professional and educational conditions the applicants had to carry out, what kind of examinations and practices they had to successfully fulfil. As a basic principle the decree has put down that the general practitioner shall have a general medical diploma, and besides this he should meet further requirements. Because the practising physicians' qualifications and professional examinations varied to a relevant degree in the beginning of the 1990s, an opening time was ensured until the end of 1998 in order to become suitable for the standardized conditions. Until that date those persons, who had another qualifications (mostly internists) could be the part of the system and those physicians as well who had been already working for a certain time. But since the beginning of 1999 only those doctors can be general practitioners who have successfully gained either the general medicine or the internist qualification. In the latter case there is other requirement: at least ten years practising is needed. Those persons could maintain their positions who have been continuously working for at least 25 years regardless to their qualifications. Those doctors, who practiced in the end of 1998, were authorized to get temporary operational licence if they had still five years to the pension able age.

Another, already mentioned preconditions of practicing are the registration by HMC, the issued certification of the former, and the acquisition of the 'practice right'. About issuing the latter the HMC informs NPHOS and HIF as well. Both the general practitioner having 'practice right' and the applicant, and the local government and the applicant shall conduct previous contracts about the passing of this right and the local government's employment purpose. A further requirement of health service is that the physician shall have an operational licence issued by the NPHOS. This licence can be issued only in the case of existence of suitable personal and professional minimal conditions. The detailed list of these is an integrate part of the mentioned 1992 ministerial decree. About any kind of change in operational registration the NPHOS continuously informs the HIF because the latter's lower organs can conduct financial contracts with the organisers of health services. These contracts are usually not fixed-term. Because the entrepreneurs have been featuring the system of general practitioners, a valid contract of third-party insurance is also needed as another important prerequisite. Above these elements the particular details of health service are usually determined in the contract conducted between the local government and the physician.

The legal regulations enacted after the political changeover has made a clear distinction among general practitioners according to the fact that do they undertake and execute obligation of territorial care or not. Nowadays most of the general practitioners have got both the 'practice right' and the obligation of territorial care. They can be either local governmental employees or medical entrepreneurs (health economic organisations, private physicians) but the latter form has been the most popular and the former seems to be rather exceptional. These general practitioners carry out the primary care for the population of around 6800 districts determined by local governments. These districts are usually around the same size and they cover the entire territory of the country. There are special districts just for either children or adults but mixed districts exist, too. With those doctors, who have the suitable preconditions, undertake the primary care of a certain number of registered people, the HIF must conduct financial contracts. In contradiction to them the general practitioners' minority has not got obligation of territorial care: in this case they can work either in the framework of economic organisations or as private physicians and above a fixed number of patients the practice is also financed by the HIF.

What general practitioners do

According to the relevant 4/2000. (25 Feb.) Health ministerial decree being succeeded after the mentioned 6/1992. decree, the general practitioners' main tasks are the personal and continuous care in order to preserve the health status, to cure and to prevent. They shall hold their surgeries at least two hours on weekdays but at least 15 hours a week. They shall receive the registered patients and those people who are although not registered and accepted but are endangered by worsening health status. Besides these other tasks have been also enacted such as consultation, screening tests for the healthy population, medical examinations, treatments, control of health status, medical rehabilitations, and referral both to specialist clinic and to hospital if necessary. In addition they contribute in antenatal care, execution of public health-epidemiological tasks, health education and information, medical expert⁴⁵, and coroner works. According to the contract conducted with the local government they can participate in local duty service.⁴⁶

In contradiction to the above listed tasks there is no other legal document authorized with pressure which list would include the general practitioners' compulsory tasks in a more detailed way. In this field the so-called 'competence list' should direct somehow: the first version was written by the main actors of the physicians' profession in the beginning of 1993. In fact it is a list of activities which have not been a legal regulation yet but it represents the highest limit of the general practitioners' work. It includes those cases which are expected from a physician to solve, the second type is when a specialist is also needed, and the third is definitely not the general practitioners' competence right after the recognition.

So both the legal regulations and the competence list clearly moves them to fill the gate-keepers' role and in this area the regulation gets even stricter although the system of finance has paradoxically different effect.

How are they financed?

The main principles of the finance of general practitioners' system have not really changed by the change of political system and by the relevant changes of Hungarian health policy. One option for financing the system can be the support of performance, so the owed finance for really cured patients. But this solution can easily become unfair, if there are no ills actually. In addition the whole medical work can be characterised by a special standby situation regardless to the fact that do ills come or not. Another option is the quota system determined by the certain number of registered persons. But as a lineal consequence of this latter is that it does not urge to increase personal performance: general practitioners are interested in registration of as many people as possible, but not in their real cure. In Hungary this latter system has developed right after the basic financial structures of district physicians' system, so it has not really changed on the whole. But it is corrected by certain indexes of results and performances in a way.

