

# **REFGOV**

***Reflexive Governance in the Public Interest***

***Services of General Interest***

**Reflexive Governance and Health Policy  
The Case of Hungary**

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**Introduction**

Public sector restructuring has proved to be one of the most demanding tasks of post-communist transformation. This paper focuses on health reform in Hungary after the political changes of 1989-90. It is a widely shared political argument that the Hungarian health sector still awaits the introduction of serious reforms. We intend to demonstrate that the sector has already undergone a major transformation, while we also explore the political context of healthcare management, and argue that the legacy of post-communist political culture and the polarisation of the party system have considerably impeded the introduction of certain policy measures.

**Healthcare under Communism**

*Main features of the Communist system*

The communist systems of Central and Eastern Europe were characterised by centralised and concentrated state power. Therefore, the state played an exclusive role in most sectors in most countries. Health sector in communist Hungary was not an exception: services were managed, provided and financed by the state; health institutions were owned and run by the state.

Under the communist regime the codification of fundamental human and political rights rarely went beyond mere formalities, since principles of constitutionality and rule of law were not respected. Due to the lack of proper institutional mechanisms, the effective protection of rights was not guaranteed, and legal remedies were hardly provided for the violation of declared rights.

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. The act declared the equality before the law which had only limited practical effect. Despite labelled as “insurance”, health services were accessible to all citizens (i.e. universal coverage), and were freely provided to all patients at the point of use. However, citizens, in practice, were far from equal: both services available to them and the level of services provided to them showed great differences in light of informal connections, under-the-table payments, and gratuities.

The laws that regulated the sector did not incorporate the concept of patient rights, and they completely missed to address health ethical issues. In fact some emphasis on patient rights and ethical questions were only made in the 1980s, when university clinics began to respond to respective international legal developments. Yet, it was well after the change of system that such issues appeared on the political agenda.

The Constitution expressed the state obligation to protect “the workers’” good health by means of organisation and maintenance of medical treatment.<sup>1</sup> 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

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<sup>1</sup> §. 47., Act 20 of 1949 on the Constitution of the Hungarian People's Republic.

very much in line with the ideal type of ‘bureaucratic’ public interest governance (albeit the system was not built on democratic, representative government).

Decision-making and policy management in the health sector were thus centralised. Policies were often driven by ideological considerations as all fundamental questions were decided within the (communist) party leadership. State institutions were politically inferior, subordinated to the ruling party. Independent interest groups were mopped up, and replaced by centrally organised, politically controlled “social” organisations. Some of the organisations were formally engaged in policy formulation, but their role was not interest representation, but rather earning legitimacy to party decisions.

However, with political suppression easing, these organisations more and more provided umbrellas for alternative views, and channels of lobbying for central resources. At the same time, officially required behavioural patterns were supplemented, and often replaced, by unofficial values and informal rules. Since political leaders breached their own laws, they did not make serious efforts to enforce obedience with laws.

While problems in the management and operation of the health sector began to grow, and growing structural problems (inefficiencies, redundant capacities) became more and more apparent. By 1978 the Communist leadership practically 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 reforms. As an outcome, the regime began to tolerate some kind of market elements with private arrangements presenting a new form of service providing. From as early as the 1970s part-time private practices were permitted for specialists like dentists, dermatologists, urologists and gynaecologists. Corollary, a dual structure emerged where public services prevailed dominant in the sector, but private services also gained their share.

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 detached from the central budget, and it became the main source of financing the operation of healthcare institutions.<sup>2</sup> At the same time, restrictions on private provisions were eliminated; already existing private practitioners were recognised, and full time private entrepreneurship was legalised. Uniquely in the Communist region, these changes took place ahead of the political transformation, prior to free elections.

#### *The operation of the system of district physicians*

Under the Communist regime the standing laws of those times stipulated that only persons meeting the legal-professional requirements could operate as physicians. They were expected to be graduates of medicine, and they had to register themselves with the Ministry of Health. From the late 1950s, the legal provisions made a clear distinction between physicians with and without private practices.<sup>3</sup> Conditions of private practicing were very much restrained, and left hardly any room for other than working as public employees in public surgeries.

Physicians fit for the conditions of providing primary care were employed within the Soviet type (local) council system. These councils were not local decision-making bodies of politically autonomous local communities. On the contrary, they existed and operated as local branches of central state administration, and till the 1970s they had rather limited room for representing local interests.

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<sup>2</sup> 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.

<sup>3</sup> See 8/1959. Statutory rule and 8/1959. (31 December) Health ministerial decree on the medical system.

Physicians were obliged to control and serve the population of their given district, the boundaries of which were determined by higher level (parish and county) council organisations. The foundation of new districts was subject to consent by the Ministry.<sup>4</sup> Before the early 1970s it was the competence of superior council organs, after that local councils got the right to appoint doctors for the positions of district physicians. Parallel to that change, local councils were made responsible for organising medical care in their districts.<sup>5</sup> Thus councils could establish, reorganise and eliminate health institutions. That was also valid for those that the district physicians were assigned to. Such primary care centres remained in the hands of the state, but local councils became responsible for the supervision and maintenance of those units.

In the educational field it marked a significant development when general medicine was introduced as a separate qualification among those who graduated in medical sciences. Later general medicine became a firstly or secondly obtainable university degree. The detachment of this “specialisation” in education transformed the job of district physicians into a separate profession in Hungary. In the 1970s the system of vocational training emerged, and many elements prevailed for the new, democratic era as well. According to these regulations, physicians (male doctors until the age of 60, females until age 55) had to take part in centrally organised, two-week long boarding courses in every fourth/fifth year. These trainings were coordinated by the Institution of Medical Vocational Training. It was also specified 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 provided the district physicians with more elaborated compulsory tasks. Nevertheless, it remained a serious shortcoming that the institutional framework of medical supervision did not evolve. Disciplinary procedures for physicians were initially defined by the disciplinary council of the territorial hospital. Later, from the beginning of the 1970s, those procedures were dealt by the appointing organs. In the monitoring of legal regulations and deontology rules the Trade Union of Physicians and Health Workers played a rather limited role and exercised very weak rights. In 1972 the National Public Health and Epidemic Supervision came into existence. It was responsible for controlling the performance of the physicians’ public health and epidemic tasks. In order to accomplish its tasks effectively, strong rights, such as issuing resolutions, were allocated to the Supervision.<sup>6</sup>

Compared with developments in medical care, the financing of the public health sector fell behind the desirable degree. The Communist regime invested most resources into the development of war-related heavy industries. At first it ignored key issues and held back allocations from the fields of agriculture, light industry and public services, even though they could have served the people’s living standards much better. The share of these sectors only increased significantly later in the Kádár era. At the same time the number of persons incorporated into the compulsory social insurance system increased dynamically. That system of social insurance entitled the citizens for obtaining free medical care, hospital treatment and cheap medicines. Despite the rising number of physicians and the expansion of social insurance expenses, health expenditures fell far below the respective data of developed welfare states. The output of the system was also very sad in some areas: the health and mental condition of Hungarians got actually worse with particularly worrying figures on suicide, alcohol consumption and mental illness.

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<sup>4</sup> 42/1961. (22 November) Governmental decree on the allocation of certain health tasks to lower council organs.

<sup>5</sup> See Act 1 of 1971 on the councils and 11/1971. (31 March) Governmental decree on the implementation of Act of 1971 on the councils.

