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Structural and financial changes in the Hungarian health services

The third millennium is only a few years away from now. We honor the hope and ambition that by the years following the turn of century Hungary will be a modern nation which will have been integrated organically into the community of European countries.

Intertwined with world economy, a competitive national economy that will be based on private ownership, individual initiatives, a socially concerned market and solidarity will have provided the grounds for social security and a rising standard of living for the majority of the population. The mechanisms to decrease the regional and social inequities will have been well established.

The prerequisites to achieve the objectives include the need for improvements in the population's health status, for the government to handle health promotion as a strategic objective and to organize society's co-operation for developing better health from a public health perspective.

The urgently needed modernization of the health care system is part of the economic and social transformation and reform.

The reform's major directions were outlined by the Government's Health Care Program approved during the fall of 1994. While relying and building on the government's program, this document elaborates the objectives and means which are necessary for the modernization of the health care system. The reform also aims at bringing the nation's health care services closer to the European norms within the limits set by the social and economic conditions.

The Hungarian population's health status has been gradually declining since the middle of the sixties with a tragic increase seen especially in the mortality of the active age groups and decrease in life expectancy at birth. The health status and mortality patterns of various socially determined population groups are getting increasingly different. As a consequence of the high overall mortality and low birth-rates the number of the population is steadily and increasingly diminishing. The age

distribution of the population is unfavorable, and the number of dependent disabled people is growing considerably.

The crisis of the Hungarian health care system, similarly to other areas of the economy, is primarily of a structural nature, and is pushed to the limits by the worsening economic environment. However, even in times of economic recovery, it would be of little help to try to solve the crisis if the issue of fundamental transformation and restructuring of the institutional system is not addressed. The structural reform is the most difficult task since, in addition to affecting a substantial part of the population, it forces the providers and almost the entire health care community to accomplish an existential change.

The "price explosion" seen in the field of health care, the increasing costs of diagnostic and therapeutic developments together with a level of financing that has failed to keep up even with the rate of inflation and the stagnant institutional system, which is due to the government's restrictive economic stabilization package and the reform within the public sector, may set uncontrollable processes in motion, if the institutional system and structure are left unchanged. In other words, the collapse of the whole institutional system has become a real danger.

The health care system operates appropriately if it meets the following requirements:

⇒ each and everyone can have access to the basic package of services of guaranteed quality, in the frames of mandatory insurance based on the solidarity principle;

⇒ the service structure is tailored to the real health care needs and 'consumer' demands and it follows the morbidity and demographic changes flexibly;

⇒ the efficiency and effectiveness of procedures and interventions are appropriate;

⇒ there is visibility in service structure, in the possibilities of accessing the services and in spending public funds;

⇒ the health services are run in a system that is financially affordable;

⇒ the efficiency of resources spent on health care is improving.

Due consideration has to be given to realities when planning the restructuring of the system and when designing our vision of the future. Of specific importance will be the considerable gap between the economic potential and the demands from the health sector in the medium run. Furthermore, no change for the best of socio-economic factors that sustain negative public health trends can be expected within a reasonable period of time.

The dramatically deteriorating health of the population and the tensions within the health sector justify that the government must handle the case of health as a strategic objective. In order to modify the current situation, a public health approach and health promotion will need to be decisive elements of public policies that are equally important as economic considerations. As a result of the interdepartmental co-ordination efforts of the National Public Health Committee, the different sectors are increasingly taking into consideration the public health impacts in taking measures, issuing decrees or drafting new pieces of legislation. In the years to come, the responsibilities and duties in public health that all actors including the government, the local governments, NGOs and the public (the individual) need to bear, will become more and more clearly defined.

The State Public Health and Medical Officer Service (SPHMO) will continue to play a special role within the health sector in the field of prevention and public health organization. However, a significant portion of the expected measures will go beyond the limits of the public health services, as it exists today. The Ministry of Welfare's interests support a strong and efficient State Public Health and Medical Officer Service.

The teaching of hygiene and healthy life-styles will be included and assigned growing importance in school curricula. The written and electronic media will assume a bigger role to favorable influence a shift in life-styles. In line with the strategies of the National Public Health Committee and the Mental Health Project Office one of the major thrusts is directed at controlling addictive disorders, alcohol and drug abuse, and decreasing smoking.