The main elements of the finance of general practitioners' system evolved around 1992-1993. The basic units ordered by the regularly changing financial decrees have become the followings. The number of controlling counterfoils of insurance certificates is very determining, so the *number of persons* who applied and have become accepted by a general practitioner. The patients' minimal number was firstly regulated in 1993: according to this a financial contract shall not be conducted with those health services in which districts the

⁴⁵ It means the examination of aptitude (for example: driving licence), suitability (for example: schooling), and competence (for example in case of deficiency assistance).

⁴⁶ 4/2000. (25 Feb.) Health ministerial decree on the general practitioners', paediatricians' and dentists' activity. European FP6 – Integrated Project Coordinated by the Centre for Philosophy of Law – Université Catholique de Louvain – <http://refgov.cpdf.ucl.ac.be> WP-SGI- 6

number of population is not over either 800 or 400 in case of children.⁴⁷ This threshold does not concern to those physicians who do not have obligation of territorial care. In this case 500 insured persons' written declaration was firstly needed to realize a financial contract (since 1995 the threshold is 200 persons). In the case of obligation of territorial care it is evident that in one district only one contract can be signed with just one health service which is obliged to carry out primary care freely for the local insured persons.⁴⁸ In the remuneration several other elements play an important part, just like the *age-group points* composed by the patients' ages, and the *qualification multiplier*. In the case of obligation of territorial care the service can get *territorial allowance* connecting with the local conditions, and *traffic payment*. Besides these *fix amounting prize* has been initiated since 1993 which depends on the number of local population, age-groups, and the conditions of surgery.

The developed system meant that the remuneration went on the basis of a difficult calculation system from the closed desk of the social insurance. The fundamental element of finance was the multiplier of the number of insured persons and the age-group points, which multiplier was then corrected by the so-called *digression factor*. This value was finally multiplied by the qualification multiplier. With the execution of this digression several exceptions were made later by the decrees (for example: if there is not enough insured person in a certain district). The fix amounting prize owed on the basis of the fulfilled tasks, the number of local population, and the conditions of the surgery. Besides these, *territorial complementary allowance* could be also paid which could have been appointed as a traffic support. In case of establishment of a new district it is possible to conduct a financial contract if the number of persons was above the determined threshold which has been continuously changing since the beginning of the 1990s (this time it is 1500 adults). For supporting the newly established districts additional provisions could be founded and they could call for another additional support for the following year. In 1994-1995 extra resources could be achievable by applications for those general practitioners who had obligation of territorial care and got into an extremely hard financial situation.

In the later period the most important changes of finance were the followings. In 1996 it has been put down that a financial contract can be conducted in the case of minimally 1200-1500 adults, 600 children within the framework of obligation of territorial care.⁴⁹ In the same year the so-called *medical care multiplier* was installed until the beginning of 1998. This new element could be taken into account by the execution of certain medical care programmes.⁵⁰ Right after it was ceased a new element was founded until the spring of 1999 which multiplier could be included after the regular fulfilment of certain screen tests in ordered ages.⁵¹ The calculation changes in the case of either a specialist-applicant or a specialist's employment as well.

The practical functioning of 'practice right', the establishment of permanently vacant medical districts brought on the correction of its financial dimension, so an additional finance

⁴⁷ Act 84 of 1992 on the financial bases of social insurance and their 1993 budget.

⁴⁸ *The current Hungarian cabinet plans to install the so-called round-payment by general practitioners which would be a relatively low amount of money, would concern to everybody, but in case of the poor it would be much lower. A yearly maximum amount would be also determined, so over this payment should not be paid in the given year. See T/1093. draft law on certain amendments of laws concerning health care and connecting with health care reforms.*

⁴⁹ 62/1996. (26 April) Governmental decree on the amendment of 103/1995. (25 Aug.) Governmental decree on the certain questions of social insurance finance of health care.

⁵⁰ 238/1996. (26 Dec.) Governmental decree on the amendment of 103/1995. (25 Aug.) Governmental decree on the certain questions of social insurance finance of health care.

⁵¹ 13/1998. (30 Jan.) Governmental decree on the amendment of 103/1995. (25 Aug.) Governmental decree on the certain questions of social insurance finance of health care.

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had to come into existence. According to a 2005 governmental decree the finance of these districts, where the local governments can fulfil their care obligation over a year just with deputyship, goes on with increased monthly prize, if the number of local population was over 1200 persons.⁵² In this case the deputy physicians become public employees of the NIPC, and in addition to this they are able to complete their necessary educational practices.

The financial decrees usually mention the matters of financial contract in a very detailed way. So they include such questions that with what kind of health services, with which existing conditions a contract can be signed. They also contain those data which must definitely be in a contract (for example: type of primary care, obligation of territorial care, time of availability, capacity, personal and objective conditions, information, payment, operation of the contract etc.). As an exchange for the monthly paid out payments, which reflect to a three months earlier situation, the health service is obliged to inform the organs of the HIF. This early type of information has been transformed into a detailed reporting about the executed medical care since 1999.