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

To sum up, the system of district physicians was characterised by top-down management, strongly regulated environment, which mostly relied on bureaucratic, hierarchical, strictly subordinated relations among the key actors. State employed district physicians could be posted to anywhere by the health minister to accomplish certain temporary tasks. Local councils could also command them to carry out such temporary tasks and to substitute other doctors missing from service providing. Once their contract of employment with local councils had entered into force seeking other employment opportunities was prohibited for the district physicians for one year.

The rigid system of medical districts and the lack of competition and/or performance measurement did not urge the physicians to improve their services. The system did not offer the right to freely choose a physician and it made district swap very difficult. On the other hand, formal legal regulations of symbolic-declarative functions did not have real practical relevance, and despite the extension of the social insurance system, the availability of free medical services for citizens was not granted for every one.

The difference between the capital city and the countryside was reduced, but did not disappear entirely. On the contrary, the number of physicians working in Budapest as compared with the number of inhabitants had significantly exceeded those in countryside. Therefore, in countryside medical care was less accessible, and especially in small, remote villages there was a shortage of doctors. In most cases only one doctor could take care of the inhabitants of several settlements leading to serious problems in terms of availability and replacements. Paradoxically, while the political regime declared itself to be based on full-scale egalitarianism, territorial differences along with the informal and rapidly expanding practice of under-table payments made serious differences in terms of patient opportunities.

Nearly complete nationalization and all-pervading paternalism resulted in medical paternalism within the health sector. That refers to the doctors' attitude of knowing the patients' interests better and deciding on the methods of medical attendance without patient involvement. At the same time, the representatives of the political regime generally mistrusted the physicians because their services did not produce any value from the perspective of the Communist ideology. The dual system of values and morality as well as political cynicism led to unwarranted (ab)use of the national health insurance scheme.

## **Legal and institutional framework after the system change**

At the time of the 1989-1990 political changes the structures of the party state dismantled, democratic institutions were established, and the principle of rule of law was incorporated into the Constitution. This complex process was hallmarked by the extension of a competitive multi-party system, the formulation of a new, pluralistic constitutional arrangement to replace the unified power structure of the Communist period, and the codification of fundamental human and political rights along with institutional guarantees. Nevertheless, in a completely renewed environment seeking solution to many problems was mostly delayed to after the 1990 parliamentary elections. As part of those reforms, the Soviet-type council system was replaced by a democratically elected but rather fragmented structure of local governments.<sup>7</sup>

Economic transformation means a transition from the formerly centralised state economy into a capitalist market economy. As in most transition countries, the Hungarian economic transformation was also accompanied by serious social tensions and difficulties.

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<sup>7</sup> Hungary, a country with ca. 10 million inhabitants, has nearly 3200 municipal governments.

For quite a few years the governments had to face major difficulties in managing the economic changes, while also tackling the emerging social crisis.

#### *Changes in the legal framework*

The 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 health. Since 1989, as a result of general amendments to the Constitution, the highest legal regulation has already declared the right of those people who live in territory of Hungary to the best possible physical and mental health. This provision is guaranteed by the state that translated this principle into practice mainly via arrangement by public health institutions and public medical care.<sup>8</sup> Thus, the standing Constitution of Hungary recognises the citizens' right to healthy environment, physical and mental health. It assigned responsibility for (public) social welfare and health care provisions to the national government. At the same time healthcare cannot be preserved as a state monopoly any longer, private practice may also offer services and operate as individual or collective enterprises. In 1990 it was also stipulated that natural and legal persons with the appropriate personal and material conditions could pursue health activities, establish and operate health institutions.

After the democratic parliamentary elections of 1990, the first four years in the health sector were devoted to restructuring. 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 were clearly separated and their relations are now typically settled by laws and contracts.

The first major change to the healthcare system was brought about by the act on municipal and county governments.<sup>9</sup> The former council system ceased to operate and new forms of local and territorial governments were established. With regard to their functions, the political decision-makers stipulated the performance of compulsory duties, while also provided the possibility of undertaking further tasks freely and voluntarily. The new legal regulation incorporated local provision of health care into the compulsory tasks of municipal governments. So the act put municipal governments in charge of organising basic healthcare services within their administrative boundaries. In return, they became the owners of—formerly state-run—primary care surgeries, polyclinics and hospitals. Gaining ownership rights 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 to local governments. In addition, some clinics and national institutes remained under the control of either the Ministry of Health or 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.

#### *The organisational structure and major actors of the health sector*

As opposed to the former Communist system, the new healthcare system divided responsibilities among various institutional actors. As a result of fundamental political-legal and institutional changes the formerly existing 'bureaucratic' form of public interest governance was replaced by a 'hybrid' form of governance. In the new 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.

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<sup>8</sup> Act 31 of 1989 on the amendment of the Constitution.

<sup>9</sup> Act 65 of 1990 on local governments.

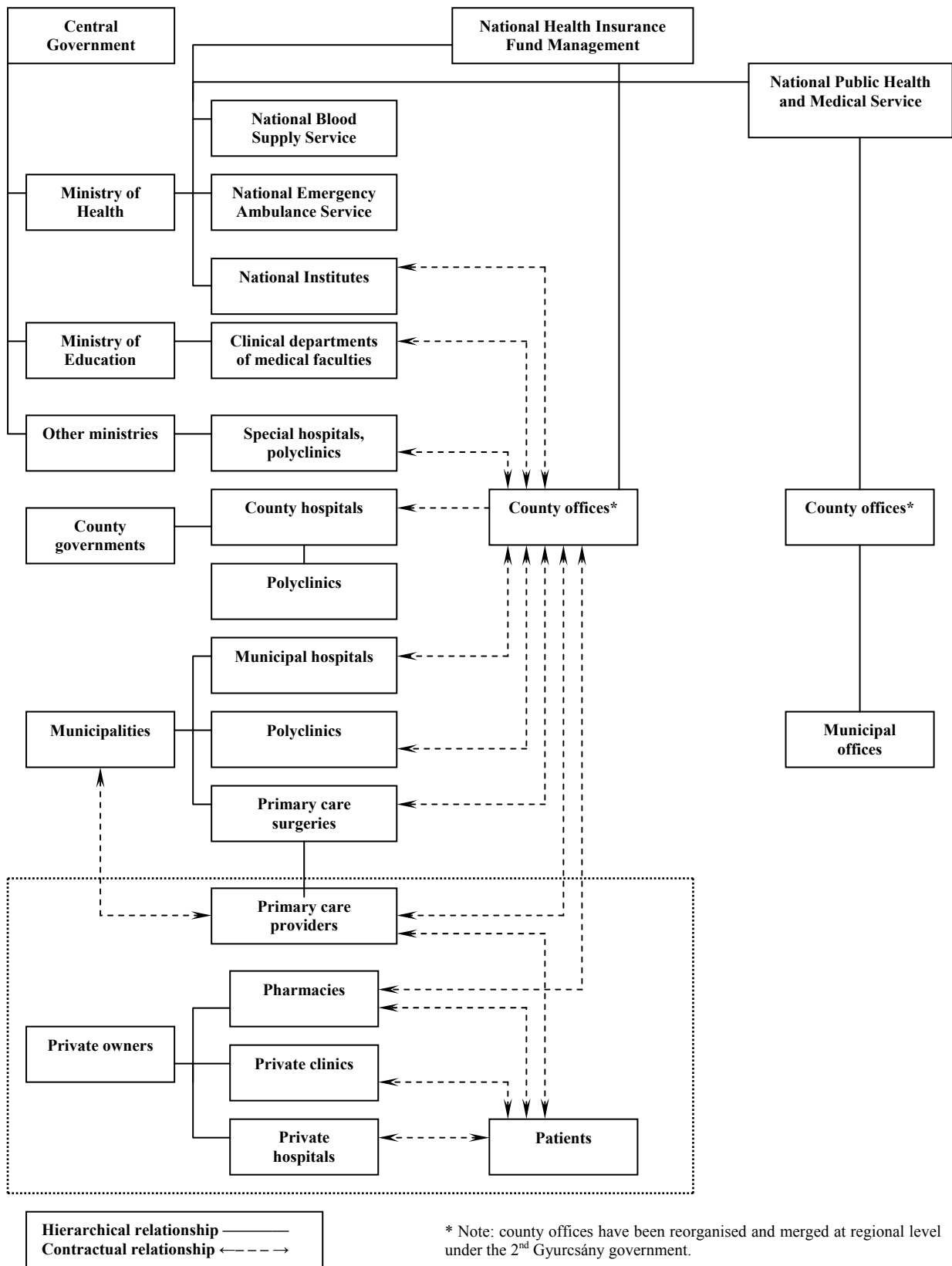
*Figure 1.* shows the chart of the organisational structure of the post-communist Hungarian health care system. The first column of stakeholders was grouped along the principle of ownership/management. In the second column we can find service providers. The third column includes those actors who finance 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.<sup>10</sup> 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 so-called "family doctors" (GPs). 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.

