

HEALTH BASKET

Work Package 2: Benefits Report HUNGARY



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I. OVERVIEW OF BENEFIT BASKET

According to the provided questionnaire, the following concepts have been identified and defined for the purpose of the research:

- Benefit basket (or benefit package),
- Benefit catalogue (or benefit list),
- health services and goods,
- public/statutory schemes.

While the definitions used within the framework of this study provide relatively clear boundaries for the concepts, there are still some ambiguities which are worth to discuss:

1. According to the Observatory glossary the definition of ‘Benefit package’ includes “advantages in money”. This is in contradiction with our ‘Benefit basket’ definition, which considers only health services and goods. Cash benefits, such as sick pay, should not be considered health care benefits, rather income replacement, as they are not included in health expenditures either.
2. The key element of our ‘Benefit basket’ definition is that the majority of funding comes from general government and/or social security funds. However, the Observatory’s core definition of ‘Benefit package’ rather places emphasis on the entitlements on the basis of “meeting particular criteria”. This issue should be revisited, since there could be services, which are financed from private sources, but still people are entitled to them by meeting particular criteria and not by contributing to it financially.¹ A good example of this is occupational health services, which have to be financed by employers in Hungary.
3. The criterion of ‘majority of public financing’ also raises the question whether we are talking about the benefit basket as a whole, or the criterion also applies to individual items in the basket. This question is particularly relevant for pharmaceuticals in Hungary, as in general the co-payment for subsidized medicines in the outpatient setting is as high as 50% of the consumer price. It is clear that products or services that are not covered by public/statutory schemes at all are excluded from the benefit basket, but what is the extent of subsidy (or co-payment) where the border of inclusion (exclusion) lies? In this respect another interesting phenomenon (widespread in former communist countries) is informal payments for health care, which are a form of out-of-pocket payments, usually made by patients to health care staff for services, which they are entitled to receive free of charge. Similar questions can be raised regarding services, which are declared to be excluded from the benefit package, but the fee for the service that patients has to pay is

¹ I assume that “meeting particular criteria” in the core definition means criteria other than ‘making direct financial contribution’.

set centrally, and that does not cover production costs. A good example of this is detoxifying of drunk people.

4. If the above question is answered then it is relatively easy to distinguish between partial and total inclusion. However, it is less clear what we mean by implicit and explicit inclusion (exclusion). If implicit is defined as “not written down” the question still arises whether or not the degree of service specification (from “all necessary” to “items”) matters in this respect. Eventually a benefit basket is defined as “health services and goods covered under public/statutory schemes” and the less explicit specifications of “all necessary services”, or broad functional categories, such as “primary care”, by definition, do not specify service items, i.e. which services are included is in fact not written down.
5. It is not clear whether or not the concept of ‘benefit catalogue’ implies higher explicitness (as it is said on p.9: “documents, which provide a definition of benefits beyond a short and general description of benefits”), and if yes then where the border between the “short and general description” and the description which goes beyond this lies. This also raises the question whether a benefit catalogue can be a negative list (i.e. exclusions are specified), or a benefit catalogue is by definition a positive list (i.e. inclusions are specified). In any case a negative list has to be accompanied with a statement on that all other services are included, to regard it as a benefit catalogue, since parts of the not explicitly excluded services can still be excluded implicitly, if other regulations provide a more explicit specification of what is included in the benefit package (this is the case for instance with the payment catalogues in Hungary).

I.1. REGULATION OF ENTITLEMENTS IN HUNGARY

Although it is not required to provide a detailed description of the Hungarian health care system, to understand how the components of the present system of entitlements evolved, it is worth to introduce health sector reforms and the main features of the system.

I.1.A. OVERVIEW OF THE HUNGARIAN HEALTH CARE SYSTEM

By the end of the 1980's, Hungary witnessed the beginning of a large scale health care reform. The uniform model of the highly centralized, integrated health services which were characterized by the overwhelming dominance of the state in both the financing and the delivery of services (the so-called state-socialist, Semashko system) was abolished. Replacing the tax based financing of the state-socialist system, as one of the first countries in the Central and Eastern European region, Hungary reverted to the earlier Bismarckian model of compulsory social insurance in 1990, established the Health Insurance Fund (HIF) in 1992 and its administration (NHIFA) in 1993. Ownership of the majority of hospitals and other health care facilities were transferred to local governments, and new, performance based

provider payment methods were put in place. Primary care providers are capitated, outpatient specialist services are paid for by fee-for-service, but with a national budget ceiling, and from the 1st of July 1993 hospitals are paid for acute inpatient services on the basis of the Hungarian adaptation of the Diagnosis Related Groups (DRGs). Chronic care and some expensive tertiary care services are reimbursed differently, on a per diem basis and by fee per case, respectively. The vast majority of medical doctors and other health workers remained salaried public employees, with the only exception of primary care. The minimum salary is determined on a pay scale according to qualifications and years of work experience, but the average salary in the health sector has remained among the lowest compared to other sectors of the economy.

I.1.B. PUBLIC/STATUTORY SCHEMES OF HEALTH CARE FINANCING

Since 1990 the main system of finance has been compulsory social insurance, which is complemented from general and local taxation. As a general rule the HIF covers only the recurrent costs of services. The owners of health care facilities, mainly local governments, are responsible for maintenance according to *Act CLIV of 1997 on Health*. They are obliged to cover the capital costs of services, which usually come from general and local taxation.

In addition to the HIF and national and local government taxes, private sources complement health care financing in the Hungarian health care system. These are almost exclusively out-of-pocket payments to pay health workers informally, to cover formal co-payment, or to utilize private health care services, which are not covered by the social health insurance scheme, since private for-profit and voluntary health insurance has not yet taken root in the system.

Social Insurance

Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services determines the rules of participation in the statutory health insurance scheme, and the entitlement for in-kind and cash benefits. Membership in the social health insurance scheme is compulsory for all citizens living in Hungary (that is, people with personal identification card) and opting out is not permitted. As a general rule, Hungarian ethnic minorities living in neighbouring countries are not entitled to health services in Hungary, but as of 1 January 2002, those who work in Hungary must participate in the social health insurance scheme.²

The population is divided into three groups:

1. employees,
2. population groups, who are covered, but do not have to contribute, including:
 - the dependants of group 1 and 3,

² *Act LXII of 2001 on the Hungarians, who Live in Neighbouring Countries* (promulgated: 7/7/2001).

- special groups — for instance pensioners, those who are on maternity leave, conscripts, the socially indigents — and their dependants,
3. all other inhabitants with personal identification card.

All three groups are entitled to health services, but only group 1 and 3 have to pay health insurance contribution. Foreigners who work in Hungary for a longer period are not obliged to participate, but may do so if they wish. Homeless persons are also covered if they register with the local government as socially indigent. As a result population coverage is virtually universal with less than 1% of the population not covered.

The health insurance contribution is split between employer and employee. The proportional contribution is universal and determined annually by the National Assembly. In 2004, the employer paid 11%, the employee 4% of their gross salary. Special rules apply to the self-employed, who must pay contribution according to the centrally determined minimum wage, and to small farmers, who can choose to pay only 11% of the actual minimum wage, but they are not entitled to cash benefits. By paying the full, 15% contribution, they can get full coverage, including cash benefits. Provisions for non-contributing groups are shared between the HIF and the government. Those who are on sickness and disability benefits should be covered by the Fund, while the government transfers the revenue from the so-called “health care contribution” to the Fund to compensate for the rest of group 2. This hypothecated tax was introduced in 1996, as a lump sum tax, which has had to be paid in addition to the social insurance contribution as of 1 January 1997.³ Later, it was complemented with a proportional, 11% tax, which has been levied since 1 January 1999 on those types of income, previously exempt from social insurance contribution.⁴ As a result, the employer and employee health insurance contribution and the health care contribution now constitute the two major revenue sources of the HIF.

The chronic problem of the HIF is that it has been in deficit since its inception. Successive governments of the past 10 years have targeted the revenue side of the social health insurance system, and only minor modifications have been implemented in the almost comprehensive benefit package. By and large, the benefit package is negatively defined and applies equally to all, who are covered by the social insurance scheme.

Tax-based financing

The second important source of health care financing is general and local taxation. Tax revenues are used for four main areas of financing:

1. The central government is obliged to cover the deficit of the HIF.⁵

³ *Act LXXXVIII of 1996 on Health Care Contribution and its executive order Government Decree No. 202/1996. (XII. 23.) Korm.*

⁴ *Act LXVI of 1998 on Health Care Contribution.*

⁵ *Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services Article 3, section (2).*

2. As the HIF covers only the recurrent costs of health services, and the owners (mainly local governments and the central government) are responsible for capital costs, local and general taxes are the main source of capital costs in the system.
3. There are certain special services, which are financed entirely from the central government budget:⁶
 - public health, including compulsory immunisation, control of infectious diseases, public hygiene, health promotion and health education,
 - family planning and maternal care,
 - catastrophe medicine,
 - experimental medical technologies within the frame of biomedical research.
4. The central government budget covers the co-payment for certain medicines, medical aids and prostheses for socially indigents (KÖZGYÓGY). The eligibility for this co-payment exemption scheme is based on a means test administered by local governments.⁷

I.1.C. OVERVIEW OF REGULATIONS

The entitlements within both systems are regulated by various laws and regulations, from the Constitution to various ministerial decrees and orders. The various types of regulations represent the decisions of various decision-making actors (bodies or persons), with different decision-making rules/processes and power. The higher a particular regulation is in the hierarchy of regulations, the stronger its provisions are, should there be a conflict between various regulations. In terms of health care benefits, however, the lower the level of regulation, the more specific the benefit regulation is. The general decision-making processes regarding the most important forms of regulations (the so-called 'legal regulation', or 'legislation') are shown in Figure I.1.

The National Assembly (parliament) is a key actor in national level decision-making of all areas of public policy, including health. By passing Acts, the parliament decides for instance the final size and sub-budget divisions of the HIF, the methods of payment of providers, or the rough composition of the benefit package in the frame of the social health insurance scheme and services that are financed from the central government budget.