It also proved to be a determinative tendency that legal regulations enacted around the millennium have tended to direct the general practitioners to undertake the whole care obligation from local governments. While the local government had to grant the conditions of functioning (surgery, equipments) in the beginning of the 1990s, but since the early 2000s general practitioners have been able to call for extra support from the HIF to buy different equipments, furniture, and real estate. This support can be claimed also in the case of bank loans raised for buying either real estate or equipments, so the finance has increasingly an effect on the establishment of entrepreneur physicians and economic organisations. These new forms of medical care should have own surgeries with own equipments, and employ workers if it is possible.

Quality control

According to the relevant 4/2000. ministerial decree the quality control is one of practising general practitioners' tasks but their technical supervision is provided by the organs of the NPHOS. As it has earlier emerged the NPHOS regularly controls the practice of different health services. In the quality control the HMC can also contribute if it was called upon to take part. The HIF plays a great part in controlling regarding to the questions of finance. But its controllers investigate the realization of primary care only in the case of articulated complaint. They look after those cases as well when a general practitioner reports both unrealistic claims of money and medicines, and nearly unimaginable number of patients to the HIF.

Further education

In this field the main features have been remained by the legal regulations after the change of political system. At first, according to a 1998 ministerial decree both compulsory and facultative further educational programmes shall be organised which aim to keep up the knowledge acquired in the university and professional training, and to gain new skills in connection with recent developments. The execution of these courses is compulsory every five years.⁵³ The new 1999 ministerial decree connected the issue of further education with the physicians' operational registration dealt by the HMC. According to the new regulations, every general practitioner shall fulfil 250 credits through conceptual and practical further

⁵² See 104/2005. (11 June) Governmental decree.

⁵³ 11/1998. (11 Dec.) Health ministerial decree on the higher educational health professional training and further education.

educational courses during the five years long time of operational licence. In a year only 100 credits can be officially accepted. At least 50 credits must be fulfilled through execution of university levelling courses. These programmes are usually organised either in health higher educational institutions or in health services. The valuation of these, so the determination of credits is made by the Council for Health Professional Training and Further Education.⁵⁴

The new 2003 ministerial decree has brought so many changes in comparison with the earlier, that it has differentiated three types of courses which can be fulfilled in the framework of conceptual further education. These are the compulsory levelling, the compulsory optional, and the facultative courses. The first type, the levelling course can be organised only by universities which have to take into account the proposals of the professional college. There is also a practical module which means that every general practitioner must work in this occupation for at least three certificated years. Those doctors who have not been able to gain these practical credits then they must take part in an additional practical further education organised by either a university or a health service. Another important feature of this special course is that it can be executed only under supervision. The concerning credits are integrate parts of the decree, which credits are decided by the council's competent committee having the previous proposals of the professional college.⁵⁵

Citizens' participation and representation in healthcare management

Utilizing the collaborative/relational approach the following chapter on the one hand concentrates primarily on the major features and problems of patient associations after the change of system, and on the other hand it introduces and examines those institutional mechanisms and arrangements that enable the specific patient interests to be participated and represented. Within this framework the chapter aims to analyse 1.) the patient associations' role in the decision-making processes, including the formulation of the determinative 1997 law on health care, 2.) the different methods of their representation in various bodies, on various levels, and finally 3.) the special system of advocates of patient rights.

The patient associations in Hungary: a general overview

Until 1989 *patient organisations* could not and did not really function in Hungary. The act 2 of 1989 on the freedom of association made it possible to establish democratic and civic associations. On the grounds of this right the patients could also found their organisations in a different manner: ones were established by doctors or on the basis of local clubs, whilst others were absolutely new and missed any kind of antecedents. In line with the formation of patient organisations another kind of associations focusing on the protection of patients' rights has been also developed. So by this time more than 100 associations representing and protecting patients and patients' rights exist in the country. They can be ranked into two main categories:

- firstly those organisations which intend to represent and possibly enforce separate patients' interests and
- secondly those associations which aim to provide legal protection for the injured party of patients, to protect patients' rights.⁵⁶

⁵⁴ 73/1999. (25 Dec.) Health ministerial decree on the physicians', dentists', pharmacists', and hospital psychologists' continuous further education.

⁵⁵ 52/2003. (22 Aug.) Health, Social and Family Protection ministerial decree on the physicians', dentists', pharmacists', and hospital psychologists' continuous further education.

⁵⁶ This latter category of organisations is described and analysed in a subsequent chapter examining the best practices.

The organisations of the first category are usually grouped by various diseases. It virtually means that they have been making efforts to cover all major illnesses but this structure can not be assessed as being totally developed because some disease groups have not got detached associations yet. In consideration of the political and social influence the most powerful organisations are the National Alliance of Persons with Diabetes, the National Alliance of Associations of Hungarian Nephropatic Patients and the National Alliance of Disabled Persons' Associations. In order to coordinate and articulate their common issues and goals, and to support the functioning of the associations several organisations established the so-called *Chain Alliance* as an umbrella organisation in 1989. In the course of time the Alliance united 27 affiliated patient associations and proved to be a strong safeguarding actor of patient interests in law-making. The leaders and experts of the Alliance tended to express their opinions on draft laws and took part in the formulation of the new 1997 law on health care. They could succeed in developing continuous cooperation with the Ministry of Health and with other relevant agencies and institutions. But by now it seems that after the enactment of the 1997 law the Alliance has been tending to lose ground and its power and relations have been cut back due to personal conflicts and structural causes.