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



**Figure 1: The organisational chart of the Hungarian health care system<sup>11</sup>**



<sup>11</sup> Source: Gaál Péter: Health care systems in transition: Hungary. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004

While describing the main role of each actor in the following part of the paper, we continue— in line with our project requirements—to lay a special emphasis on functions that affect primary care and the operation of general practitioners.

### *The Hungarian Parliament*

According to the 1989 amendment of the Constitution, the main organ of state authority and representation is the Parliament. It enacts the Constitution, its amendments, and all acts; and it also approves the programme of the Government. Through these activities it develops the constitutional order of the society, determines the organisation, directions and necessary conditions of the governance. Whereas it is for the Parliament to pass the most important legal regulations and documents involving both the legal and political frameworks, it 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 (relative) majority. In contrast, any decision that would affect the competences of the municipal governments shall be approved by a qualified (2/3<sup>rd</sup>) majority in Parliament.

The Hungarian Parliament can be classified as a “working parliament”. It is characterised by a relatively strong committee system. The orientation, the working field of these organs corresponds mainly to the governmental institutions and their compositions correspond to the actual parliamentary power relations. These committees sometimes offer considerably more room for the MPs to attract support for their policy ideas and proposals than the Assembly. Based on policy oriented cooperation between governmental and opposition MPs it can easily occur that such experts of their own fields do not follow party discipline or give up the logic of *ab ovo* opposition. Moreover, either governmental-opposition cooperation at committee level or the influence of respectful governmental MPs in the committees often leads to modifications to governmental proposals. The typical pattern of coalition governments further increases the possibility of such changes.

In 1990 the Social, Family and Health Committee was founded as a standing committee to replace the formerly existing Social and Health Committee. In the parliamentary terms that followed the competences and tasks of the Committee usually changed in line with the modifications to its name. From 1994 to 2002 it worked again under the name of Social and Health Committee, while in 2002 the health area was detached and a separate Health Committee was set up. The roles of the committee include decision formulation, and keeping contact with governmental apparatus, partner organisations and other experts. It also exercises control and monitors governmental activities in the given policy field. In short, this structure means that the most important policy decisions certainly go through the committee which offers opportunities to represent and to enforce different conceptual ideas and purposes in the form 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 framing of health policy has been the ministry in charge of the health portfolio. Between 1990 and 1998 it was the Ministry of Public Welfare, between 1998 and 2002 it was the separate Ministry of Health, between 2002 and 2004 it was the Ministry of Health, Social and Family Affairs, and after 2004 it has been the Ministry of Health again. The minister's main tasks include the following: 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 classified other resorts to the tasks such as the realisation 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 both the formulation of the most important policy decisions and the conduction of related negotiations belong to the ministry.

Regarding the system of general practitioners it is very important that the ministry deals with the physicians' so-called basic register that includes personal data on persons who had successfully graduated as doctors. The collection of those data can also be initiated at personal request, after which the ministry shall issue a certification of the registration stating that the person concerned is entitled to get a medical stamp of her/his own.<sup>12</sup>

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.

The minister shall, *inter alia* entrust the members of the Council for Health Professional Training and Further Education from the persons proposed by health institutions of higher education, professional chambers, representative professional organisations and colleges. This official body shall deal in particular with the higher education and further education of health sciences and its tasks mostly include the formulation of decisions, putting proposals, and expression of opinions. Regarding the system of primary care it plays a great part in the assessment of compulsory further education programmes.<sup>13</sup>

In line with the respective ministerial decree, special professional bodies had to be established with rights of giving opinions and making proposals in each health care field. These organs shall support and confirm the decisions of ministerial leaders and apparatus with considerable experience and knowledge. The Professional College of General Practitioners dealing with primary health care also functions as a preparatory and decision implementing body, and it also plays a role in monitoring. The members are elected indirectly, by a special electoral body, which represents several professional, scientific and educational institutions. Only those persons can be elected for four years who had graduated as doctors, had themselves registered in the basic register, show outstanding personal performance, and has irreproachable past. In the past decade the tasks of the college were extended to a considerable degree: at first it used to express its opinion on professional conceptions, educational, financial, supervision questions, and drafts of methodology procedures. Since the end of the 1990s it has got the right to formulate such proposals and drafts. The opportunities

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<sup>12</sup> See 30/1999. (16 July) Health ministerial decree on the basic and operational registers of physicians, dentists, pharmacists and hospital physiologists, and on the permission of the registered persons. The existence of the medical stamp is very important because it authorises the physician to subscribe medicines and therapeutic equipments. See 20/1991. (5 November) Public Welfare ministerial decree on the medical stamps.

<sup>13</sup> 10/1998. (11 November) Health ministerial decree on the organisation and operation of the Council for Health Professional Training and Further Education.

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 whereas it mostly left the minister's subordination and its operation was assigned to the tasks of the Hungarian Medical Chamber. In 2004 the college was declared to be the minister's professional organ again.<sup>14</sup> The relevant legal regulations have enabled to establish special working groups at professional colleges. Nowadays this college on primary care works with 23 members and has a special paediatricians' working group. In addition to 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.

In addition to 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.<sup>15</sup> The Prime Minister's Office 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 capacity<sup>16</sup> 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.<sup>17</sup>

#### *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.

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<sup>14</sup> 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.

<sup>15</sup> 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 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.

<sup>16</sup> 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.

<sup>17</sup> While health policy is the responsibility of the Ministry of Health, the macroeconomic implications are the concerns of 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.

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 it, inter alia, 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 shall be licensed by the NPHOS which registers the granted permissions. Furthermore a 1996 law has ordered that every health care service shall have an operating licence that is issued by the NPHOS upon request.<sup>18</sup> The preconditions for issuing operating licence (or temporary authorisation to operate if necessary) shall be conditional on the necessary staff and technical facilities that are controlled in surgeries by inspectors both before and after publishing. The issued operating licences are registered by the National Officer’s Office, one of the leading bodies of NPHOS.<sup>19</sup> To its professional supervising-controlling functions effective rights have been attached by the legal regulations, such as 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 entitled to restrict or even suspend certain doctor’s activity, too. It also has an important role in capacity-planning: local governments may only decide on reducing capacities if their decisions meet the approval of the local/regional chief medical officer.