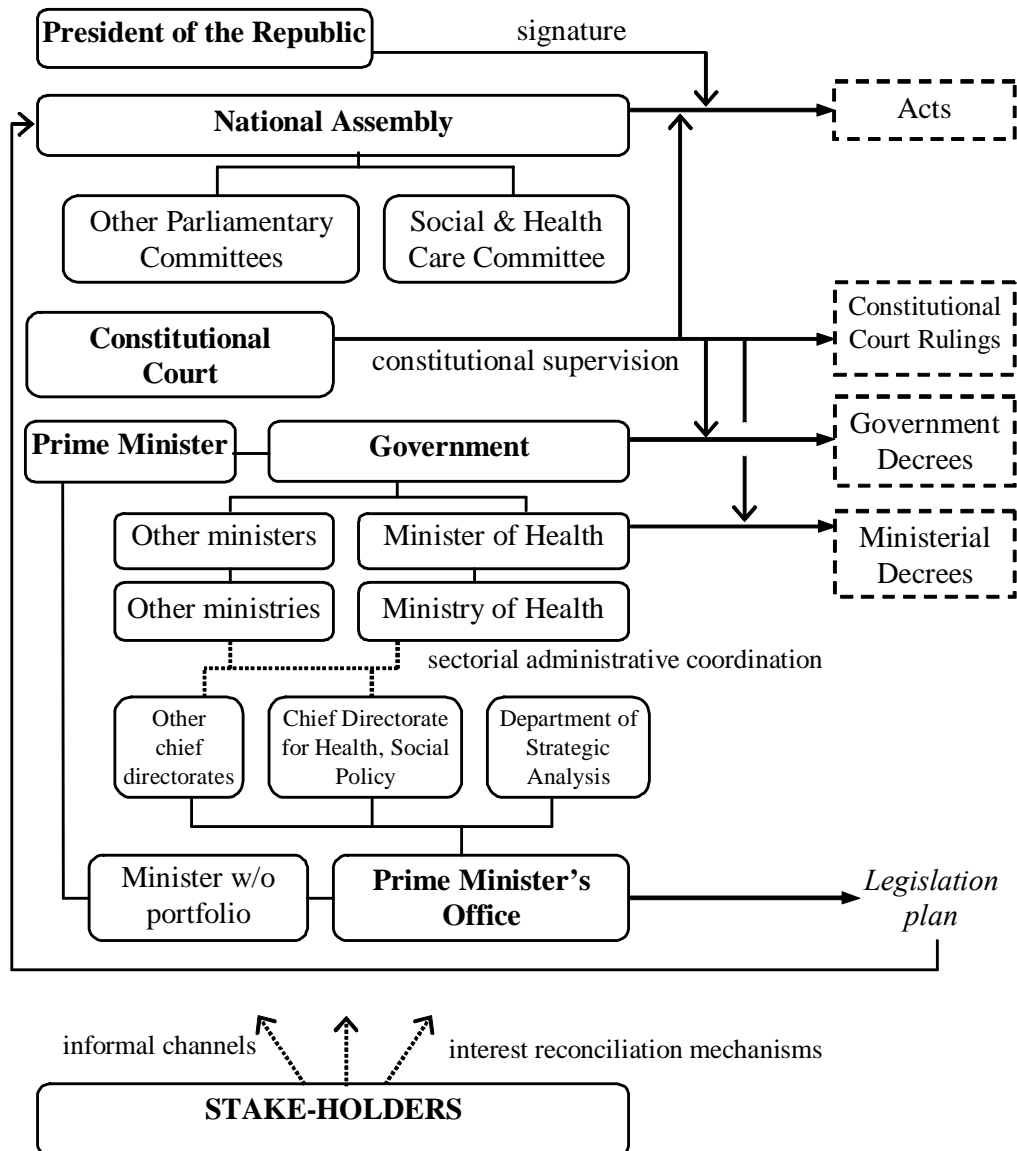
While most decisions of the parliament require a simple majority, the Constitution as well as the acts on the fundamental democratic institutions, such as local governments, can be changed with a two-third majority vote only. The main acts in the area of health, such as *Act CLIV of 1997 on Health* and *Act LXXIII on the*

⁶ Until the end of 2003, emergency ambulance services and high-cost, high-technology interventions were also financed from the central government budget. As of 1 January 2004 these services have been incorporated into the social health insurance scheme (*Act CXVI of 2003* Article 98, sections (1) (2); Article 107, section (1) k) 1)).

⁷ *Act III of 1993 on Social Services* (promulgated: 27/01/1993).

Services of Compulsory Health Insurance, however, belong to the simple majority category.

Figure I.1. National-level decision-making process in Hungary, 2004



The parliament debates, proposes amendments to and votes on bills, which are prepared and submitted for approval by the government on the basis of the policy framework set by the overall governmental policy. First, the relevant parliamentary committees discuss the submitted bill, before it can go on to the plenary sessions of the National Assembly. Passed bills are promulgated as acts, on the basis of which governmental and ministerial decrees are issued, which regulate the implementation of the various clauses of acts in detail. The President of the Republic must sign the acts before they are promulgated and has the right to send them back to the National

Assembly for further debate, or ask for a constitutional examination, but cannot withhold a signature after these options are exhausted.

Citizens have the right to challenge laws and regulations in the Constitutional Court, which promulgates its decisions in the form of Constitutional Court Rulings. Constitutional rights are also protected through the institution of the parliamentary commissioners or ombudsmen, who can investigate any abuse of these rights.

Beside acts, governmental decrees, ministerial decrees and local government decrees, which represent generally valid and obligatory behavioural norms and are called 'legal regulations' or 'legislations', there are lower level regulations, which are categorized as 'other means of state control', such as resolutions, orders, policies, statements and announcements,⁸ as well as organizational operational rules and procedures of various organizations and decision-making bodies. Resolutions, for instance, can be issued by the National Assembly, the central government, governmental committees, local governments and their organs to regulate the tasks of organizations controlled by them, the rules of their own operation and plans within their scope of authority, while orders can be issued by ministers and heads of organizations with national scope of authority (such as the National Health Insurance Fund Administration) to regulate the activities of the organizations under their control.⁹ The various types of regulations are summarized in Table I.1.

Table I.1. Main types of regulations in Hungary

#	Type of regulation	Decision-maker	Method of decision-making	Consultation with relevant stakeholders
1	Constitution	National Assembly	two-third majority vote	required
2	Fundamental acts	National Assembly	two-third majority vote	required
3	Acts	National Assembly	simple majority vote	required
4	Governmental decrees	Central government	simple majority vote of the government or exceptionally the prime minister (one person)	required
5	Ministerial decrees	Ministers	one person	required
6	Local government decrees	Local government assemblies	simple majority vote	required
7	Rulings of the Constitutional Court	Constitutional Court	simple majority vote	-
8	<i>Resolution</i>	National Assembly, central government, governmental committees, local governments	according to decision-maker	-
9	<i>Order</i>	Ministers, heads of organizations with national scope of authority	one person	-

⁸ Act XI of 1987 on Codification, Articles 46-56.

⁹ Act XI of 1987 on Codification, Articles 46, section (1).

#	Type of regulation	Decision-maker	Method of decision-making	Consultation with relevant stakeholders
10	<i>Policy</i>	National Assembly, central government, ministers, heads of national organizations	according to decision-maker	required
11	<i>Statement of interpretation of legislations</i>	National Assembly, central government	according to decision-maker	?
12	<i>Announcement, communication</i>	Ministers, heads of organizations with national scope of authority	one person	-

Notes: 'Legal regulations' or 'legislations' are in bold, 'other means of state control' are in italics.

Source: Act XX of 1949 on the Constitution of the Republic of Hungary; Act XI of 1987 on Codification; Resolution No. 1088/1994 (IX.21) on the Decision-making Procedures of the Government; Act LXV of 1990 on Local Governments;

Regarding the entitlements for health care benefits the content of the benefit basket, as well as the process of decision-making are usually regulated at least in ministerial decrees. This does not mean, however, that the decision-making has no input from a wide-range of actors in the health care arena. *Act XI of 1987 on Codification* explicitly requires that relevant non-governmental and interest representation organizations have to be consulted in the phase of preparation of legislations.¹⁰ Some of these consultative process have been formalized in committees, but in most cases the opinion of the relevant stakeholders are sought on an individual basis, whereby stakeholders are invited to comment on proposals (for instance bills) within a particular (usually short) period of time. In any case, there are also informal channels through which various stakeholders can try to further their interests.

The most important regulations regarding the definition of the benefit package (process and content) are summarized in Table I.2.

Table I.2. Regulations of entitlements and benefits in Hungary

#	Regulation	Type	What is regulated?	C/P
1	Act XX of 1949 on the Constitution of the Republic of Hungary	1	right to health	C
2	Act CLIV of 1997 on Health	3	right to health services scope and broad content of health services	C
3	Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services	3	participation in and contribution to the social health insurance scheme (who is covered)	-
4	Act LXXXIII of 1997 on the Services of Compulsory Health Insurance	3	framework for benefits of social health insurance scheme (inclusions and exclusions)	C,P
5	Government Decree No. No. 217/1997. (XII. 1.) Korm.	4	executive order of Act LXXXIII of 1997	P,C

¹⁰ Articles 27-32.