As a general rule the patient organisations have to face several problems in Hungary: some of these are attached to the troubles of the Hungarian civil society, whilst others are rather typical of this segment. Aside from the above mentioned formations most of the patient organisations were relatively weak associations as compared to the professional chambers of the physicians, pharmacists and health care workers. Until the latest reform the relevant laws granted large powers for them and the ruling governmental attitude also favoured their positions because this approach often professed that consultations must be carried out only with the leaders of chambers. Contrary to these professional bodies most of the patient organisations struggle with problems of legitimacy and have limited representative capacities. Paradoxically they are not able to cover all groups of diseases but their structure developed after the change of system proves to be quite fragmented – with this number of organisations effective negotiations can be barely realized. Furthermore there are strong divisions along political lines, and the personal conflicts and rivalry are well-known phenomena. Several organisations are in fact one-man associations without any kind of division of labour, preparedness, relations and language skills. They often miss the qualified professionals and lawyers who are much rather employed by the other type of organisations providing legal protection. Besides the lack of expertise crucial problem is also the lack of human capacity: the leaders are usually either pensioners or persons aspiring political careers and they do not really like to cooperate with each other. The associations are regularly busy doing the tasks related to certain groups of diseases. As a result the segment of patient organisations is not really able to formulate and enforce common interests and goals. Numbers of times the aim for them is simply the media appearances. In their activities the different operational functions have not really separated yet: the dissimilar scopes of services and interest representation often combine. Above all there are shortcomings in their financial support as well. Although they provide for many functions that should rather belong to the tasks of the healthcare system, the organisations are only occasionally state-subsidized. Instead of support from the central budget the patient associations are used to financial assistance of the relevant pharmaceutical firms. These above mentioned factors all contribute to weaken their position in decision-making.

Patient associations and law-making

Nevertheless the Ministry of Health is obliged to consult with civil organisations affected by prospective legislation, which is a legal provision of the act 11 of 1987 on

legislation. In practice it means that the patient associations may give opinion on draft laws and government decrees after these organisations and service-providers registered freely with the Ministry. So after the registration on the so-called “lobby-list” of Ministry the associations regularly receive draft laws and decrees in the formulation stage. One problem with this type of consultation is that these civic opinions shall usually be given at short notice and to top it all these opinions are rarely taken into account. In some cases it eventually happened that the representatives of the patient organisations received the documents later, in such a stage where there was not any chance to achieve relevant modifications. That is why several organisations do not really make any efforts to define their positions because in their view these standpoints will be neglected anyway and the debates of the framing process are not really substantive. By now some of them seem to become weary of the whole processes of political decision-making. The representatives of patient organisations also criticise that this so-called “lobby-list” is not transparent for them, more precisely they are not fully aware of the facts that which associations and with what deadline receive the drafts. An additional problem is that they would need up-to-date databases and statistics in order to express their opinion but in several cases these data are not available for them.

Besides the consultative mechanisms of Ministry there is another possible way for the civic organisations to affect law making. According to the standing orders patient associations can also register with Parliament and—on invitation—attend respective parliamentary committee meetings because the MPs have the declared right to come to know the opinion of relevant civic formations.

The patients’ institutional representation

The 1994 Amsterdam Declaration patronised by the World Health Organization stated that “*Patients have a collective right to some form of representation at each level of the health care system in matters pertaining to the planning and evaluation of services, including the range, quality and functioning of the care provided.*”⁵⁷ But in Hungary this proposed and extensive collective representation came to fruition only in a limited way for a while (Heuer 2002. Molnár 2001.). After the enactment of the 1997 law on health care the National Health Council was established as an advisory and consultative body on national level, granting positions for patient organisations, too. At local level service-providers had to bring into life supervisory councils but for many years there were no institutional arrangements concerning the decision-making processes of local and county councils which proved to be a serious deficiency of the system. That is why both the parliamentary commissioner for civil rights and experts criticised the Hungarian structures because in their view these mechanisms did not correspond to the international recommendations and concepts in case of civic control. Nevertheless several forms of institutional arrangements have been developed in the past decade, which guarantee the representation of patient organisations and interests and with the help of these granted positions their potential influence on political and professional decisions.