The NPHOS is organised very hierarchically on town, regional and national levels. Its medical inspectors, who are excellent experts and well-informed persons on certain medical fields, work on the basis of a specified, annually updated working plan. In the framework of their investigations they shall monitor the observation of legal regulations and other managing documents, and the existence of the necessary staff and technical conditions. They shall also look after the practical realisation of the general practitioners’ gate-keeping role. The arrangement of availability and duty shall be controlled as well. About their experiences they usually inform both the leader and maintainer of the institution investigated and so do they to their superior organs, too. The work is assisted by the National Centre for Inspector Methodology. This institution has contacts with the professional colleges, and gives the methodological direction for the NPHOS inspectors.<sup>20</sup> Summing up the NPHOS plays a great part in the permission of operating licences and in the execution of continuous monitoring and supervision regarding primary care.

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.

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<sup>18</sup> Act 63 of 1996 on the territorial care obligation and on the territorial financial provisions.

<sup>19</sup> 2/2004. (17 November) Health ministerial decree.

<sup>20</sup> 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.

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 from 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 an important part in the coordination of execution, monitoring the processes, and being of assistance to general practitioners' activities. It shall also undertake the relevant evaluating works, expression of professional opinions, and putting forward proposals. Its working plan is specified by the Ministry annually and it shall give an account of the performance of tasks prescribed to the Ministry, too.

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.<sup>21</sup> 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 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.<sup>22</sup>

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.<sup>23</sup> 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 under a contract between a central administrator and the operator of a local GP system. 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 a local government, an association of local governments, health institution, medical entrepreneurs etc. So the HIF and its organs play a predominant role in conclusion of finance contracts and in the remittance of amounts granted either by the Parliament or by the cabinet in the past decade.

### *Local governments*

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<sup>21</sup> 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.

<sup>22</sup> Tax rebates were introduced in 1995.

<sup>23</sup> Act 72 of 1995 on the 1995 additional budget of Hungary.

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. They try to adjust the tasks and competences of the adequate level of territorial governments in line with the needs arising *sur place*. At the same time these tasks and competences have not been matched by sufficient resources. It has made the whole situation even worse that the relating law on self-governments can only be amended by the MP's two-thirds majority.<sup>24</sup> The municipal governments (the district governments in Budapest) are one of the most important actors of health policy on local level. These governments have very broad competences including infrastructure development, primary and secondary education 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. There has been a significant change in this field since the beginning of the 2000s. Since 2001 the local governments have not got the compulsory task to ensure that different licensing conditions for medical care are met the requirements imposed by the competent authority. Furthermore 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 discharge their obligation by contracting with any 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.<sup>25</sup> 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) plays an important role in formulation of health policy in Hungary. This organisation was established in 1989<sup>26</sup> but its detailed tasks, competences, and structures started to outline only in the middle of the 1990s. Pursuant to the relevant 1994 law the HMC is the doctors' professional public body with self-

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<sup>24</sup> See Act 65 of 1990 on local governments.

<sup>25</sup> Church hospitals are the few marked exceptions.

<sup>26</sup> Act 57 of 1989 on the amendment of Act 2 of 1972 on the health care.

government and representation of interests. Its main feature was the compulsory membership for those who would like to do any kind of activity requiring medical diploma in the country (physicians and dentists).<sup>27</sup> In the past years member of HMC could be a person who

- 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 the HMC also has the right to be consulted on various medical issues. It has got several additional rights such as agreement, expression of opinion, putting proposal, participation etc. Regarding the system of general practitioners its main tasks and rights are the followings:

- it in particular deals with a registration of its members (registration was a precondition for medical work in Hungary),
- it has been issuing certificates for applicants since 1999 that certifies that the person concerned 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 expressing opinions mostly when health issues are being decided. In addition it plays part in designing professional training and further education requirements, the investigation of professional competence in case of employment, and in the establishment of standard contractual clauses between municipal governments and general practitioners. By the formulation of contractual clauses between the HIF and physicians the HMC has veto power. With respect to its organisation the HMC is represented at settlement (capital city district) – county (capital city) – national levels. It has set up a special section for primary care in order to ensure that the functions are performed more effectively. It is subject to legal supervision which is provided by the minister and the court. In cases of issuing operating licence and official certificate legal remedy is available in respect of decision of the HMC.<sup>28</sup> The Chamber issues a code of ethics for medical activities, and has the right address persons who do not comply with its provisions.

Following a similar pattern, the Hungarian Chamber of Pharmacists and the Chamber of Non-medical Health Professionals were also established.<sup>29</sup>

In addition to 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 included in the list of social associations and then they are able to express their opinions about draft laws in preparation. But their formal rights involve only the opportunity of expressing opinions, formulation of criticism, and preparation of possible own proposals. In respect of these organisations there is for instance the National Alliance for General Practitioners Practising in Villages and Small Settlements organised by clear geographical features.

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<sup>27</sup> This constellation has been changed to some extent whereas the Gyurcsány government abolished the compulsory membership of the professional chambers in 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 in policy-making.

<sup>28</sup> Act 28 of 1994 on the Hungarian Medical Chamber.

<sup>29</sup> In 1994 and 2003, respectively.



## Patient choice and preferences

### *Healthcare financing 1990-2006*

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.<sup>30</sup> 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.<sup>31</sup> 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.<sup>32</sup> 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).<sup>33</sup>

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.<sup>34</sup> 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.

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<sup>30</sup> E.g. for the maintenance of their office; ad hoc visits by patients registered with other family doctors; territorial allowances.

<sup>31</sup> Should the fund be smaller than required, the number of points would mean proportionally less money in each service category.

<sup>32</sup> The basis of calculation: the hospital’s budget (1992) divided by the performance of the given hospital (1992).

<sup>33</sup> 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.

<sup>34</sup> The Act on Pharmacies permitted and set the conditions of the privatisation of pharmacies. Nearly 100% of the pharmacies were privatised.

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 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 services<sup>35</sup> 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 reduced<sup>36</sup> 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

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<sup>35</sup> A year later tooth-preserving treatments and services were again incorporated into the Fund coverage.

<sup>36</sup> 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 1/20<sup>th</sup> of all insured). The first assessments suggested that the model operated successfully<sup>37</sup>; 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.<sup>38</sup> 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.<sup>39</sup>

### *Delayed reforms*

After the change in government in 2002, the new government decided to suspend the implementation of the ‘Mikola Act’.<sup>40</sup> 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 and/or other employees for which subsidised loans were to be offered. However, the Act did

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<sup>37</sup> In the districts of the pilot projects doctors earned more, patients experienced more attention and better care, and the consumption of medicines decreased significantly.

<sup>38</sup> 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.

<sup>39</sup> This ban affects roughly half of all hospitals that are owned by county and municipality governments.

<sup>40</sup> The new minister argued that the Ministry would prepare an entirely new law within a few months.

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.<sup>41</sup>

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 (1/5<sup>th</sup> 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 services in contractual relationship with the Fund. In secondary outpatient care many

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<sup>41</sup> 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.