Screening systems based on cost-benefit analysis will be introduced which can be efficiently operated using the health insurers' *'bonus-malus'* point system. The bonus system will enhance the utilization of screening and the choice of healthy lifestyles in order to increase the individuals' responsibility for their own health.

It has become clear by now, though difficult for the people to accept, that despite the obligatory social insurance contribution which is rather large by international comparison, the National Health Insurance Fund Administration is unable to purchase services unrestrictedly. As subsidies are decreasing, drug prices are increasing, dental services are not free any longer, one must pay for care in sanatoriums or for sports and occupational health services.

In the upcoming years the transformation of the institutional system will speed up extraordinarily. Although important steps will be taken already within 1-2 years, an institutional system that would be best suited to the demographic and morbidity patterns and based on a variety of forms of ownership and structures can only be developed by the turn of the century at best.

The unity of the institutional system operating in different organizational structures and frequently in new forms (e.g. group practice) is secured by the strict and modern requirements of operating conditions and the quality control mechanism involving all levels of services.

The quality control policies harmonize the elements of control by the profession with those by the insurer (payer) or by the owner (local government), and ensure that minimum service protocols and good practice guidelines are prepared, implemented and enforced.

The priority development of primary health care will continue. The current number of medical practices is 6,700, which will increase to 7,500 - 8,000 within three or four years. Thus the target of 1,200 - 1,300 population per physician can be met, which already makes efficient preventive work possible. The decrease in the list-size will not entail a decline in the income level of the family physician practices; in fact, shifts in reimbursement arrangements are expected to lead to better quality performance and better equipped practices. In order to establish new family physician clinics and create new practices, local governments will need government resources, whereas family doctors working as private contractors will need to have access to preferential loan arrangements. Therefore, the speed of the process is dependent upon the potential of the national economy.

In the field of speciality care, the modernization program will result in the creation of a state-of-the-art network of institutions that is smaller and effective, but more efficient than the current one. In order to ensure safe

provision of services and due to close interrelationships, the reorganization of hospital facilities must be taken into consideration during the modernization of outpatient care.

The direction of the development, enhanced by reimbursement and control arrangements, too, is to enable independent outpatient polyclinics and ambulatory hospital departments to provide definitive care for a widening range of health problems. In many areas preparations are being made to provide 'one-day surgery'.

The number of active hospital beds will decrease at least by 20% in a few years, primarily as a result of reconstructing sites or complete institutions. The capacities freed up this way will substitute for the missing social care network and a wide network of nursing homes and rehabilitation facilities will develop.

Services that meet needs by demographic and morbidity patterns will take shape at an increasing pace during the next three to five years. Beside chronic long-term care hospital departments, clinical nursing units and nursing homes will also appear in the Hungarian health care system, together with the presently almost entirely unknown hospices that provide the most humane care for terminally ill patients. In connection with this process home nursing services will also appear and expand.

In order to promote the professional foundations for the structural change in speciality care and hospital care, a document will be prepared in which the amount and geographical location, by the population's real needs, of expensive diagnostic and therapeutic equipment (MRI, CAT scanning, radiotherapy machines, etc.) will be determined.

As a new tool of decision making the scientifically valid assessment and evaluation of procedures, which are already applied or about to be introduced, will be initiated and carried out continuously, with the aim of making sure that the funds available for health care of the population yield the greatest possible benefit in terms of their health status.

In health care financing, the principle of performance measurement will be maintained, with additional normative principles to enhance the provision of better quality and more visible services well adapted to actual needs, thus making economic management more foreseeable and accountable. With the increasing decentralization of financing, the negotiations to iron out conflicts of interests will get closer to the actual

points of service. The arrangements for supervision by the funding agency will strengthen, in harmony with professional control.

The transformation of health services and the attainment of health policy objectives are supported by more unified and flexible legislation. A new and unified Health Care Act is accepted by the parliament, in line with the new act on the rights of patients and the act on health insurance. The new legislation harmonize Hungary's legal system with that of Europe.