The National Health Council

One of these bodies is the already mentioned National Health Council which was founded in 1999, later than originally planned. According to the 1997 law on healthcare the Council is an advisory and consultative body to the Cabinet. It makes initiatives and proposals, analyses, carries out assessments and monitoring activities. In addition it gives

⁵⁷ Declaration on the Promotion of Patients’ Rights in Europe (Amsterdam, March 1994). 5. 2.
<http://infodoc.inserm.fr/ethique/Ethique.nsf/0/901e922bf0f1db42c12566ac00493be8?OpenDocument>
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opinions, can be consulted, and exchanges information in healthcare. The Council consists of ca. 30 members representing several actors, including professional chambers, local councils, universities, scientific associations, the Hungarian Academy of Sciences etc. Among its members there are 10 representatives of national patient organisations corresponding 10 main groups of diseases.⁵⁸ These groups are determined by the Council itself and it supervises them once in two years. The 10 patient deputies are chosen from the candidates of the registered national patient organisations within the framework of a special panel discussion organised by the Ministry. The favoured persons are delegated for two years but their charge can be extended for one more period.⁵⁹ Their term is worth mentioning because the other members receive mandates for four, and from 2004 for six years. In practice it often occurs that patient organisations delegate physicians or other experts to the Council. The body sits at least four times a year but a quarter of the members can initiate a meeting. It makes decisions by single majority which means that the 10 patient deputies can be easily voted down. With regard to its functioning it is still not clarified whether the Council receives conceptions or detailed proposals. Moreover it can not really decide whether it should deal either with theoretic or with practical issues.

The Regional Health Councils

The Regional Health Councils were founded in seven administrative regions of the country on 1st January 2005. Although their denomination may suggest it but in fact they are not subordinated bodies of the National Health Council examined above. Their role lays generally in the development of regional health policy. It means that these territorial bodies design, monitor and evaluate regional healthcare programmes. They also participate in the allocation of regional capacities. They coordinate and reconcile regional actors including service-providers, maintainers, local councils, local population and patient organisations. In addition the regional councils should survey patients' satisfaction in the given region. With regard to their composition each consists of ca. 20 representatives of regional policy actors but additionally other deputies may take part in their meeting only with consultative rights. This latter group of delegates includes one common deputy of territorial patient associations and advocates of patient rights.⁶⁰

The Supervisory Councils and ethics committees

As it was already mentioned above several service-providers had to establish supervisory councils which also yields some ground for patient participation and representation. These bodies have been functioning since 1st January 1999 and operating in those hospitals that are obliged to provide services in a given territory. They consist of ca. 9-15 members: around half of them –in certain cases one third of them– were delegated by local civic associations being active in the given territorial unit. Moreover the president shall represent civil organisations. Representing consumer interests their main task is to follow up the operation of institution, and with regard to the functioning to express opinions and make proposals. They can play an active role in the representation of patient interests and in the mediation between the management and local population. The crucial deficiency is that there

⁵⁸ These are the diseases of cardiovascular system, malignant tumour, respiratory organs, metabolism, nervous system and sensory organs, digestive system, immune system, addiction, and the congenial, psychiatric and locomotor disorders.

⁵⁹ See act 154 of 1997 on healthcare. 148-149 §. 229/1998. (30th December) Governmental decree on the task, structure and functioning of the National Health Council.

⁶⁰ See act 154 of 1997 on healthcare. 149/A-E. §.

is, however, no safeguard that the decision of these supervisory councils will be really taken into account.

Another important organisation at local level is the ethics committee: the establishment of these bodies is compulsory for every health care institution. Like the supervisory councils they have been functioning since 1st January 1999, too. They have got 5-11 members invited by the management. Here the main task is to issue attitudes on ethical questions and with the help of this activity they can also contribute to the enforcement of patient rights at local level, in certain institutions. The ethics committees sit at least four times a year but in case of necessity it can be more. Concerning the rights and competences of these committees the main deficiency is that they should not deal with concrete incidents, the physicians' tangible defaults, but they should rather concentrate on general issues and recommendations. Until the recent past the Hungarian Chamber of Physicians had partially the right to take ethics proceedings against suspected doctors but since 2007 this competence has been delegated to the county ethics committees. These newly established organs consist of mostly the deputies of institutions and maintainers in the given territory but besides the physician members local patient associations can also delegate one person to each committee.

Lastly, the so-called *Health Care Roundtable* is another formation realizing patient participation which was established in May 2004 and has one member representing patient organisations. Among its founders there was one representative of the patient associations. The Roundtable is much rather a civic construction because it is not accepted by the current cabinet and the coalition parties have not joined. That is why it is considered to be an oppositional organisation against the policies, concepts and goals of the cabinet and this fact can account for its marginality. This Roundtable usually deals with conceptual questions, organises theoretical debates and it has developed an alternative health care programme. According to the participating patient representative' opinion it is really that kind of organisation in Hungary whose members take the patients and patient organisations seriously. But telling the truth other patient leaders can tell us quite dissimilar opinions about the role and functioning of this Roundtable.

The advocates of patient rights

The experiences gathered during the pilot project could be utilized in the formulation of the law, more precisely in the drafting of the advocates' new institution. Originally they did not really want a strong institution but preventing, localizing and managing local conflicts and carrying out mediation. The aim was to dissolve the previous forms of doctor-patient relationships based on hierarchy and paternalism and to portray different viewpoint embodied by the advocates of patients' rights. These advocates must know and understand both the healthcare workers' and patients' interests. According to the relevant regulations of the new Health Care Act the advocates' primary task is to protect and inform the patients and others from the healthcare staff about patient rights and legal environment. They should help them to enforce their declared rights, so to assist and make complaints and proposals in case of possible violation of their rights. In certain and only individual cases they are able to represent patients, too. They are obliged to help the patients to gain access to relevant medical documentation, to formulate the related questions and comments. They have the right to enter different healthcare territories, to access documentation and ask for further information. Their complaints shall be investigated within a certain deadline. (Sándor 2004.)