#	Regulation	Type	What is regulated?	C/P
6	Decree No. 46/1997. (XII. 17.) NM of the Minister of Welfare on Health Services, which are not Covered by Social Health Insurance	5	specifies services that are excluded from public financing specifies experimental technologies that are excluded from social insurance coverage, but are covered from central government budget	C
7	Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees of Certain Health Services which cannot be Utilized Free of Charge	4	co-payments exclusions (full fee)	C
8	Act XCIII of 1993 on Labour Safety	3	occupational health services	C
9	Government Decree No. 89/1995. (VII. 14.) Korm. on Occupational Health Service	4	occupational health services	C
10	Decree No. 27/1995. (VII. 25.) NM of the Minister of Welfare on Occupational Health Services	5	occupational health services	C
11	Decree No. 5/2004. (XI. 9.) EüM of the Minister of Health on Balneotherapy for Medical Rehabilitation that can be Utilized with Social Insurance Subsidy	5	Benefit catalogue of balneotherapy	C
12	Decree No. 20/1995. (VI. 17.) NM of the Minister of Welfare on the Treatment in Sanatoria in the Frame of Medical Rehabilitation	5	Benefit catalogue of treatment in sanatoria	C
13	Decree No. 48/1997. (XII. 17.) NM of the Minister of Welfare on Dental Services which Can Be Utilized in the Frame of the Compulsory Health Insurance	5	Benefit catalogue of dental care	C
14	Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare on Infertility Treatments which Can Be Utilized in the Frame of the Compulsory Health Insurance	5	Benefit catalogue of infertility treatments	C
15	Decree No. 47/1997. (XII. 17.) NM of the Minister of Welfare on the Supply of Breast Milk in the Frame of the Compulsory Health Insurance	5	Eligibility for free breast milk	C
16	Decree No. 50/1997. (XII. 17.) NM of the Minister of Welfare on Course-type Treatments Eligible for Patient Transportation	5	Eligibility for patient transportation	C
17	Decree No. 51/1997. (XII. 18.) NM of Minister of Welfare on Health Services for the Prevention and Early Detection of Diseases, which Can Be Utilized in the Frame of the Compulsory Health Insurance and the Certification of Attendance	5	Benefit catalogue of screening	C
18	Decree No. 56/2003. (IX. 19.) ESzCsM of the Minister of Health, Social and Family Affairs on the Subsidies of Balneotherapy, which can be Prescribed with Social Insurance Subsidy	5	Benefit catalogue of balneotherapy	C
19	Decree No. 19/2003. (IV. 29.) ESzCsM of the Minister of Health, Social and Family Affairs on the Medical Aids and Protheses which can be Prescribed and Rented with Social Insurance Subsidy, on the Amount and Extent of Subsidies and on the Professional Requirements of Prescription, Distribution, Renting and Repair	5	Benefit catalogue of medical aids and protheses	C
20	Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services (Annex 8.)	4	Benefit catalogue of chronic care	C

#	Regulation	Type	What is regulated?	C/P
21	Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services	5	Benefit catalogue of outpatient specialist services; acute inpatient care; dental care; day cases of curative care; dialysis; chronic outpatient care;	C
22	Decree No. 1/2003. (I. 21.) ESzCsM of the Minister of Health, Social and Family Affairs on the Medicines which can be Prescribed with Social Insurance Subsidy and on the Amounts of Subsidy (valid until 1 July 2005; then the list will only be published as an Announcement in the Health Insurance Gazette of the NHIFA)	5 (12)	Benefit catalogue of medicines	C
23	Decree No. 20/1996. (VII. 26.) NM of the Minister of Welfare on Home Care	5	Benefit catalogue of home care	C
24	Decree No. 49/2004. (V. 21.) ESzCsM of the Minister of Health, Social and Family Affairs on the Regional Mother-and-Child-Health Nurse Services	5	Tasks of MCH nurses	C
25	Decree No. 26/1997. (IX. 3.) NM of the Minister of Welfare on School Health Services	5	Tasks of school health services (doctor, MCH, dentist, assistant)	C
26	Government decree No. 168/2004. (V. 25.) Korm. on the System of Centralized Public Procurement and the Scope of Tasks and Authority of the Central Procurement Agency	4	Regulatory regime (price negotiations for special medicines)	P
27	Decree No. 6/1998. (III. 11.) NM of the Minister of Welfare on the Regulation of Updating Professional Classification Systems and Financing Parameters Used in Health Care	5	Regulatory regime (payment)	P
28	Government Decree No. 112/2000. (VI. 29.) Korm on the Scope of Duties and Authority of the Social Insurance Price and Subsidy Committee	4	Regulatory regime (price negotiation)	P
29	Decree No. 32/2003. (IV. 26.) ESzCsM of the Minister of Health, Social and Family Affairs on the Rules of the Procedure for the Inclusion of Registered Medicines and Nutrients Satisfying Special Nutrition Needs in the Scope of Social Insurance and on the Modifications of Inclusion or Subsidy	5	Regulatory regime (medicines)	P
30	Order No. 6/2005. (Eb. K. 3.) OEP of the Chief Executive Officer of the National Health Insurance Fund Administration on the Procedure of Inclusion of Registered Medicines in the Scope of Health Insurance Fund Subsidy and of the Modification of Inclusion or Subsidy	9	Regulatory regime (medicines)	P

Notes: C = content regulation; P = Process regulation

I.1.D. COVERAGE

The provision of universal and comprehensive coverage was the founding principle of the previous, state-socialist health care system. Health services were free-of-charge except for very small co-payments for medicines, medical aids and prostheses (therapeutic appliances). The tension between the changing-increasing needs and the available resources created shortages, but this was not admitted and dealt with explicitly. Rationing probably occurred through queuing, implicit waiting lists, the dilution of services and informal payments.

In the early years of health care reform, more emphasis was put on structural reform than setting priorities in terms of health care benefits. Parallel to the establishment of social health insurance, a negative list of services was defined in amendments to *Act II of 1975 on Social Insurance*,¹¹ which was broad enough to cover virtually everything, but co-payments for prescribed medicines, medical aids and spa treatments (balneotherapy)¹² were upheld and raised significantly. Certain exclusions from the benefit package of social health insurance were also stipulated, such as treatments for aesthetic and recreational purposes.¹³

The first steps towards a less generous benefit package were taken during the economic crisis of 1995, when the HIF deficit called for urgent action. *Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization* (better known as the "Bokros package", named after the minister of finance) curtailed in-kind and cash benefits. The main exclusion was tooth-preserving dental services. Certain cases of treatment in sanatorium were also excluded. Subsidies for balneotherapy were removed, a co-payment for patient transfer (ambulance) services was introduced, and the sickness benefit was decreased. In addition, the financing of occupational health services became the responsibility of employers.¹⁴ The adverse effects of these measures – for example, a sharp drop in the use of dental services – forced the government to retreat, so that dental services were reintroduced with some co-payments,¹⁵ while the succeeding government abolished co-payments for tooth preserving dental treatments in 2001, eventually restoring the original situation.¹⁶

The economic stabilization efforts of the government stirred a controversy regarding the interpretation of the constitutional right to health. The opposition parties challenged the measures of curtailing the benefit package at the Constitutional Court, on the basis of the provisions of the Constitution, which defined health as a right of Hungarian citizens. Article 70/D of the Constitution declares that:

(1) People living within the territory of the Republic of Hungary have the right to the highest possible level of physical and mental health.

and that:

¹¹ *Act IX of 1992 on the Amendment and Complement of Act II of 1975 on Social Insurance*, Articles 4, 5 (15, 16/A); (promulgated: 09/03/1992)

¹² According to the terminology used in various regulations, these services are also called "therapeutic services" ("gyógyászati ellátások").

¹³ *Government Decree No. 107/1992. (VI. 26.) Korm. on Health Services which Can Be Utilized with Co-payments Only and on the Method of Payment*; Articles 2, 3.

¹⁴ *Government Decree No. 89/1995. (VII. 14.) Korm. on Occupational Health Services*

¹⁵ *Act XIV of 1996 on the 1996 Budget of the Social Insurance Funds* (promulgated: 29/03/1996) and *Government Decree No. 61/1996. (IV. 26.) Korm.*

¹⁶ *Act LXX of 2001 on the Amendment of Various Acts Concerning Health Care, Supply of Pharmaceuticals, and Social Care, and of Act LXXXIII of 1997 on the Compulsory Health Insurance, and of Various Acts Concerning Social Insurance Contribution and Hypothecated Health Care Tax* (promulgated: 25/10/2001) and *Decree No. 34/2001. (X. 17.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of Minister of Welfare*

(2) *The Republic of Hungary implements this right through arrangements for labour safety, with health institutions and medical care, through ensuring the possibility for regular physical training, and through the protection of the man-made and natural environment.*

It had not been clear what responsibilities this “right to the highest possible level of physical and mental health” posed to the state in terms of the provision of health services. In *Ruling No. 56/1995. (IX. 15.) AB* the Constitutional Court states that the right to health has to be interpreted within the confines of the performance of the economy, and does not mean that all health services have to be made available free of charge in the frame of the social health insurance scheme. Nevertheless the Constitutional Court also states that the benefit package can not be curtailed infinitely, as a disproportionate decrease of available health services (“*laesio enormis*”) would violate a number of constitutional rights and principles, including property rights, legal stability, the protection of trust and the obligation of the state for constitutional guarantees. The Ruling also called the government for elaborating new acts on social insurance, which were eventually enacted in 1997. Since then, these pieces of legislation have been the most important documents which provide the legal basis of the definition of the benefit package in Hungary.