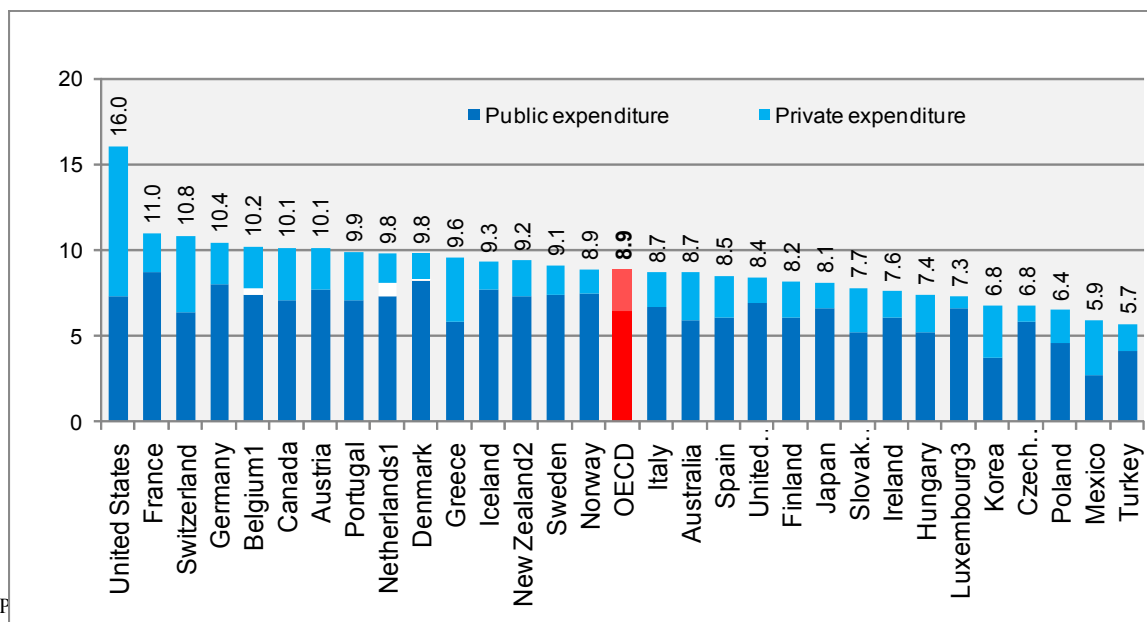
specialists have private practices and clients besides their public employment. Yet, in both specialised outpatient and inpatient care the role of private providers remained very limited.<sup>42</sup>

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*

Hungary spends less than 7.5% of her GDP on healthcare. By international comparison (Figure 2.) this is well below the OECD average, but is mostly in line with the other Visegrád countries.

**Figure 2.: Health spending in % of GDP (2007)<sup>43</sup>**



1. P  
3. Health expenditure is for the insured population rather than resident population.

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

<sup>42</sup> Less than 10 of the ca. 150 public hospitals have been privatised (‘functional privatisation’), and just a few were returned to the Churches.

<sup>43</sup> Source: OECD Health Data 2009, OECD (<http://www.oecd.org/health/healthdata>)

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.<sup>44</sup> 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 (2/3<sup>rd</sup>), 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 (1/3<sup>rd</sup>) and general practitioners (2/3<sup>rd</sup>). The detailed description and analysis of the latter are in following subchapter.

The outpatient specialist care, diagnostics and dialysis partake around 20% and nearly 2/3<sup>rd</sup> 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.

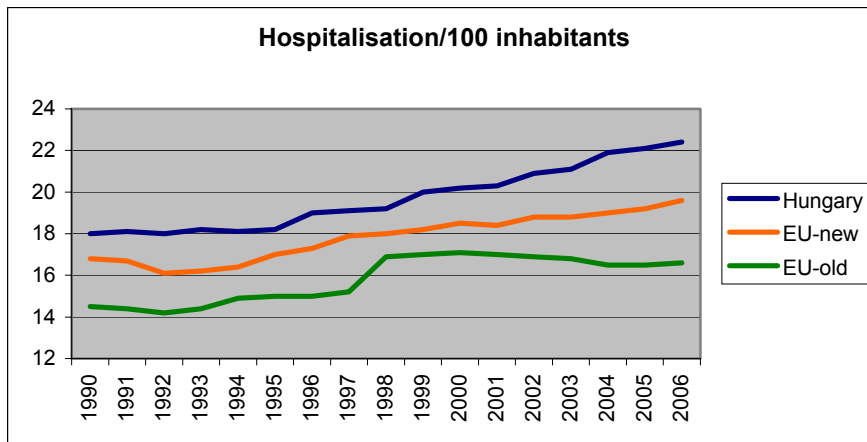
In the sector of financing acute and chronic inpatient services a performance-based payment mechanism has been introduced. Here the already mentioned Homogenous Disease Groups (quasi DRG) system has been applied for acute care and rehabilitation cases with the exception of high-cost interventions which 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 (Figure 3.), which is twice as high as the

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<sup>44</sup> Doctors' salaries are also distorted by under-table payments and gratuities, too.

EU average. Furthermore they often spend these days with different medical examinations and cares only on paper which phenomenon is the misinformation of the HIF.

**Figure 3.: Hospitalisation in Hungary and other EU member states**



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 specified firstly, in a very detailed way that under what professional and educational conditions the profession shall be exercisable. As a basic principle the decree has declared that the general practitioner shall have a general medical diploma, and in addition he shall meet further requirements. Whereas 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 meet the standardized conditions. Until that date those persons, who had another qualifications (mostly internists) could be the part of the system and those physicians, too, who had been already working for some time. But since the beginning of 1999 only those doctors who have successfully received either the general medicine or the internist qualification may act as

general practitioners. In the latter case there is another requirement: at least ten years practising is needed. Only those persons could maintain their positions who have been continuously working for at least 25 years irrespective of their qualifications. Those doctors, who practiced in the end of 1998, were authorized to get temporary operating licence if they had still five years to the legal retirement age.

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

The legal regulations enacted after the political changeover has made a clear distinction between general practitioners according to whether they undertake and perform 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 perform the tasks of primary care for the population of around 6800 districts of which boundaries are 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 meet the necessary preconditions, undertake the primary care of a certain number of registered people, the HIF shall conduct financial contracts. In contradiction to them a minority of general practitioners has not got obligation of territorial care: in this case they can work either in economic companies or as private physicians and beyond a certain number of patients the practice shall be also financed by the HIF.

#### *What general practitioners do*

Pursuant to the relevant 4/2000. (25 Feb.) Health ministerial decree replacing the mentioned 6/1992. decree, the general practitioners' main tasks are to perform 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 care of the registered patients and those people who are although not registered and accepted but are endangered by worsening health status. In addition, 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. Furthermore they contribute in antenatal care, execution of public health-epidemiological tasks, health education and information, medical expert<sup>45</sup>, and

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



coroner works. Under the contract conducted with the local government they can participate in local duty service.<sup>46</sup>

In contradiction to the above listed tasks there is no other legally binding document that 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. It is in fact a list of activities that have not been a legal regulation yet but it represents the highest limit of the general practitioners' work. It includes, however, a special range of cases. Firstly those ones are enumerated which are expected from a physician to solve alone. The second type is when a specialist is needed, too, and for the third element they are definitely not responsible, these diagnoses are out of the general practitioners' competence right after the identification.