During the formulation of law there was debate concerning the advocates' future employer. Finally the new institution was subordinated under the public health authority, namely the National Public Health and Medical Officer's Service which solution was opposed by the aforementioned civic experts. Originally they wanted the advocated to be employed by

the Office for Parliamentary Commissioners, and then they planned the creation of an Office for the Parliamentary Commissioner on Health Care that would guarantee the independent control of the system, without any potential influences of the medical profession. But this idea failed due to the parliamentary commissioners' resistance. The following conception was the establishment of a separate office within the ministry but this also failed. The final solution, the role of the public health authority was assessed by the experts as a huge failure.

It is worth emphasizing that the law came into force on 1st July 1998 but the new institution of advocates much later, on 1st January 2000 due to robust professional resistance. Around 58 advocates started work in 2000, so they were quite a few in numbers. The contributing experts argued that the public health authority was a hierarchical and bureaucratic organ and there was a strong necessity to bring into life a separate body dealing with the advocates. As a result the so-called Coordinating Council for Patients' Rights worked until 31st December 2002 but the debate and rivalry were continuous with the leaders of the organisation in that period. The National Public Health and Medical Officer's Service wanted, however, to direct the Council and the advocates' work as much as possible and this effort led to permanent conflicts. The Council consisted of maximum seven members who had to select, train the applicants, control and coordinate the advocates' work, so it carried out the professional supervision and management. The head of the Council was responsible for the territory of Budapest and the others for two to four counties of Hungary. In this respect the determinative change happened in 2002 when a parliamentary resolution after the elections aimed the establishment of an independent system of advocates.⁶¹ The relevant ministerial decree from 2004 then declared the advocates of patients' rights to be employed by the newly established Public Endowment for Patient Rights (PEPR).⁶² Furthermore it means that besides the employment the professional supervision and management have also been allocated to this Public Endowment. According to the relevant governmental resolution the PEPR is subordinated to the Ministry of Social Affairs and Labour. It has one representative in the newly established supervisory council of the Health Insurance Supervisory Authority. The Public Endowment consults on and makes proposals to respective regulations. It organises conferences and trainings for advocates of patient rights, stakeholders and civic, patient associations and publishes information bulletins as well.

According to the data of the Public Endowment this time 52 advocates and 8 volunteers work in Hungary who shall cover the entire territory of the country. It practically means that their number is below the required level. Furthermore they should be available at all service providers, so ca. 40 thousands existing altogether in the country. As a direct consequence the aforementioned means that the advocates are able to focus on mostly hospitals and serve several different healthcare providers due to their low number. They work usually between 40-168 hours a month and deal with ca. eight thousand cases a year. According to the experts' dominant opinion the advocate of patients' rights is still relatively an unknown institution in Hungary despite its multi-year functioning. With regard to the rights and competences there has been a long-lasting debate on that whether for the advocates a new state authority should be developed or the current softer structure should be maintained.

Best practice: the Advocate Foundation for Patient Rights and the formulation of the Health Care Act

⁶¹ See 38/ 2002. (4th July) Parliamentary resolution.

⁶² See 1/ 2004. (5th January) decree of the Minister of Healthcare, Social and Family Affairs.
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As it was suggested above the policy-making in Hungary is mostly dominated by the central governmental and parliamentary actors, more precisely by the relevant ministries and the permanent parliamentary committees and parties. Generally speaking the civil segment struggling with different inner controversies and problems proved, however, to be quite neglected which in practice means that besides the scientific experts the representatives and interest groups of this political sector are usually able to enforce only partial interests, have incomplete results concerning the final political and legal outputs. Furthermore, even their participation is not fully realised. The relevant decisions in the field of health care are made by the above-mentioned central organs and the original plans and drafts of civic actors, patient and professional organisations usually soften or do not come to fruition at all. But this is not the case at all times because experts can identify such processes when real and serious participation of patient and professional interests realised in the face of the above-mentioned obstacles. According to the third stage, the approach of democratic experimentalism we can identify such a case in which the citizens do have capacities to contribute in decision-making. Embodying a best practice such process was the formulation of the 1997 law on health care, more precisely that part of the law that is about the patients' rights, patient involvement and representation. In this framing process mostly those experts contributed to the formulation who could be connected to the Advocate Foundation for Patient Rights. Our further part of the paper concentrates on the description and analysis of the role of this foundation and on the broad contours of the concerning law making.