Act CLIV of 1997 on Health comprises the provisions on the basis of which the whole health sector (not just the publicly financed part) has to operate. The Act defines the rights and duties of patients as well as health care providers, the scope and broad content of health services, sets up the general framework of how they have to be carried out, regulates the roles and responsibilities of the state, including the most important actors and their tasks. For instance, the regulation of health care providers is based on the so-called professional minimum requirements, or standards. Health service delivery organizations must obtain a licence to practice from the National Public Health and Medical Officer Service (NPHMOS), which maintains a registration database.¹⁷ Before issuing the licence to any provider, medical officers inspect the facilities and ascertain whether the minimal building, hygienic requirements, personnel and material standards, set by *Decree No. 21/1998. (VI. 3.) NM of the Minister of Welfare*, are fulfilled.¹⁸ Separate or special rules apply to a number of services, such as primary care,¹⁹ home care,²⁰ patient transfer,²¹

¹⁷ *Decree No. 113/1989. (XI. 15.) MT of the Ministerial Council on Social and Health Enterprises and Decree No. 30/1989. (XI. 15.) SZEM of the Minister of Social Affairs & Health on the Practice of Medicine, Clinical Psychology and Other Health and Social Services; Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on Minimum Standards of Certain Institutions Providing Health Services; Decree No. 32/1997. (X. 28.) NM of the Minister of Welfare on the Registration and Licensing of Health Care Providers.*

¹⁸ See also *Decree No. 19/1996. (VII. 26.) NM* and *Decree No. 12/1997. (VI. 5.) NM of the Minister of Welfare.*

¹⁹ *Decree No. 4/2000. (II. 25.) EüM of the Minister of Health on the Family Doctor, Paediatric and Dental Primary Care Services.*

²⁰ *Decree No. 20/1996. (VII. 26.) NM of the Minister of Welfare on Home Care.*

²¹ *Decree No. 19/1998. (VI. 3.) NM of the Minister of Welfare on Patient Transfer.*

emergency ambulance services,²² human fertility treatment,²³ sterilization procedures²⁴, and organ transplantation.²⁵ The provision of non-conventional medical treatment is also regulated including the scope of activities, and educational, infrastructure and administration requirements.²⁶ All health care providers are obliged to obtain liability insurance to enable them to compensate patients appropriately in justified malpractice claims.

From the point of view of the benefit package the following provisions of the act have special relevance:

- in the frame of patient rights, the Act interprets the right to health services, including the general scope of services, the choice of provider and waiting lists (Articles 6-9),
- the Act defines what are considered health services and describes the rough professional content of the various types of services (public health services – Articles 35-74, health care services – Articles 75-106),
- in the frame of the roles and responsibilities of the state, the Act enumerates those health services, which have to be financed from the central government budget (Article 142).

According to the Act, the right to health services is unconditional only for emergency life-saving services, services, which prevent serious or permanent health damage, and for the reduction of pain and suffering.²⁷ Patients have right to other health services only within the limits set by other legislation.²⁸ The Act has introduced the concept of waiting lists, and requires priority-setting to be without discrimination, on the basis of uniform and explicit criteria, taking into account the health status of patients.²⁹ Within the frame of the social health insurance scheme it is explicitly prohibited to give priority to those prepared to pay extra.³⁰ So far, national waiting lists have been set up for organ and tissue transplantation, but according to *Decree No. 61/2003. (X. 27.) ESzCsM of the Minister of Health*, waiting lists have to be set up for all other services that cannot be provided within two months, either on a national basis or per provider. The detailed patient selection criteria have to be based

²² *Decree No. 20/1998. (VI. 3.) NM of the Minister of Welfare on Emergency Ambulance Services.*

²³ *Decree No. 30/1998. (VI. 24.) NM of the Minister of Welfare on the Rules of Special Procedures for Human Reproduction and on the Detailed Rules of Use and Freeze Storage of Reproductive Cells and Embryos.*

²⁴ *Decree No. 25/1998. (VI. 17.) NM of the Minister of Welfare on Artificial Sterilization.*

²⁵ *Decree No. 18/1998 (XII. 11.) EüM of the Minister of Health on the Implementation of Provisions of Act CLIV of 1997 concerning Tissue and Organ Transplantation and Storage, and Certain Pathohistological Investigations.*

²⁶ *Government Decree No. 40/1997 (III.5.) Korm. on the Practice of Alternative Medicine and Decree No. 11/1997. (V. 28.) NM of the Minister of Welfare on Certain Aspects of the Practice of Alternative Medicine.*

²⁷ Article 6.

²⁸ Article 7.

²⁹ Article 9.

³⁰ *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance, Article 20, section (3).*

exclusively on the need for the service and the expected outcome. Waiting lists of individual institutions have to be supervised by a committee comprising the professional director of the provider organization, the head of department of the speciality concerned and one specialist with at least 5 years of experience in the area concerned.

Regarding tax-financed and social health insurance financed services, Articles 141 and 142 clarify the border between the two groups. The Act states that the state is responsible for the operation of the social health insurance scheme to enable the individuals to exercise their right to health,³¹ and then lists the services, which have to be financed from the central government budget.³² As it has been discussed before, these include the majority of public health services, catastrophe medicine, health technologies in experimental phase, pre- and postnatal maternal care.

Act LXXXIII of 1997 on the Services of Compulsory Health Insurance and related governmental and ministerial decrees define health services, which are (a) free-of-charge (Articles 10-17), (b) covered with co-payment (Articles 23-25), or (c) excluded from social health insurance coverage (Article 18, sections (5-6)). The starting point of the Act is that all health services are fully covered and exclusions are stipulated. Article 18, section (4) of the Act states that within the frame of the social health insurance financing, all professionally justified treatments can be used, but diagnostic and treatment protocols, issued by the minister of health, can further specify the actual services for which the patient are entitled to (Article 19, section (1)). Physicians are allowed not to adhere the protocols, if the deviation is justified by the status of the patient and therapeutic considerations. It must be noted, though, that broad functional areas are listed (i.e. there is a scope for implicit exclusions) in the Act in three main categories:

1. services for the prevention and early detection of diseases (Article 10),
2. curative services, including family doctor services (Article 11), dental care (Article 12), outpatient specialist service (Article 13) and inpatient care (Article 14),
3. other services including deliveries (Article 15), medical rehabilitation (Article 16), patient transportation (including the reimbursement of travel expenses and transportation by service providers) and emergency ambulance services (Articles 17, 22).

In certain cases, such as screening, the covered services are further specified in ministerial decrees.³³

Co-payment is required for:

1. medicines,
2. medical aids and prostheses,

³¹ Article 141, section (2), paragraph b).

³² Article 142, section (2).

³³ *Decree No. 51/1997. (XII. 18.) NM of Minister of Welfare on Health Services for the Prevention and Early Detection of Diseases, which Can Be Utilized in the Frame of the Compulsory Health Insurance and the Certification of Attendance.*

3. balneotherapy,
4. dental prostheses,
5. treatment in sanatorium,
6. long-term chronic care, and
7. some 'hotel' aspects of inpatient services, including meals and conveniences, such as one-bed room, telephone and colour TV.

Between 1996 and 2001, co-payment had to be paid for tooth-preserving dental treatments as well, but this was abolished as discussed before.³⁴

Co-payment is applied if the rules of service utilization are not observed:

1. if specialist services are obtained without a referral from an authorized medical doctor (usually the family doctor), except for the case of emergency and for certain specialties listed in *Governmental Decree No. 217/1997. (XII. 1) Korm.*,³⁵
2. if patients choose to go to a provider other than they were referred to,
3. if patients want to have more services than the doctor prescribed.³⁶

Special rules apply to a few services, such as infertility treatments, where the number of attempts is limited.³⁷

Beside the various forms of co-payment, the other main type of out-of-pocket payments in the Hungarian health care system is informal payment. Informal payments took roots and became widespread in the state-socialist health care system. Despite several official anti-campaigns, the regime not just tolerated informal payment, but included it in the calculation of salaries of medical doctors, and in 1989 tried to tax it. Since then informal payments must be declared for income tax. According to various study estimates, the exact amounts of informal payment vary considerably, even in the case of the same health service, such as deliveries. Nevertheless it is a conceptual question, whether informal payments should be considered, when entitlements to services are studied, and if yes, to what extent.

Patients pay the full price of services that are excluded from public financing. The same applies to services that are in principle covered, but obtained from a private provider with no contract with the NHIFA.³⁸ On the other hand providers who do

³⁴ *Act LXX of 2001 on the Amendment of Various Acts Concerning Health Care, Supply of Pharmaceuticals, and Social Care, and of Act LXXXIII of 1997 on the Compulsory Health Insurance, and of Various Acts Concerning Social Insurance Contribution and Health Care Contribution and Decree No. 34/2001. (X. 17.) EüM of the Minister of Health on the Amendment of Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare.*

³⁵ Article 2, section (1).

³⁶ *Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees of Certain Health Services which Cannot be Utilized Free of Charge*

³⁷ *Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare on Infertility Treatments, which Can Be Utilized in the Frame of the Statutory Health Insurance.*

³⁸ Article 9.

have a contract with the NHIFA are not allowed to charge extra for services covered by the HIF.³⁹

The costs of medical examinations for certificates required for instance driving and holding firearms are not covered,⁴⁰ and the Act explicitly excludes treatments for aesthetic or recreational purposes and those not proved effective in improving health.⁴¹ As it has been mentioned before, some other health services, like public health services and catastrophe medicine have also been excluded, but covered from the central government budget.⁴² A special scheme is in place for compulsory occupational health services, where financing is the responsibility of the employer.⁴³

I.2. REGULATORY REGIMES AND CATALOGUES

Given that the existing benefit catalogues are almost exclusively incorporated into acts, governmental decrees and ministerial decrees, the general features of the regulatory regimes are common to each type of regulation, as described before. While in the case of these types of regulations it is straightforward who makes the decision, on the basis of what method, the real issue is who are consulted in what form in the preparatory phase of the decision making process, for which the acts discussed so far provide only very general and vague guidance.

In many cases the decision support mechanisms have not yet been formalized in lower level regulations. In these cases the process of preparation and codification of various legal regulations are based on tradition. For instance, the need for the creation of a ministerial decree can originate from the provision of a higher level legislation (act or governmental decree) – in this case the Legal department of the Ministry initiate the codification process at the relevant professional department –, or it can be initiated internally or by an external actor/stakeholder. The proposal is usually prepared by a civil servant, working in the relevant professional department, with input from the relevant stakeholders either on an individual basis or by convening an ad hoc committee. Although each department has to work on the basis of specific regulations on issue-handling, in which cases, who has to be consulted and how, are usually not specified in these regulations, but passed from one civil servant on the other.⁴⁴

Nevertheless, there are certain areas, such as pharmaceuticals, therapeutic appliances, where various factors, such as financial interests, have enforced the formalization of the decision-making processes. These developments got a new push in Hungary with

³⁹ Articles 24, section (1); 38/A.

⁴⁰ Article 18, section (5), point f).

⁴¹ Article 18, section (6).