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 financing the 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 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 ill actually. In addition the whole medical work can be characterised by a special standby situation regardless to the fact that do ill come or not. Another option is the quota system determined by the certain number of registered persons. But as a natural consequence of this latter is that it does not stipulate doctors to increase their personal performance: general practitioners are interested in registration of as many people as possible, but not in their real care. In Hungary this quota system has developed right after the earlier structures of basic financing of district physicians' system, so it has not really changed on the whole. But it is corrected by certain indicators of achievements and performances in a way.

The main elements of the finance 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 number of population does not exceed either 800 or 400 in case of children.<sup>47</sup> 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 perform the tasks of primary care freely for the local insured persons. In the remuneration several other elements play an important role, 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 in relation to the local nature, and traffic payment. In addition, fix amounting prize has been initiated since 1993 which depends on the number of local population, age-groups, and the technical 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

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<sup>46</sup> 4/2000. (25 Feb.) Health ministerial decree on the general practitioners', paediatricians' and dentists' activity.

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

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. In addition, territorial complementary allowance could be also paid which could have been appointed as a traffic support. In establishment of a new district it is possible to conduct a financial contract if the number of persons was above the specified 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 request 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 specified that in case of obligation of territorial care a financial contract shall be conducted if it covers minimally 1200-1500 adults, 600 children.<sup>48</sup> 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 performance of certain medical care programmes.<sup>49</sup> 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.<sup>50</sup> The calculation changes if either a specialist-applicant or a specialist is employed.

The practical functioning of 'practice right', the development of permanently vacant medical districts brought on the correction of its financial dimension, so an additional finance had to come into existence. Pursuant to a 2005 governmental decree the finance of these districts, where the local governments can discharge their care obligation only through deputyship over a year, goes on with increased monthly prize, if the number of local population exceeded 1200 persons.<sup>51</sup> In this case the deputy physicians become public employees of the NIPC, and in addition they are able to complete their necessary educational practices.

The financial decrees usually mention the matters of financial contract in a very detailed way. They include such questions that with which health services, under which conditions a contract shall be signed. They also contain those data that shall 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 payments paid out monthly that 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 performed 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 necessary 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

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<sup>48</sup> 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.

<sup>49</sup> 238/1996. (26 December) Governmental decree on the amendment of 103/1995. (25 Aug.) Governmental decree on the certain questions of social insurance finance of health care.

<sup>50</sup> 13/1998. (30 January) Governmental decree on the amendment of 103/1995. (25 Aug.) Governmental decree on the certain questions of social insurance finance of health care.

<sup>51</sup> See 104/2005. (11 June) Governmental decree.

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 companies. These new forms of medical care shall have own surgeries with own equipments, and employ workers if it is possible.

#### *Quality control*

Pursuant to the relevant 4/2000. ministerial decree the quality control is one of performing general practitioners' tasks but their technical supervision is provided by the NPHOS organs. As it has earlier emerged the NPHOS regularly monitors the activities 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 the questions of finance. But its controllers may investigate only as a result of complaint. They look after those cases, too, when a general practitioner reports to the HIF both unrealistic claims of money and medicines, and nearly unimaginable number of patients.

#### *Further education*

In this field the main features have remained since the change of political system. At first, pursuant to a 1998 ministerial decree both compulsory and facultative further educational programmes shall be organised that aim to keep up knowledge acquired in the university and professional training, and to gain new skills related to recent developments. The completion of courses is compulsory every five years.<sup>52</sup> The new 1999 ministerial decree linked 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 educational courses during the five years long time of operating licence. Per year only 100 credits can be officially accepted. At least 50 credits shall be fulfilled through completion 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 development of credits is made by the Council for Health Professional Training and Further Education.<sup>53</sup>

The 2003 ministerial decree has brought significant changes in comparison with the earlier. It has differentiated three types of courses which can be completed 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 they then shall 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 shall be under supervision. The credit values are integrating parts of the decree. They are specified by the council's competent committee on the previous proposals from the professional college.<sup>54</sup>

## **Citizens' participation and representation in healthcare management**

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<sup>52</sup> 11/1998. (11 December) Health ministerial decree on the higher educational health professional training and further education.

<sup>53</sup> 73/1999. (25 December) Health ministerial decree on the physicians', dentists', pharmacists', and hospital psychologists' continuous further education.

<sup>54</sup> 52/2003. (22 August) Health, Social and Family Protection ministerial decree on the physicians', dentists', pharmacists', and hospital psychologists' continuous further education.

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 enabled citizens to establish democratic and civic associations. Under this law 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. Therefore they can be divided 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.<sup>55</sup>

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 whereas 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. This approach often professed that consultations must be carried out only with the

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<sup>55</sup> This latter category of organisations is described and analysed in a subsequent chapter examining the best practices.

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 is 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. In addition to 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 moreover 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 do not really know 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. Pursuant 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 “[P]atients 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.*"<sup>56</sup> 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 that guarantee the representation of patient organisations and interests and by means 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. Pursuant to the 1997 law on health care 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 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.<sup>57</sup> These groups are determined by the Council itself and it examines them once every two years. The 10 patient deputies are chosen from the candidates of the registered national patient organisations on the basis 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.<sup>58</sup> 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 may request 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 shall 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 1<sup>st</sup> January 2005. Although their denomination may imply 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

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<sup>56</sup> Declaration on the Promotion of Patients' Rights in Europe (Amsterdam, March 1994). 5. 2.

<http://infodoc.inserm.fr/ethique/Ethique.nsf/0/901e922bf0f1db42c12566ac00493be8?OpenDocument>

<sup>57</sup> 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.

<sup>58</sup> See act 154 of 1997 on healthcare. 148-149 §. 229/1998. (30<sup>th</sup> December) Governmental decree on the task, structure and functioning of the National Health Council.

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.<sup>59</sup>

#### *The Supervisory Councils and ethics committees*

As it was already mentioned above several service-providers had to establish supervisory councils that also yields some ground for patient participation and representation. These bodies have been functioning since 1<sup>st</sup> January 1999 and operating in those hospitals that shall 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 monitor 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 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. Again as in the case of the supervisory councils they have been functioning since 1<sup>st</sup> January 1999. They have got 5-11 members invited by the management. Here the main task is to issue attitudes on ethical questions and by means of this activity they can also contribute to the enforcement of patient rights at local level, in certain institutions. The ethics committees meet 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 shall 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 in addition to physician members local patient associations can also delegate one person to each committee.

Finally, the so-called Health Care Roundtable is another, more political formation that also ensures patient participation. The Roundtable was established in May 2004 and has one founding member who represents patient organisations. The Roundtable is Partly a civic construction, partly an opposition initiative. The incumbent cabinet does not regard it as a legitimate initiative, so the coalition parties in power have not joined the forum. That is why it is generally considered to be an opposition organisation against the policies, ideas and goals of the cabinet, and this is why its policy influence does not go beyond marginality. The Roundtable mostly deals with conceptual questions, organises theoretical debates and it has developed an alternative health care programme. According to the participating patient representative, it is really that kind of organisation in Hungary whose members take the patients and patient organisations seriously. But as a matter of fact other patient leaders can tell us quite dissimilar opinions about the role and functioning of this Roundtable.

#### *The advocates of patient rights*

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<sup>59</sup> See act 154 of 1997 on healthcare. 149/A-E. §.

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 performing 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 patient rights. These advocates shall know and understand both the healthcare workers' and patients' interests. Pursuant 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 shall 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 time limit specified (Sándor 2004.).

During the formulation of law there was debate about 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 a special 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 next idea was the establishment of a separate office within the ministry but that also failed.