In fact the institution of the advocates of patient rights and the codification of separate patient rights in the 1997 law on health care were as a direct result of civic activities and initiations. It started at the end of the 1980s and the beginning of the 1990s when doctors, professionals, researchers and university professors dealing with bioethics, patient rights and patient involvement tended to get acquainted with one other because they worked at separate places, different universities and hospitals in the country and did not really know one other. For a while they did not even recognized that they concentrates on the same developing discipline. In Central and Eastern Europe this research area, the bioethics has developed from the former university departments of Marxist-Leninist philosophy or social sciences. Later on they organised the first conference on medical and bioethical issues in Kecskemét. That was the time when it proved to be quite revolutionary to speak about patient rights and patient involvement in Hungary. In time the representatives of this professional and committed group were invited to different other events, workshops, conferences and lectures, especially for patient organisations. They also made efforts to express the importance of human element, the patient rights and the means of rights enforcement through their publications. The first relevant textbook on bioethics written by József Kovács was published in 1995. During their journeys they were able to gather experiences, collect information from different points and institutions of the country that helped them to get to know people and formulate later policy recommendations. Moreover this 'raising right consciousness' movement formed by several university professors, philosophers, lawyers, and doctors tended to come to know the foreign examples and experiences as well (Exter – Sándor 2002.). According to a contributing expert, Judit Sándor's writing "the first support for reforms in the doctor-patient relationship at the dawn of the political transition came from U. S. scholars, mainly from the New York-based Hastings Center. It was in 1989 that lawyers, medical doctors and bioethicists met for first time at the so-called East-West bioethics talks in Pécs (Hungary) and in Dubrovnik (that time Yugoslavia, now Croatia). These conversations acted as catalysts in launching the rights revolution movement in those countries. (...) Later the first Central European Bioethics Association was also founded in Pécs." (Exter – Sándor 2002. iv.)

It was that period when they searched for models to be applicable in the changing Hungarian conditions. Amongst the different effects the US proved to be more important and more impressive for these experts than the contemporary European examples. Some of them received US scholarships, and several books and studies concerning patients' rights and patient representation. So according to the finding of the article cited already above: "patients' rights in the various health laws of Central and Eastern Europe were inspired by the Anglo-Saxon school of legal theory. This not only included a simple expression of rights, but also provided effective means for rights enforcement through legislation." (Exter – Sándor 2002. iv.) The US influences could therefore gain ground in Hungary because the relevant documents of the Council of Europe (Convention on Human Rights and Biomedicine, Ovideo, 1996) was still at the preparatory stage. But in 1993 the aforementioned movement invited a well-known Dutch expert as well who visited many institutions and gave several lectures in the country.

On the grounds of their activity doctors, bio-medicals, sociologists, lawyers and advisors on biomedicine established the Advocate Foundation for Patient Rights in 1994. Here the example was the Swedish-model. Its major aim was to examine the relevant legislation, the ruling practice, and after collecting data to formulate policy recommendations, help to make experiments in order to find new solutions and institutional mechanisms. The Foundation also aimed to cooperate with both domestic and foreign patients' rights organisations and tried to inform the press and publicity about the necessity of patients' rights and related and current health care issues. (Civil szervezetek 2000.) It set up a Consultation Centre for Patients' Rights granting legal assistance to injured and defenceless people.

As already mentioned above it was a mercy that the first relevant university textbook was published in 1995 because that was the time when the formulation of the new law on health care begun in the Ministry for Welfare and the coordinating official invited the well-known experts of bioethics in Hungary to take part in the labour of the different working groups and write professional studies, policy recommendations concerning the possible future legal regulations and institutions. The 1994 governmental programme aimed the adoption of separate laws on patients' rights and health care (Török 1999.) but in time these legislative goals linked up. Furthermore, in the respect of the chapter on patients' rights the issue of patients' rights and the planned institution of advocates of patients' rights sonly combined. "This legal reform was implicitly based on two principles. One was to stress the new, autonomy based doctor-patient relationship. The second aim was to cover the areas of new technologies and development of the national healthcare system. As a result of these efforts a new, comprehensive act was produced by the participation of about 150 experts." (Sándor 2004.) More precisely, the first version of chapter focusing on patients' rights was written by these civic experts but this original draft paper softened later on although all of the parliamentary parties acted as defenders of patient interests at that time. With regard to the main outlines they could be succeeded but several modifications happened in comparison with the civic experts' original plans when the draft law was sent to other organisations in order to obtain their opinions on the text. The later amendments of the draft law could be identified in both parts on patients' rights and advocates and as a result the final output proved to be much more uncertain, and left space for different explanations. Correspondingly it was a crucial problem that these legal regulations were not direct products of an organic and internal development and had to be adopted in such conditions that were quite hostile and controversial. According to a contributing expert's opinion the patient shall be defenceless in order to pay under-table payments in a poor country's poor health care system.

Examining the possible causes of codification of patients' rights some other factors must be also taken into account besides the domestic experts' determinative role. The function

of international influences was not irrelevant at all: the professionals could cite all the corresponding international documents and proposals. At that time some lawyers tended to sue for damages and within the framework of these litigations the bad experiences of the Hungarian health care could come to the surface, too. The role of the press is also worth mentioning in this respect.