⁴² *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance* and its executive order of *Government Decree No. 217/1997 (XII. 1.) Korm.*, Article 18, section (5), points a-d) and h); and *Act CLIV of 1997 on Health*, Article 142.

⁴³ *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance* and its executive order of *Government Decree No. 217/1997 (XII. 1.) Korm.*, Article 18, section (5), points e).

⁴⁴ Kovácsy, Zs (2005); personal communication.

the accession of the country to the European Union, as the requirements of EU directives, for instance in the case of pharmaceuticals, have had to be incorporated into the Hungarian regulations. The decision-making process of the inclusion of a particular medicine in the benefit package of the social health insurance scheme has been regulated down to the details of the decision-making criteria.

Furthermore, the introduction of new payment mechanisms created indirect means of defining benefits through the classification of cases and services for the purpose of provider reimbursement. Such classifications have been developed, for instance, for acute inpatient care (DRGs) and outpatient specialist services (fee-for-service point system). Since the introduction of these payment mechanisms, these classifications (catalogues) have been regularly updated and therefore the process of instituting changes has been formalized.

In any case, the existing benefit regulations and catalogues are universal in that for any functional areas, only one regulatory regime and benefit catalogue exist (of course if they exist at all), which are valid for the whole country with no regional variations (or variations by payer).

In summary, the regulatory regimes include:

- traditional (not formalized) decision-making process for special services, including public health services, screening, dental care, supply of breast milk, infertility treatments, patient transportation and travel subsidy, home care,
- formalized as ‘price negotiations’ for medical aids and prostheses, and balneotherapy,
- formalized as the ‘procedure for the inclusion of registered medicines in the scope of the social health insurance system’ in line with the provisions of the Council Directive 89/105/EEC of 21 December 1988,
- formalized as the ‘procedure of updating professional classification systems and payment parameters’ for outpatient specialist and inpatient care services.

As a result of the various regulatory regimes, benefit catalogues exist for the following functional areas:

- acute inpatient curative care (DRGs),
- day cases of curative care,
- haemodialysis,
- outpatient dental care,
- outpatient specialist services (somatic and mental, as well as diagnostic services),
- chronic outpatient care,
- balneotherapy,
- treatment in sanatoria,
- home care,
- chronic inpatient care,
- medicines,

- medical aids and prostheses (therapeutic appliances and other medical durables),
- prevention and public health services, including screening, infertility treatments, (maternal and child health, school health services).

I.3. THE ROLE OF THE CENTRAL GOVERNMENT, MAIN ACTORS AND RESPONSIBILITIES

As it has been discussed before, the key decision-makers in the Hungarian health care system are the National Assembly, the central government, and the minister of health. While in the health sector, these are the actors, who make the final decisions, as the most important regulatory regimes and benefit catalogues are incorporated into acts, governmental decrees and ministerial decrees, there are a large number of governmental and non-governmental organizations, which are consulted in the preparatory phase either formally (according to written regulations) or on the basis of tradition.

There are only few cases, when the decision on entitlements and benefits has been decentralized to other organizations. One such example is the area of pharmaceuticals, where the decision is made by the NHIFA.

In this section, we provide a brief description of the relevant actors in the decision-making process on entitlements and benefits.

I.3.A. NATIONAL ASSEMBLY

The National Assembly is the highest level decision-making body, which regulates the framework for health care financing, entitlements to health services and the benefit package within public schemes, through the Constitution and various acts.

I.3.B. CENTRAL (NATIONAL) GOVERNMENT

The national government (or central government) formulates health policy and it is also the most important regulator of the health sector. Certain health services, for which entitlements are based on citizenship, are financed entirely from the central government budget. It keeps control over social health insurance financing, resource allocation and payment together with the National Assembly and through direct control of the purchasing organization, the NHIFA. As it has been discussed before, the central government issues governmental decrees, which provide more detailed regulation of the implementation of the provisions of various acts. For instance, governmental decree regulates the co-payments for services that are only partially covered by the social health insurance scheme.⁴⁵

Within the central government responsibilities are divided among ministries according to *Act XI of 2002 on the Enumeration of the Ministries of the Republic of*

⁴⁵ *Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees of Certain Health Services which cannot be Utilized Free of Charge*

Hungary amended by *Act XCV of 2004*, and to various governmental decrees. The primary responsibility for health services rests with the Ministry of Health.⁴⁶

I.3.C. NATIONAL HEALTH COUNCIL

On the basis of the provisions of *Act CLIV of 1997*, a new body, the National Health Council, was established in 1999 to advise the government on health policy, promote consensus on health priorities, thereby facilitating implementation. The members with a six-year mandate are representatives of the relevant stakeholders such as professional and patient organizations, unions and local government representatives.⁴⁷

I.3.D. MINISTRY OF HEALTH

The Ministry of Health's dominant role of managing the health care system was confirmed by *Act CLIV of 1997 on Health*. The main functions of health policy formulation, coordination and regulation (through the aforementioned ministerial decrees) are carried out with the help of a number of institutions under the direct control of the minister of health. Beside these administrative functions, some of these institutions provide health services themselves including public health, emergency ambulance service, blood supply, tertiary care services and rehabilitation. Since January 2001, the minister also controls the NHIFA directly.

I.3.E. NATIONAL PUBLIC HEALTH AND MEDICAL OFFICER SERVICE

The National Public Health and Medical Officer Service (NPHMOS) is one of the most important agencies of the Ministry of Health. The NPHMOS provides public health services – including the traditional public hygiene and infectious disease control –, disease prevention and health promotion. It is also the central authority of the implementation, control and enforcement of regulations, including the registration and licensing of health care providers. The NPHMOS is responsible for monitoring the quality of health services.

The NPHMOS was formed in 1991 on the basis of the State Supervision of Public Hygiene and Infectious Diseases.⁴⁸ It is headed by the national chief medical officer, who is appointed by the minister of health. The NPHMOS is organized at three levels on a territorial basis. It has a national office, and offices at county (19+1) and municipal levels. Its central organ is the Office of the National Chief Medical Officer, which has two centres, each responsible for one main area of public health:

⁴⁶ *Government Decree No. 288/2004. (X. 28.) Korm. on the Scope of Duties and Authority of the Minister of Health.*

⁴⁷ *Act CLIV of 1997 on Health, Articles 148-149, and Government Decree No. 229/1998. (XII. 30.) Korm. on the Scope of Duties, Organization and Operation of the National Health Council.*

⁴⁸ *Act XI of 1991 on the National Public Health and Medical Officer Service (promulgated: 09/04/1991) and Decree No. 7/1991. (IV. 26.) NM of the Minister of Welfare on the Organisation and Operation of the National Public Health and Medical Officer Service.*

the Fodor József National Centre of Public Hygiene, and the Johan Béla National Centre of Epidemiology. The Fodor József National Centre of Public Hygiene has five national institutes, in the area of occupational health, chemical safety, nutrition health, radiation safety and environmental health.

I.3.F. NATIONAL BLOOD SUPPLY SERVICE AND NATIONAL EMERGENCY AMBULANCE SERVICE

Blood and blood products and emergency ambulance services are provided by national organizations. The National Emergency Ambulance Service has a long history in the Hungarian health services. For the whole country it provides emergency ambulance services and patient transportation.⁴⁹ The National Blood Supply Service was established in 1998 through the regional reorganization of blood supply units of hospitals.

I.3.G. ADVISORY BODIES AND ORGANIZATIONS

Institutes and various advisory bodies assist the minister of health. Some of them provide expert input in a particular medical speciality, like the national institutes of health and the professional colleges,⁵⁰ while others deal with a particular area of all specialities, like science and policy issues, or education, such as the Health Care Scientific Council.⁵¹

Professional colleges

Professional colleges are advisory boards, whose members are elected from the leading consultants of particular medical specialties, by and from the members of a so-called election body, which comprises the delegates of the Hungarian Medical Chamber, the relevant scientific associations and medical schools. Currently there are 38 medical professional colleges, from internal medicine to neurosurgery. In addition, in the middle of 2004, 3 pharmaceutical and 4 other non-medical professional colleges (nursing, mother and child health nursing, clinical psychology and medical informatics) were established.

National institutes of health

The national institutes of health are the methodological centres of their particular medical specialty.⁵² They supervise and support clinical work across the country,

⁴⁹ Decree No. 55/1996. (XII. 27.) NM of the Minister of Welfare on the National Emergency Ambulance Service

⁵⁰ Decree No. 6/1989. (III. 22.) SZEM of the Minister of Social Affairs and Health on Professional Colleges (see also Decree No. 16/1995. (IV. 13.) NM and Decree No. 53/1996. (XII. 27.) NM and Decree No. 52/1999. (IX. 12.) EüM on the Medical Professional Colleges and Decree No. 20/2004. (III. 31.) on the Professional Colleges)

⁵¹ Order No. 5/1989. (SZEK 9.) SZEM of the Minister of Social Affairs and Health on the Health Care Scientific Council (see also Decree No. 10/1997. (V. 23.) NM and Decree No. 17/2001. (IV. 28.) EüM)

⁵² Act CLIV of 1997 on Health (promulgated: 23/12/1997), Article 150.

undertake continuing education, scientific research and in certain cases prevention activities and patient care, usually highly specialized, tertiary care services for the whole population of the country. National institutes issue clinical guidelines, setting out protocols and standards. Some national institutes are attached to university departments, such as the National Institute of Surgery, while the others are independent institutes with their own buildings, such as the National Institute of Neurosurgery.

There are certain national institutes that carry out special tasks and administrative duties:

- The National Institute for Health Development is the methodological centre for health promotion activities.
- The Health Strategic Research Institute (ESKI) is a methodological centre for health informatics, health economics, health care systems, and health technology assessment.⁵³
- The Information Centre for Health Care of the Ministry of Health (GYÓGYINFOK) has piloted and still runs the system of provider performance measurement, on the basis of which service providers are paid.⁵⁴ It has recently been incorporated into the organization of the NHIFA.
- The National Institute of Pharmacy operates registration and licensing of pharmaceuticals.⁵⁵
- The recently established Authority for Medical Devices of the Ministry of Health runs a similar system for medical equipment, including medical aids and prostheses.⁵⁶

I.3.H. OTHER MINISTRIES

Three large ministries have retained their health care facilities, hence they are involved in the provision of care. The origin of these parallel systems dates back to the first half of the twentieth century, when several private and public insurance funds employed medical doctors and owned health care institutions.