Although the law came into force on 1<sup>st</sup> July 1998, the new institution of advocates began to operate much later, on 1<sup>st</sup> January 2000 due to robust professional resistance. Around 58 advocates started to work in 2000, so—compared with the number of service providing institutions—they were quite a few in numbers. The experts involved in the project 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 31<sup>st</sup> 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 there was a significant change in 2002 when a parliamentary resolution after the parliamentary elections aimed the establishment of an independent system of advocates.<sup>60</sup> 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).<sup>61</sup> Furthermore it means that besides the employment the professional supervision and management have also been allocated to this Public Endowment. Pursuant 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

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<sup>60</sup> See 38/ 2002. (4<sup>th</sup> July) Parliamentary resolution.

<sup>61</sup> See 1/ 2004. (5<sup>th</sup> January) decree of the Minister of Healthcare, Social and Family Affairs.



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 shall be available at all service providers, so at the ca. 40 thousands existing altogether in the country. As a direct consequence it 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 is to be developed or the current softer structure is to be maintained.

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

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 in addition to the scientific experts the representatives and interest groups of this political sector may usually 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 effective 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 specifically that part of the law that is about the patients' rights, patient involvement and representation. In this framing process mostly those experts who could be connected to the Advocate Foundation for Patient Rights contributed to the formulation. The further part of the paper concentrates on the description and analysis of the role of this foundation and on the broad contours of the related 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 some time they did not even recognize that they concentrated 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 patient rights organisations and tried to inform the press and publicity about the necessity of patient rights and related and current health care issues. (Civil szervezetek 2000.) It set up a Consultation Centre for Patient Rights granting legal assistance to the 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 began in the Ministry for Welfare. The coordinator 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 on 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 rights and the planned institution of advocates of patients' rights only 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. There were significant changes after the draft law was sent to other organisations in order to obtain their opinions on the text. The later amendments 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 in addition to the domestic experts' significant role. The international influences were 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 only wanted to enforce and realize 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 that was previously unknown in Hungary. (Sándor 2004.) They employed lawyers and other experts, started to train volunteers, so the first advocates of patients' rights could begin work in January 1997. 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 institutions and workers involved generally welcomed them but a significant 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 patient rights as the table below shows it. It was quite interesting that not only the patient and the relatives made complaints but so did the doctors and healthcare workers, too. Around 80% of complaints resulted in some kind of final solutions.

#### **Complaints by type of patient 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 that there was lack of enough money and the Hungarian society was still not prepared for such an institution at that time.<sup>62</sup> 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 in the system of under-table payments and defenceless patients. They judged the doctors to neglect the patients' interests and prefer the ethical issues to be discussed within the framework of the former ethical committees of the Hungarian Chamber of Physicians.<sup>63</sup> After lengthy preparation, negotiations and debates the 1997 law on health care was finally enacted in December 1997. The act 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.

### **Recent reform measures and the need for a 'genetic' approach**

From the middle of 2006 the second Gyurcsány government introduced several measures into the system of health care in order to change the actors' attitudes and the sector's structures and mechanisms. The main goal was to create a balanced health budget without the allocation of additional resources. 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 (Dózsa 2008.). The "reform dictatorship" resulted in serious political conflicts, which finally culminated in the collapse of the government coalition in spring 2008. The reforms revealed a strong need for changes in healthcare and a considerable demand for an effective participation of relevant social actors in the process of policy formulation. With regard to the final phase of the social learning process we claim that the lack of a 'genetic' approach (Lenoble-Maeschalck 2007.) in policy-making has also reduced support for the introduced measures and contributed to the failure of policy management.

#### *Unhealthy health culture*

The most recent Health Report (Egészségjelentés, 2010) has demonstrated again the generally very poor health condition of the Hungarian population. Prevention budget in 2008 was only one-third of that of 2001. Partly for that reasons, partly for the very unhealthy way of life, indicators for serious illnesses in Hungary show generally 20-70% higher figures than the average of the other three Visegrád countries.<sup>64</sup> While Hungary does not spend less on health than the other V4 countries, life expectancy figures are lagging behind that of those countries (Figure 4.).

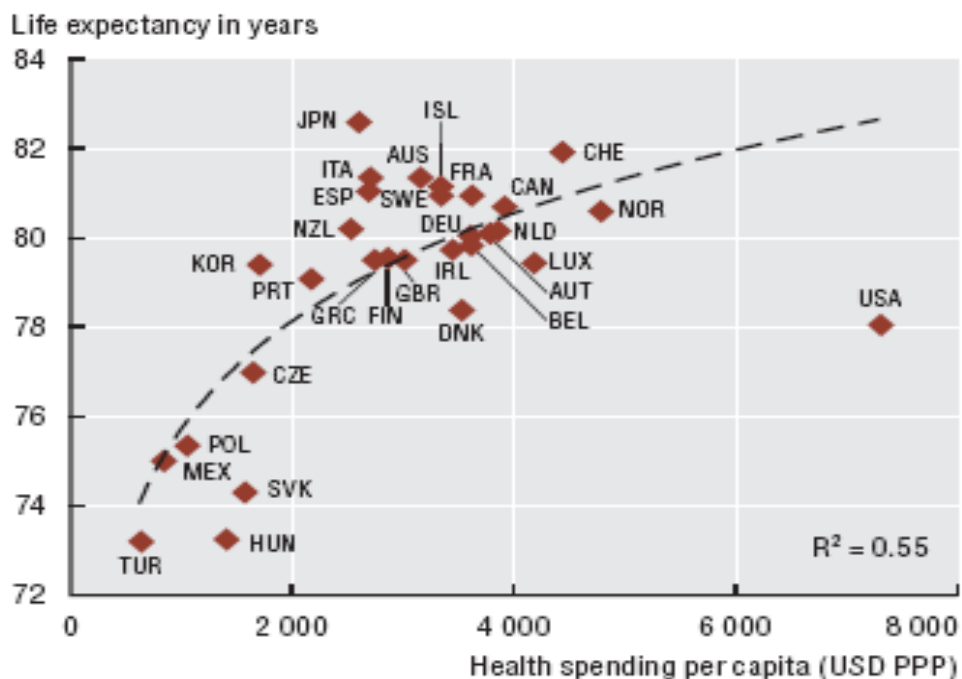
#### **Figure 4.: Spending and life expectancy(2007 or latest)<sup>65</sup>**

<sup>62</sup> See: Fábán: Betegjogok érvényesítése a gyakorlatban.

<sup>63</sup> See: Blasszauer: Egészségügyi törvény – betegjogok.

<sup>64</sup> The only exception is the proportion of those suffering from depression. Their the Hungarian figure stands at exactly 100% of the V3 average.

<sup>65</sup> Source: OECD Health Data 2009, OECD (<http://www.oecd.org/health/healthdata>)



Although expected lifetime has continued to increase in Hungary too, the difference compared with the V3 average (minus 2 years) did not change in the past 20 years. Mortality rate among the 50+ male population are particularly high, and indicators for health-related mortality causes also higher by 20-100% than the respective figures of V3 average. The situation pictured in the health report resembles the main findings of the Green Book (Zöld könyv, 2006) that had been published under the auspices of the Prime Minister's Office in 2006, and served as a reference to legitimise the reform measures introduced by the first health minister of the second Gyurcsány government.