The members of foundations were several times accused in the middle of the 1990s that they wanted to enforce and realize only foreign examples and models in Hungary. That is why they intended to run a pilot project of advocates of patients' rights financially supported by the Soros Foundation at the turn of 1996/1997. The major aim was testing the possibility of patients' rights representation previously unknown in contemporary Hungary. (Sándor 2004.) They started to train volunteers, so the first advocates of patients' rights in January 1997 and employed lawyers and other experts. The project took place in five hospitals in both Budapest and the countryside and with few numbers of volunteers in 1997-1998. The project ran from March 1997 and officially finished in the summer of 1998. This first experimental project was followed later by another among the psychiatric patients in 1999. The first advocates firstly had to face a huge disapproval because the local management was afraid of that they would generate legal actions and investigate in cases of under table payments. In time the contributing institutions and workers generally welcomed them but a determinative problem was the lack of adequate infrastructure (room, telephone etc.). (Polecák 1999.) It was interesting that the pilot project revealed not only the conflicts among the doctors and patients but among the different health care workers. The contributing volunteers could be informed about different complaints according to different patients' rights as the table below shows it. It proved to be quite interesting that not only the patient and the relatives made complaints but the doctors and healthcare workers, too. Around 80% of complaints resulted in some kind of final solutions.

Complaints according to specific patients' rights (Sándor 2004. 66.)

Right to healthcare	222
Right to respect of human dignity	42
Right to maintaining contact with relatives	17
Right to leave the healthcare institution	23
Right to be informed	61
Right to self-determination	37
Right to refuse medical treatment	16
Right to access medical documentation	27
Right to medical secrecy	16
Right to privacy	17

The President of the Chamber of Physicians (later the Minister for Health) and others strongly and openly opposed the initiative because the physicians feared the possible loss of control over doctor-patient relationships. (Gyukits 2001.) The physicians' representatives were also afraid of that the doctors' rights would be pushed into background as granting effective rights to the patients. They argued there was lack of enough money and the Hungarian society was still not prepared for such an institution at that time.⁶³ It was also the lack of relevant information that made doctors unresponsive and dismissive. But the supporters could reason that the medical profession had paternalist traditions, was interested

⁶³ See: Fábíán: Betegjogok érvényesítése a gyakorlatban.

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in the system of under table payments and defenceless patients. According to this opinion the doctors neglected the patients' interests and preferred that the ethical issues were discussed within the framework of the former ethical committees of the Hungarian Chamber of Physicians.⁶⁴ After lengthy preparation, negotiations and debates the 1997 law on healthcare was finally enacted in December 1997. The law includes a relatively wide-ranging catalogue of patients' rights and declared the new institution of advocate of patients' rights. During the preparatory stage the Foundation proved to be quite successful but later on it lost ground.

The reform measures of the current government and the need for 'genetic' approach

From the middle of 2006 Ferenc Gyurcsány's second government took several measures in the system of health care in order to change its structures, mechanisms and attitudes generally. Their main goals were to create permanently the balance of the budget of HIF and to share responsibility with market actors. But these latest developments were quite disputable in terms of professionalism, were almost forced upon the relevant interest groups and different layers of the Hungarian society, and finally caused the fall of government in spring 2008. The reforms revealed the facts that there is a strong need to make changes in healthcare but there is also a robust demand to realize the effective participation of relevant social actors during the formulation of reform steps. It is quite important because their positions in policy-making have been debilitated, for example the former compulsory memberships of relevant chambers ceased. With regard to the final phase of the social learning process we can conclude that there is undoubtedly a need for the fourth, 'genetic' approach (Lenoble – Maeschalck 2007.) in Hungary.

Undoubtedly, in the first period the government was able to stabilize the revenues of HIF: with the help of aggravated laws the number of free-riders could be reduced to 400 thousands of people, many started to pay the compulsory subsidiaries. It could also successfully cut down the expenditures of the pharmaceutical sub-budget at the expense of these firms. The chronic patients must pay a minimal fee for their medicines as well which were free earlier. Besides these measures a new law made it easier to buy certain medicines out of the official pharmacies, so for example in stores or gas stations.

As a third pillar of reforms the government reduced hospital capacities and ranked the hospitals: some were able to provide the widest range of healthcare services, whilst others got lower classifications. In order to avoid cost explosion the minister determined a new ceiling of financing: it was 90% of the former reported activities. These measures resulted in serious savings on one hand but on the other hand the scores of hospitals ran up and the adaptation of waiting lists became even more often, too.

The fourth element was to increase the role of co-payment: in 2007 the government introduced the so-called visiting fee and daily allowance in hospitals for certain number of visit and days spent in inpatient services. Patients had to pay the former by visiting both general practitioners (primary care) and outpatient services. These fees were not so high (visiting fee by primary care was 300 HUF, 1,20 Euros) but both were voted down in 2008 referendum.

As another element the Health Insurance Supervisory Authority has been established with extended rights in order to protect patients' rights and take care about the operation and quality of health care institutions and service providers. To top them all, the government

⁶⁴ See: Blasszauer: Egészségügyi törvény – betegjogok.

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originally planned the creation of multi-insurance system including both private and state actors instead of the state-run HIF but this effort seems to fail due to political, professional and social resistance.

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