The Ministry of Economy and Transport (which runs the Hungarian State Railways) provides a comprehensive health service and has its own insurance fund, although railway health care is integrated into the main system of financing and delivery of health services with the provision of giving priority to railway workers and their dependants.

⁵³ See *Deed of Foundation* in Health Gazette 2004/5.

⁵⁴ *Order No. 3/1987. (Eü.K. 3.) EüM of the Minister of Health on the Information Centre for Health Care of Ministry of Health* (see also *Order No. 3/1991. (NK. 23.) NM of Minister of Welfare and Deed of Foundation* in Welfare Gazette 1995/13).

⁵⁵ *Decree No. 9/1982. (VII. 21.) EüM of the Minister of Health on the National Institute of Pharmacy* (see also the *Deed of Foundation* in Welfare Gazette 1998/11).

⁵⁶ *Announcement of the Ministry of Health on the Establishment of the Authority for Medical Devices of Ministry of Health* (see the *Deed of Foundation* in Health Gazette 2000/7).

The Ministry of the Interior and the Ministry of Defence have their own health care services for inpatients and outpatients, but special rules restrict utilization by the general population. The Ministry of Justice health services for prisoners are totally separate from the main system of provision.

I.3.I. NATIONAL HEALTH INSURANCE FUND ADMINISTRATION

The Health Insurance Fund (HIF) is the most important source of financing of the recurrent costs of health services. It also provides cash benefits such as sickness allowance. The HIF is separate from the government budget. The government cannot use any surplus of the HIF for other purposes, but is obliged to cover any deficit. The NHIFA was responsible for the collection of health insurance contributions until the end of 1998, when the revenue collection function was moved to the tax authority.⁵⁷ Since the beginning of 2001 the Ministry of Health has been controlling the NHIFA. The NHIFA has a national office and branches at the county level. They administer contracting with and payments to local health care providers, but budgets are not decentralized to the county level.

I.3.J. PROFESSIONAL ORGANIZATIONS, ASSOCIATIONS AND UNIONS

Voluntary association was restricted until the second half of the 1980s, except for trade unions, which were kept under tight control. During the collapse of the communist dictatorship, the health sector trade union of the communist regime lost its monopoly, and several unions were established, the largest being the Health Workers' Democratic Union. A notable feature of the last decade has been the rapid growth in the number of other voluntary organizations as well, some of which are not just simple interest groups, but have been delegated regulatory functions that used to be under direct governmental control before.

Hungarian Medical Chamber, Hungarian Chamber of Pharmacists

The Hungarian Medical Chamber, abolished by the communist regime, began to function again in 1988, initially on a voluntary basis. *Act XXVIII of 1994 on the Hungarian Medical Chamber* made membership compulsory for practising physicians and dentists and defined the structure, tasks and responsibilities of the medical chamber, including issuing a code of ethics for medical practice. The Chamber can discipline those who violate its rules. It has right to express opinion on a range of medical issues and to veto contract conditions between medical doctors and the NHIFA. The Hungarian Chamber of Pharmacists was also established in 1994.⁵⁸

⁵⁷ *Act XCI of 1998 on the Social Insurance Funds' Budget of 1999* (promulgated: 29/12/1998), Articles 24-31.

⁵⁸ *Act LI of 1994 on the Hungarian Chamber of Pharmacists* (promulgated: 07/05/1994).

Professional and scientific associations

The large number of professional and scientific associations includes, among others, the Hungarian Hospital Association, the Association of Health Care Financial Directors, the Association of Nursing Directors, the Hungarian Nursing Association, the Hungarian Pharmacists' Association and the Hungarian Dental Association. The largest professional organization in Hungary, the Federation of Hungarian Medical Societies (MOTESZ), has 83 member societies and more than 25 000 individual members.

Patient associations

Patient associations are growing in number and influence. In 2000, there were over 80 organizations active in various fields of health and health care.⁵⁹ They represent the interest of patients in various decision making processes, including entitlements and health benefits. Their participation has been institutionalized, for instance, in the National Health Council and in hospital supervisory councils.⁶⁰

I.4. MAIN EXCLUSIONS

As it has been discussed before only very few health services have been excluded explicitly from public financing. *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance* excludes two main service categories:

1. non curative treatments, for aesthetic or recreational purposes,
2. and those services, which fundamentally does not improve health, or have not proved effective in improving health.

Decree No. 46/1997 (XII. 17.) NM of the Minister of Welfare further clarifies what are the services that are included in these categories. The ministerial decree equates the second category with those services that are not classified in the International Classification of Procedures in Medicine,⁶¹ as well as lists four procedures, which are included in the classification system, nevertheless excluded from public financing:

- abortion without medical indication,
- sterilization without medical indication,
- prostate specific antigen test in general screening, and

⁵⁹ MEDINFO. *National Interest Protection and Self-Help NGOs for People with Chronic Health Condition*. Budapest: MEDINFO, 2000.

⁶⁰ *Decree No. 23/1998. (XII. 27.) EüM of the Minister of Health on the Hospital Supervisory Councils and Government Decree No. 229/1998. (XII. 30.) Korm. on the Scope of Duties, Organization and Operation of the National Health Council*.

⁶¹ Article 1, section (1). The International Classification of Procedures in Medicine is a classification of medical interventions published by the World Health Organization in 1987. Unlike the ICD, this classification system has not been updated by WHO since then. Nevertheless, there is an updating procedure in Hungary for the inclusion of new interventions.

- manualtherapy.⁶²

As far as the first category is concerned, the ministerial decree lists the following medical interventions:⁶³

- correction of the shape of the outer ears,
- nose correction,
- muscle reconstruction,
- nipple plastics,
- breast plastics,
- plastic surgery of breast skin,
- excision of scars,
- excision of skin cicatrix or constriction,
- plastic surgery of face wrinkles,
- hair transplantation,
- hair removal, depilation,
- dermabrasio,
- removal of tattoos.

As it has been discussed before, there are a few health services, which have been excluded from social health insurance coverage, but covered from the central government budget.⁶⁴ The cited ministerial decree specifies one such area further: experimental health technologies in the frame of biomedical research, which, according to the decree, include all technologies, including experimental medicines that are employed in research studies approved by the Health Care Scientific Council.⁶⁵

Act LXXXIII of 1997 defines two other service areas, which are excluded from social health insurance financing, but not listed in Article 142, section (2) of *Act CLIV of 1997*, i.e. are not covered from the central government budget either:

3. medical examinations required for certification and advisement with the exception of advisement required for social benefits (Article 18(5)f), and
4. occupational health services, including screening and control examinations of risk exposure (Article 18(5)e).

As far as occupational health services are concerned, *Act LXXXIII of 1995* and *Government Decree No. 89/1995. (VII. 14.) Korm. on Occupational Health Service*

⁶² Article 1, section (2); Appendix, point 4.

⁶³ Article 1, section (2); Appendix, point 3.

⁶⁴ *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance*, Article 140, section (5), and *Act CLIV of 1997 on Health*, Article 142, section (2); point b(d) – catastrophe medicine; d(h) – experimental technologies; e-f(a) – public health services excluding screening; g-h(b) – family planning and maternal care.

⁶⁵ Article 1, section (2); Appendix, point 2.

has made the financing of these services the responsibility of employers,⁶⁶ who can choose to maintain their own service or contract with and pays a capitation payment to special providers. Nevertheless, the services that are specified in the Act and governmental and ministerial decrees are compulsory, i.e. they can be regarded as part of the benefit package.

The category of medical examinations is interesting in that the specification of what services are included in this category has been incorporated into a government decree, which deals with the fees of health services that are not available free of charge in the frame of social health insurance. However, according to *Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees of Certain Health Services which cannot be Utilized Free of Charge*, the full fee of these services have to be paid, i.e. they are, in fact, excluded from public financing. The services listed in Appendix 2 of the decree are:

- medical examination for permission to own firearms,
- medical examination for driving licences (motor-vehicles, as well as ships),
- taking blood sample for blood alcohol test, and
- medical certificate for forensic purposes.

One another service is also excluded by the decree: the detoxifying of drunk persons.

As we have discussed before, patients pay the full price of all health services, if they do not utilize them at a provider which has a contract with the NHIFA. In principle, exclusions also apply to services, which are not included in the treatment protocols issued by the minister of health, but so far no such protocols have been issued.

Exclusions also apply to certain medical goods (medicines and medical aids and prostheses), for which the social health insurance scheme does not provide subsidy. One such example is the category of over the counter medicines, which are generally excluded. Nonetheless, a number of OTC drugs are included in the positive list of subsidized medicines, since the socially indigents may receive them free of charge in the frame of the co-payment exemption scheme (KÖZGYÓGY), if prescribed by an authorized medical doctor.

As we have discussed before, co-payment has to be paid for medical goods and a few health services, but it is not clear whether all of these should be considered part of the benefit package depending on the extent of the co-payment itself, and the same question applies to services, where substantial informal payments are frequently made. For instance the co-payment for most services is determined as a fixed amount, not as a percentage of the actual costs of care.

The methods applied to determine the extent of co-payment differ for different groups of services, or products. Medicines, medical aids and prostheses and spa treatments (balneotherapy) have an agreed price, for which, instead of determining the extent of co-payment, the HIF provides a price subsidy, either a certain percentage, 0, 50, 70, 85, 90 or 100% of the agreed price, or a fixed amount. The minister of health also determines the rules of prescription, which can have an effect

⁶⁶ Article 31 of the Act and Article 2 of Decree.

on the amount of subsidy the patient is eligible for.⁶⁷ For instance, certain medicines receive smaller subsidy, if the family physician prescribes it, and not the relevant specialist. Ambulatory care patients must have a valid prescription from the medical doctor, and must purchase the medicine at a pharmacy, which has a contract with the NHIFA, to be eligible for the subsidy. It has to be emphasized, that the system of price subsidization does not apply for inpatient care. Inpatient care includes the cost of medications, and hospitals buy them on a market free from central price regulations.