#### *Policy measures*

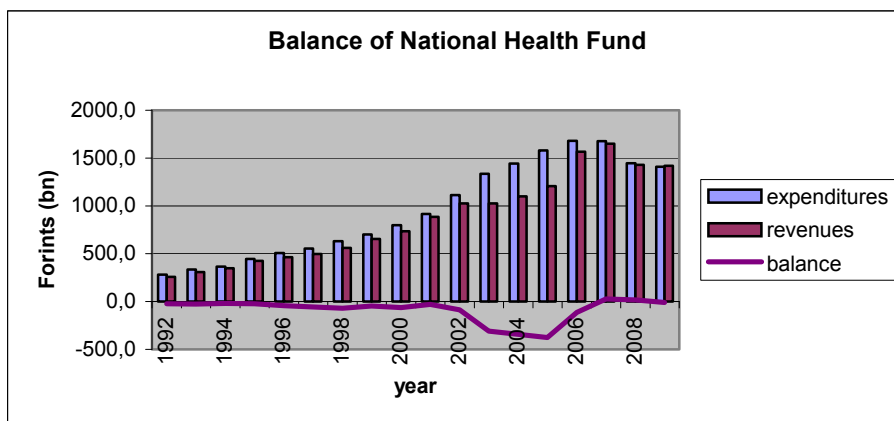
Among the first measures of the reform package, the governing majority decided to replace formerly compulsory membership in the professional chambers with voluntary membership. Since the elimination of compulsory membership was not supported by proper policy arguments, this act can only be seen as political retaliation. The leadership of the chamber of medical doctors had been rather critical of health policy under the first Gyurcsány government, and did not support the ideas of the newcomer minister Lajos Molnár either. By ending compulsory membership the minister could expect to weaken the organisation and the influence of the chambers. Another component of the first steps was the liberalisation of the pharmacy system. That measure allowed the sale of certain drugs and medicines outside the pharmacies (e.g. at supermarkets and petrol stations).

The objective of balancing the health budget was addressed by a set of measures. They included a stricter policy on free-riders (that brought in new contributors into the health insurance system) as well as a decision to redesign the number and structure of hospital capacities. The government divided the hospitals into different categories: some were obliged to provide the broadest range of health services, while others got lower level classifications with limited services (Mihályi-Molnár 2007). As an outcome hospital capacities were reduced by partly closing down redundant hospital beds, and by partly transforming them into beds for social services. Patients were obliged to use the facilities and services of the designated

(nearest) hospitals. In order to avoid cost explosion, the government continued to control spending on inpatient services by extending the scope and validity of the performance volume limit. At the same time, the minister introduced a new ceiling on financing that was defined to stand at 95% of formerly reported activities (Sinkó 2008.).

Besides cutting expenditures, the government also made efforts to raise additional revenues. The so-called solidarity tax imposed on pharmaceutical companies generated additional revenues was a significant step in controlling the sub-budget of medicines. These measures indeed brought the health budget into balance (Figure 5.), but—as a side effect—the hospitals generated serious debts, and long waiting lists became unavoidable in most surgical areas.

**Figure 5.: Central revenues and expenditures in Hungary**



Nevertheless, the introduction of various forms of co-payment proved to be the politically most sensitive issue. Chronic patients were compelled to pay a minimal fee for their medicines that had earlier been free of charge for them. More importantly, the government introduced the payment requirement of the so-called visiting fee and daily allowance in hospitals that were to be paid after the number of visits paid to general practitioners and outpatient specialists, and after the number of days spent in hospitals. Although the fees were not too high (ca. EUR 1 per visit), the issue became the symbol of health reform and target of political attacks by the opposition. It became the subject of a referendum initiated by Fidesz, the main opposition party.

The referendum initiative was successful, the vote was valid and produced an overwhelming majority in favour of the opposition's position. Thus the government had to back down from the idea of co-payment, and the internal tension within the cabinet led to the collapse of the coalition. The referendum also put a definite end to the most ambitious reform idea of the government. The Ministry had originally planned to create a multi-insurance system that would have incorporated private actors into the management of the decentralised insurance funds. After the referendum of 2008, the government decided to withdraw the Act on health insurance funds. The only element that remained in place was the Health Insurance Supervisory Authority. However, in lack of a privatised insurance system the role of the Authority remained limited.

In the new political situation, the health reforms were practically stopped and one year ahead of the parliamentary elections the government decided to consolidate the hospital sector and to lift up the performance volume control. The former ceiling of financing was abolished and a new control mechanism was introduced. In the new system the Health Fund pays only 70% of the values of the services of the previous year, while the remaining sum are shared among the service-providers according to their actual performance. On top that withdrawal,

the government also pushed another legislation through parliament: it has practically abolished the system of managed care, although the government had earlier envisaged the expansion of the system to the entire territory of the country (Baraczka-Mihályi 2009.).

### *Impact of party politics*

It is evident from the above-mentioned development that party politics in Hungary has strongly interfered with policy formulation and considerably reduced the policy options of decision makers. Between 1998 and 2006 the Hungarian party system went under a remarkable level of concentration resulting in the emergence of a quasi bipartisan structure. The logic of bipartisan competition produced total opposition to government measures and led to U-turns in policies, and the expulsion of party members dissenting from the official party lines. Referendum became a political means of blocking government initiatives, governmental policies. Public values suggest prevailing sentiments towards security, free services, and state intervention. On the other hand, there remains a considerable fear of uncertainty, and the strong emotional motivations with the legacy of communist values and culture (Gallai 2009) serve as hotbed of populism.

Private capital investments are held back by unsuccessful experience with hospital privatisation. Two legislation attempts failed that had been initiated to regulate the conditions of hospital privatisation. Strong public sentiments against private capital in hospitals had been demonstrated in an invalid referendum in 2004, which—despite the lower than required turnout—produced a convincing majority against privatisation. Moreover, early birds that were brave enough to enter into the management of hospitals in forms of functional privatisation deals seem to struggle with financial difficulties. New deals are not about new private actors; on the contrary, municipal governments started to get back most of the few functionally privatised hospitals. It is also for electoral considerations that despite being called health *insurance* system, it actually provides nearly universal access that leaves the “basic package” (of services) undefined. Politics thus made a major impact in policies among which co-payment became the victim of the so-called “social referendum”. Managed care became the victim of the multi-insurance initiative, while the multi-insurance initiative itself became the victim of coalition politics and the premier’s struggle for political survival.

### *Conclusion*

Transformation in the health sector has separated purchasers from providers and financiers. The regulatory regimes and the monitoring and supervisory bodies are mostly in place. Nevertheless, the operation of health institutions is tainted by cultural patterns and mechanisms. Citizens’ fears and reservations, vague regulation of services granted, low respect for regulations, dual structure of formal and informal, legal and illegal practices), and incentives against further transformation remain to present a problem for policy makers.

In terms of financing, bureaucratic macro-management seems to be the most effective way of controlling public expenditures. Administrative measures, command and control approaches can indeed cut back expenditures and offset the existing system of state-capture. On the other hand, such interventions usually lead to the underfinancing of certain services and institutions, which again provokes the actors to see semi-legal or illegal ways of revenue generation.

The opposition was able to block governmental policies by using popular referendums so successfully that the government had to give up the most significant reform initiatives. The political task of the opposition was facilitated by incumbent professional interests against any restructuring. Based on that experience, the governments can either adopt a stop and go policy line, which usually leads to inconsistent policies and management, or they can also opt for reform “dictatorship”, which increases the possibility of political failure. All in all, policy

options of health management have considerably been reduced by party and electoral politics, and this may also limit the room of manoeuvre of a new government that is expected to take power after the elections of April 2010.



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