THE POPULATION'S HEALTH STATUS

It is the population's health status, which is created and modified as a result of the societal, economic and social factors, that determines directly the actions to be taken by the health sector and the directions to be followed by the restructuring process.

The health status of Hungary's population has been extremely poor for decades now and unfortunately, continues to exhibits signs of further deterioration. The situation is especially bad if one is to apply the World Health Organization's definition of health, which includes mental and social welfare in addition to physical well-being.

Hungary's population has been declining since the early eighties. This trend can be explained by two factors taken together, a) the decreasing number of live births (148,673 in 1980 compared with only 117,033 in 1993) and b) the simultaneously increasing trend of overall mortality (145,355 in 1980 compared with 150,244 in 1993). In 1993, Hungary reached the lowest point ever in terms of live births, the number of deaths and the resulting natural decrease.

While in the first decade of our century those under thirty accounted for over 60% of the population, in 1994 their portion was only 40.6%. During the same period of time, the proportion of those in the 40-59-year age-group grew considerably (from 18.7% to 26.0%), and the number of those aged sixty and over increased 2.5-times.

Besides aging, the very high age-adjusted mortality rates of the population groups of active age are the most important problems. As a consequence life expectancy at birth is declining for males, while for females it remains practically stagnant. While in 1992 in Europe the overall life expectancy at birth was 75.6 years, in Hungary the life expectancy at birth was 73.8 years for females and 64.5 years for males in 1993. The

differences in life expectancy between Western European countries and the newly independent states in Eastern and Central Europe are characteristic, to the disadvantage of the latter group. In respect of these rather important figures Hungary slipped back to the bottom of the list even among the former communist countries.

Almost 90% of the overall mortality can be ascribed to five groups of diseases: almost 50% of the deaths is caused by cardio-vascular diseases, 22% is due to malignant neoplasms, 9% to violence (including suicide), and 4% is caused by chronic lung disease and cirrhosis of the liver respectively.

Since 1980-1981, Hungary has been ranking first among 50 countries in terms of mortality due to neoplasms. There has been an 8-10-times increase in mortality due to certain types of cancer (in 1970 Hungary and Austria were in an almost similar situation in terms of cancer mortality).

Suicide has special significance in Hungary, as until the last year the country ranked first in the world in terms of self-inflicted death. Although there was a slight decrease in the total number of suicide cases (from 4,809 in 1980 to 3,694 in 1993), the high incidence of suicide in the 15 - 39 year age group and the differences between the Western and the Eastern part of the country still give cause for concern.

Although decreasing significantly from 35.9 in 1970 to 12.5% in 1993, infant mortality is still considerably higher than the European rates of 5-8 per 1,000. The major underlying cause of the difference is the large number of premature births.

The mental health condition and individual lifestyles of the population, especially of the young individuals, are extremely unfavorable. The strong interrelationship between unhealthy lifestyles that are primarily determined by socio-economic factors, and the mortality pattern is obvious.

Patterns of alcohol consumption are influenced by both social and economic stress. The per capita alcohol consumption is still 11.6 liters (in absolute alcohol) in Hungary, with not only the amount of alcohol consumed, but also its composition being harmful to health.

According to traditional cooking and eating habits, nutrition is unhealthy in Hungary. The Hungarian diet is characterized by a high level of fat, carbo-hydrate and protein content, a result of which 23% of Hungarian males and 31% of Hungarian females are overweight. The components of

nutrients are inappropriate: 36% of the energy intake comes from fat and foodstuffs with too high cholesterol levels are eaten. Current price policies do not help healthier nutrition to be come more widespread.

Smoking plays an outstanding role in shaping the Hungarian mortality pattern: almost 40% of the deaths can be related to this harmful, though seemingly relaxing habit. The trend showing a significant increase in the number of smokers at the time when a substantial decrease characterized Europe gives cause for concern. One third of the adult population smokes cigarettes and every second of them can be regarded as a heavy smoker. Although the proportion of smokers decreases together with age, it would not be appropriate to conclude that this would be the result of an increasing rate of quitting. Any attempt at data analysis must take mortality figures into consideration, and within them, the fact that the mortality rate of smokers are very high.