The co-payments for above standard hotel services are determined by the providers themselves, within the limits of certain rules set by *Act LXXIII of 1997*.⁶⁸ In contrast, the government centrally set the amount of co-payments for long-term, chronic care, and services, which are utilized bypassing the referral system. These fees equally apply to all providers, although in the case of the latter, providers are allowed to increase the centrally set fee by up to 30%.⁶⁹ Providers are allowed to retain the revenue from any of these sources, but HIF reimbursement on these cases is reduced accordingly.⁷⁰

Table I.3. summarizes out-of-pocket payments in the Hungarian health care system.

Table I.3. Formal out-of-pocket payments in the Hungarian health care system

ITEM	AMOUNT	WHO DETERMINES THE AMOUNT?	REMARKS
Pharmaceuticals	0, 50, 70, 90, 100%, or fixed	Criteria defined in ministerial decree	price subsidy
Medical aids and prosthesis (including dental prostheses)	50,70, 85, 100% or fixed	price negotiations	price subsidy
Balneotherapy	85 or 100%	price negotiations	price subsidy
Treatment in sanatorium (rehabilitation)	per diem	government	co-payment*
Removable dental prosthesis for persons aged 19-60	varies	provider	full costs of labour
Above standard hotel services			
room	per diem	provider	co-payment
meal	difference between the cost of standard meals and what is required	provider	co-payment
Other conveniences	not specified	not specified	not specified
Utilization of more services, than what is ordered by the doctor	difference between the cost of materials of the required service and what was medically indicated, including extra patient days	provider	co-payment

⁶⁷ Decree No. 44/2004. (IV. 28.) ESzCsM of the Minister of Health, Social and Family Affairs on the Prescription and Dispensing of Pharmaceuticals for Human Use.

⁶⁸ Article 25, sections (2-4).

⁶⁹ Act LXIII of 1997, Article 25, section (5) and Government Decree No. 284/1997 (XII. 23.) Korm. on the Fees of Certain Health Services which cannot be Utilized Free of Charge, Article 2, section (1).

⁷⁰ Act LXIII of 1997, Article 24, sections (1-2).

ITEM	AMOUNT		WHO DETERMINES THE AMOUNT?	REMARKS
	(1)	(2)		
Utilization of services without referral (1) Utilization at other provider, where the patient has been referred to (2)			government, provider can increase the amount up to 30%	co-payment
outpatient specialist care	2000 HUF	1500 HUF		
acute inpatient care admission	4000 HUF	4000 HUF		
until the 31st day	1000 HUF/day	800 HUF/day		
after the 31st day	500 HUF/day	400 HUF/day		
chronic inpatient care admission	4000 HUF	4000 HUF		
until the 31st day	600 HUF/day	500 HUF/day		
after the 31st day	400 HUF/day	400 HUF/day		
long term care admission	4000 HUF	4000 HUF		
for the duration of stay	1000 HUF/day	400 HUF/day		
Chronic long term care according to referral		400 HUF/day**	government	co-payment
Medical certificate for driving license		800-15000 HUF	government	full cost
Medical certificate for firearm license		3000-9000 HUF	government	full cost
Blood alcohol test		3500 HUF	government	full cost
Medical certificate for forensic purposes		2000 HUF	government	full cost
Detoxifying of drunk person		5000 HUF	government	full cost
Other excluded services, like cosmetic surgery		prices varies	provider	price
Services which are utilized at a provider with no NHIFA contract		price varies	provider	price

Notes: * Currently there are no rules in effect, which would determine the extent of co-payment.

** Before 1998 it was determined on the basis of the minimum pension, and greater flexibility was allowed to providers, to deviate from the centrally set co-payment.

I.4.A. SERVICE CATEGORIES

In summary the following functional categories are excluded:

HC.1.1. Services of curative care, special area

Hungarian category: detoxifying of drunk persons

Regulation: 7

HC.1.2. Day cases of curative care, special area: cosmetic surgery

Hungarian category: treatments for aesthetic and recreational purposes

Regulation: 6

HC.1.3.9. All other outpatient curative care, special areas: osteopathy; chiropody; podiatry

Hungarian category: manualtherapy

services not included in the International
Classification of Procedures in Medicine

Regulation: 6

HC.4. Ancillary services to health care (clinical laboratory and/or diagnostic imaging), special areas

Hungarian category: prostate specific antigen test in general screening,
medical examination for permission to own firearms, medical examination for driving licences (motor-vehicles, as well as ships), taking blood sample for blood alcohol test, and medical certificate for forensic purposes.

Regulation: 6

HC.5.1.2. Over-the-counter medicines

Hungarian category: not specified

Regulation: 22

HC.6.1. Maternal and child health; family planning and counseling, special area: reproductive health

Hungarian category: abortion without medical indication, sterilization without medical indication, IVF – more than 5 attempts

Regulation: 6

Criteria:

1. Ineffective services: services not included in the ICPM (not specified further)
2. Services that are not included in treatment protocols: so far no treatment protocols have been issued by the minister of health

II. DEFINITION OF ENTITLEMENTS AND BENEFITS BY SECTOR, DECISION-MAKING PROCESSES

As it has been described in section I.2, there are four main types of decision-making processes for the definition of benefits and entitlements (from the least to the most formalized processes):

1. Traditional regulatory regime guided by the general rules of codification with less formalized preparatory phase,
2. Price negotiations with more formalized preparatory phase,
3. Updating of classification systems for payment purposes with more formalized preparatory phase,
4. Inclusion of medicines into social health insurance financing with highly formalized preparatory phase and decision-making criteria.

II.1. TRADITIONAL REGULATORY REGIME

The traditional regulatory regime is the most commonly used decision-making mechanism regarding entitlements and benefits. The documents include acts, governmental and ministerial decrees with the National Assembly, the central government and the minister of health being the final decision-maker according to the methods presented in Table I.1, respectively. Who should be included in the preparatory phase is only vaguely defined and based on tradition. Figure II.1. provides an overview of the decision-making process.

The two key acts in the centre of the definition of the benefit package are *Act CLIV of 1997 on Health* and *Act LXXXIII of 1997 on the Services of Compulsory Health Insurance*.⁷¹ In general these acts define only a general framework in which both exclusions and inclusions are usually stipulated only at the level of broad functional categories. These laws have been passed by the parliament, signed by the president of the republic and promulgated in the Hungarian Gazette, but are not updated or modified on a regular basis. Nevertheless the modification of acts can be initiated by the government (and within that minister of health), as well as the president of the republic, members of the parliament, or parliamentary committees.⁷² Other stakeholders can also initiate changes through these actors.

The above acts contain a large number of provisions, which call the government, the minister of health, or both to specify certain functional areas further. There are two main types of ministerial decrees. *Act CLIV of 1997 on Health* has called the minister of health to regulate the professional requirements, including minimum standards and procedures of certain service categories, and these decrees may include

⁷¹ *Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services* sets the framework for who is entitled to the services of social health insurance, and does not deal with the issue of what they are entitled to.

⁷² Resolution No. 46/1994. (IX. 30) OGY of the National Assembly.

Although these decrees may require regular updating, the updating process is not regulated. In this category, updating is made on an ad hoc basis, as need arises. Although benefits are defined explicitly even in this category, services are usually not detailed. In any case, they are uniform all over the country.

II.1.A. SERVICE CATEGORIES

The following functional areas are included in this decision-making category:

HC.1.3.1. Basic medical and diagnostic services (curative primary care):

Hungarian category: family doctor services

Regulation: 2; 4

Benefit catalogue: -

HC.1.3.2. Outpatient dental care (only partially)

Hungarian category: dental care

Regulation: 2; 4; 13

Benefit catalogue: + (see payment catalogues as well)

HC.1.3.9. All other outpatient curative care:

implicit inclusion

HC.1.4. Services of curative home care

HC.2.4. Services of rehabilitative home care

Hungarian category: home care

Regulation: 4; 23

Benefit catalogue: +

HC.2.1. Inpatient rehabilitative care

Hungarian category: treatment in sanatoria in the frame of medical rehabilitation

Regulation: 4; 12

Benefit catalogue: +

HC.4.3. Patient transport and emergency rescue

Hungarian category: patient transport; emergency rescue

Regulation: 2; 4; 5; 16

Benefit catalogue: -

HC.6. Prevention and public health services

HC.6.1. Maternal and child health; family planning and counseling

Hungarian category: Mother and child health nurse services;
infertility treatments; delivery (see also acute
in-patient care); supply of breast milk

Regulation: 2; 4; 5; 24; 14; 15

Benefit catalogue: + for infertility treatments

HC.6.2. School health services

Hungarian category: school health services

Regulation: 2; 4; 25

Benefit catalogue: -

HC.6.3. Prevention of communicable diseases

Hungarian category: immunization; surveillance

Regulation: 2

Benefit catalogue: -

HC.6.4. Prevention of non-communicable diseases

Screening

Hungarian category: screening

Regulation: 4; 17

Benefit catalogue: +

Health promotion, primary prevention

Hungarian category: health promotion; primary prevention

Regulation: 2

Benefit catalogue: -

HC.6.5. Occupational health care

Hungarian category: occupational health services

Regulation: 2; 8; 9; 10

Benefit catalogue: -

HC.6.6. All other miscellaneous public health services

Hungarian category: environmental health, nutritional health;
radiation health

Regulation: 2

Benefit catalogue: -

II.1.B. EXAMPLE

Infertility treatments (HC.6.1)

Act LXIII of 1997 lists infertility treatment under obstetrical services in the group of other health services, which is in the category of health services that can be utilized free of charge in the frame of the social health insurance scheme. Article 15, section (2) of the Act states that “on the basis of medical indication, the insured are entitled to infertility treatment according to the conditions set by a separate piece of legislation.” On the other hand the closing provisions of the Act authorize the minister of health to determine these conditions in the frame of ministerial decree (Article 83, section (4), point d).