The use of psychoactive drugs has increased in Hungary. For a few years Hungary was a transit country in terms of drug trafficking, today it is a destination.

The tasks and operational conditions of the health care delivery system are defined jointly by all the economic, legal, social welfare and health factors listed above. It is under these conditions that a transformation has to be implemented in the structure of health services, such that it meets the real needs of the population better, serves health promotion and the possibilities of restoring health for the sick better and utilizes the scarce resources more efficiently.

THE PRESENT SITUATION OF HEALTH CARE

THE STRUCTURE OF THE SYSTEM OF SERVICES

From the 1870s, sickness benefit funds were created one after the other, providing free medical care for part of the population. Fund members were also entitled to free drugs and sick pay. However, even by the interwar years, less than one third of the population was covered by insurance.

In the wake of the construction of hospitals on a mass scale in the second half of the 19th century, a network of hospitals modern even by European standards was created. Even despite the standstill caused by the First World War and the following economic crisis, it was up to the general standard of the age.

The socialist state - following mainly the Soviet and British models - extended full and free health services, including outpatient specialist care and hospital care, to the overwhelming majority of the population. Together with all its limitations, this step was of epoch-making significance both for public hygiene and for the operation and development of the institutions.

Nationalization, which affected both health care and the insurers, fundamentally changed the nature of the health care system. The earlier mixed system, which provided permissive and insurance-based care, was replaced by an entirely new, national health care system. The institutions passed into state ownership and operating them also became the task of the state.

The state-financed health service system was able to meet only to a limited extent the increased demands which arose in part from the health status of the population and in part from the unrestricted access. As a result, extensive development based on the demands was begun, at first converting buildings originally intended for other purposes into health care institutes and later building new hospitals and polyclinics.

While we caught up with and even overtook the economically more developed European countries as regards the indicator of beds per 10,000 population, the differences grew in other areas such as the medical technology available in the hospitals, the standard of accommodation services and the infrastructure.

The network of hospitals and outpatient specialist clinics, which was far larger than necessary but not sufficiently efficient, was less and less able to meet the professional and economic challenges of the age. Attempts were made to bridge the growing functional disorders with organizational solutions. Creation of the system of progressive care and later integration aimed at making fuller use of the professional and economic possibilities, helped to overcome the most serious difficulties for a while, but could not serve as a substitute for the far-reaching changes needed.

The integration created the organizational frames for the coordinated operation of primary and outpatient specialized care and of hospital care. In addition to the advantages deriving from the combined financial management, it also achieved practical forms of professional co-operation among the different levels of care. With the establishment of

the network of supervisory senior consultant doctors, a new and uniform type of professional guidance and supervision was created.

Preparation of the reforms aimed at the comprehensive reorganization of the health care and social services system began in the early to mid-eighties and by the second half of the decade was approaching realization. The reform was designed to be all-inclusive and was adapted to the processes of transformation that had begun in other areas of society. In the course of the reform the introduction of performance-based financing was to be the first step since it had long been clear that the given structure could no longer be financed from the available sources with an unchanged funding system.

The program consisted of a more or less consistent system composed of interlinking steps that supposed and supplemented each other, the most important of which were the transformation of the inpatient care structure, the restriction of capacities and the increase of performance and throughput capacity. This must be accompanied by an improvement in the equipment, diagnostic and therapeutic possibilities of the institutes, a higher standard of accommodation services and creation of a suitable infrastructure.

Inpatient care on a smaller scale but more efficient called for professionally and technically reinforced specialized outpatient care and a reorganized district medical (family doctor) system. The family doctors would be required to provide full, continuous and definitive care, including also prevention, for a specified part of the population.

These stages in the program also represented the logical order for their implementation. The planned schedule and manner of implementation would have made it possible to carry out the manpower movements accompanying the restriction of capacities without endangering livelihoods on a serious scale; to strengthen specialist outpatient care professionally; to expand the family doctor system and improve its standard.

The change of political regime in 1990 brought a change in the manner of implementation of the planned reforms, disrupting the logical system that had been decided. The family doctor and family pediatric system was introduced without providing all the conditions needed, and later the switch to performance-based financing in inpatient and specialized outpatient care was also made without adequate preparation.