Article 2 of *Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare on Infertility Treatments which Can Be Utilized in the Frame of the Compulsory Health Insurance* specifies the services that are included in the category of infertility treatment as follows:

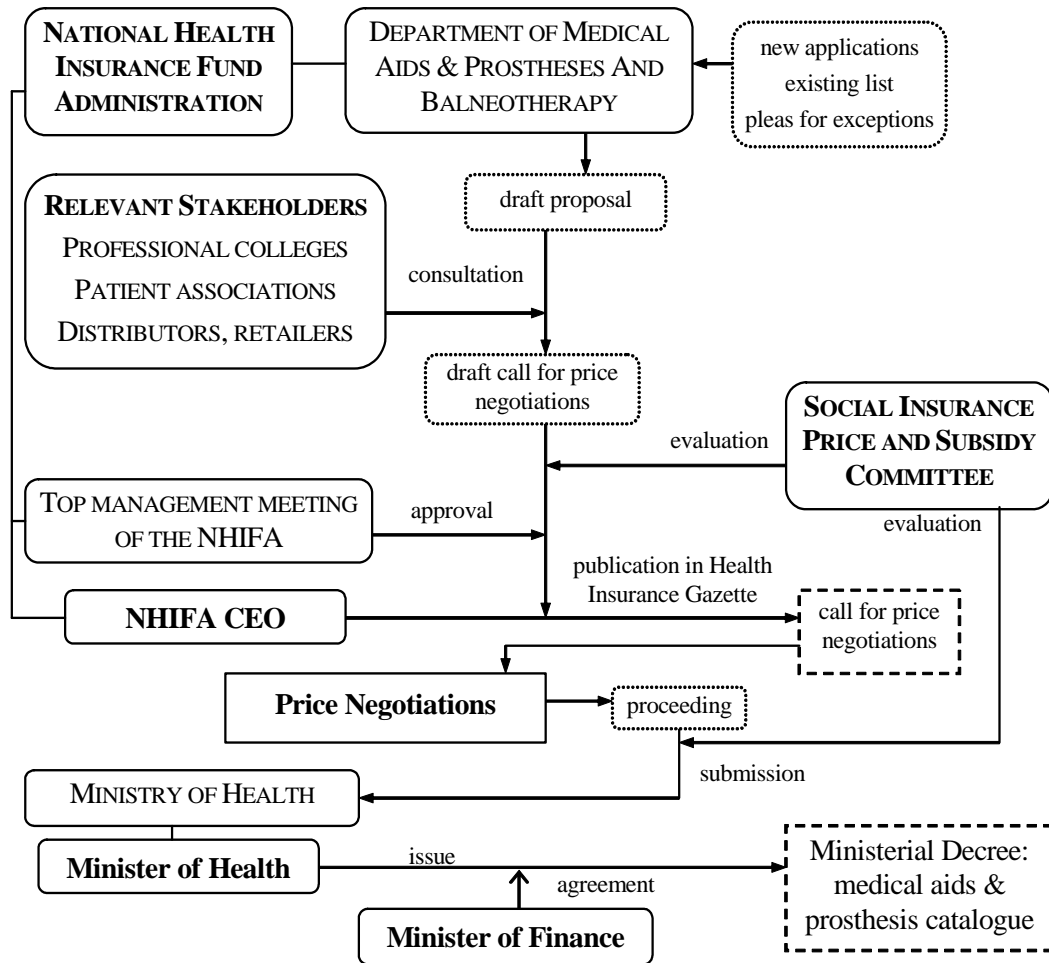
- medical diagnostic tests:
 1. examinations required for the diagnosis of sterility,
 2. medical examination of the health and genetic status of the person donating reproductive cells,
 3. medical examination of reproductive cells before storage and before use,
 4. medical examination of donated embryos and recipients,
- special interventions for human reproduction:
 5. test-tube fertilization and embryo implantation,
 6. test-tube fertilization with donated reproductive cells and embryo implantation,
 7. embryo implantation with donated embryo,
 8. other methods, which facilitates the fertility and insemination of eggs, and the implantation and growth of the fertilized egg,
- freezing storage of:
 9. the amount of reproductive cells needed for the special interventions for human reproduction, on the basis of medical indication,
 10. embryos up to 5 years.

The decree also sets certain limits and other conditions. For instance, the special interventions for human reproduction can be utilized free of charge up to five attempts in case of embryo implantation, and up to six attempts in the case artificial insemination with either own or donated sperm (Article 2, section (1), points ca-cf).

II.2. PRICE NEGOTIATIONS

The process of price negotiations, which was originally established for all products and services for which the social health insurance scheme provided subsidies (i.e. medicines, medical aids and prostheses and balneotherapy), in its complexity, currently applies to medical aids and prostheses only, as a more formalized procedure was put in place for medicines.

Figure II.2. Price negotiations



Source: Government Decree No. No. 217/1997. (XII. 1.) Korm. 7/A. 10/A. 10/B; Daubner, M (2005): personal communication; Daubner, M: Feljegyzés a gyógyászati segédeszköz ártárgyalások rendjéről.

The aim of price negotiations is to get to an agreement between the National Health Insurance Fund Administration (NHIFA) and product distributors on whether the various products will be included in social health insurance financing, what will be their gross retail price, on the basis of which to what extent they will be subsidized. The output of price negotiations is in fact a decision support document (the proceedings of the meetings), as the final decision is made by the minister of health in agreement with the minister of finance.⁷⁴ Nevertheless, the practice is that the

⁷⁴ Government Decree No. No. 217/1997. (XII. 1.) Korm. 7/A.(1)

minister of health issues the result of the price negotiations as it is, in the ministerial decree.⁷⁵

The process of price negotiations is regulated in *Government Decree No. 217/1997. (XII. 1.) Korm.* The central actor of the process is the NHIFA, whose relevant department, the Department of Medical Aids and Prostheses and Balneotherapy, first prepares a draft proposal on the basis of the new applications submitted since the previous price negotiation, of products already on the list, and of pleas for exception. The draft proposal is consulted with the relevant professional colleges, patient associations and product distributors. Using the input of relevant stakeholders, the Department prepares a draft call for price negotiations, which includes the groups of devices that should be discussed during the negotiations, the medical preconditions of prescription, the nominal duration of use, as well as the schedule for the meetings (how many rounds, etc.).

Then the draft proposal is evaluated by the Social Insurance Price and Subsidy Committee (TÁTB). The TÁTB has been established by Article 10/A of *Government Decree No. 217/1997. (XII. 1.) Korm.*, as the evaluative and proposing advisory body of the minister of health and the ministry of finance in the area of social insurance subsidies, in particular medical aids and prostheses and balneotherapy. *Government Decree No. 112/2000. (VI. 29.) Korm.* determines the members of this advisory body and the rules of decision-making. The TÁTB includes the representative of the minister of the economy and transport, and the minister of social and family affairs, two representatives of minister of health, of the minister of finance and of the chief executive officer (CEO) of the NHIFA. The chair of the committee is appointed by the minister of health in agreement with the minister of finance. One representative of the Office for the Supervision of Market Competition is also the member of the committee, but with no right to vote. Other stakeholders can also be invited to participate without the right to vote. The committee is convened as frequently as there is need for it, and decisions are made with a simple majority if at least 70% of the members are present.

The TÁTB evaluates the draft call for price negotiations and taking into account this opinion, the meeting of the top management of the NHIFA accepts the proposal, and the CEO of the NHIFA publishes it in the Health Insurance Gazette at least 4 weeks prior to the first round of negotiations.⁷⁶ The results of the price negotiations are recorded in the proceedings of the meetings and on the basis of these, the Department prepares and submits a draft ministerial decree to the Ministry of Health, together with the opinion of the TÁTB.⁷⁷

According to *Government Decree No. 217/1997. (XII. 1.) Korm.* price negotiations have to be organized in each year, and the process has to be completed by the 30th of April, while the ministerial decree must be published by the 30th of November, each year.⁷⁸ The final output of price negotiations is a positive list of therapeutic

⁷⁵ Daubner, M (2005): personal communication.

⁷⁶ *Government Decree No. No. 217/1997. (XII. 1.) Korm.* 10/B.(2).

⁷⁷ *Government Decree No. No. 217/1997. (XII. 1.) Korm.* 10/B.(4).

⁷⁸ Article 10/B. sections (1) and (5).

appliances. A similar, but less complicated process is carried out for subsidies on balneotherapy.

Although, the process of price negotiations is much more explicit and formalized than the traditional regulatory regime, the decision-making criteria, for instance, has not yet been written down and formalized.

It is worth to note that there is a variant of price negotiations for very expensive drugs, and medical devices. In these cases, prices are determined through centrally organized public tendering.⁷⁹

II.2.A. SERVICE CATEGORIES AND BENEFIT CATALOGUES

HC.1.3.9. All other outpatient curative care; special area: balneotherapy

Hungarian category: balneotherapy (or therapeutic services)

Regulation: 4; 18 (and 11)

Benefit catalogue: +

HC.5.1.1. Prescribed medicines (partly; for instance coagulation factors, interferons, erythropoietin)

Hungarian category: very expensive special medicines

Regulation: 4; 26 (previously *Joint Decree No. 46/2000. (XII. 18.) PM-EüM of the Minister of Finance and Minister of Health on the Active Ingredients of Medicines and the Therapeutic Appliance that has to be Procured on the Basis of Government Decree No. 110/2000. (VI. 29.) Korm. on the Procurement and Distribution of Certain Medicines and Therapeutic Appliances*⁸⁰)

29

Benefit catalogue: ?

HC.5.2. Therapeutic appliances and other medical durables

Hungarian category: therapeutic appliances (medical aids and prostheses)

Regulation: 4; 19

Benefit catalogue: +

⁷⁹ *Government Decree No. No. 217/1997. (XII. 1.) Korm. 10/D.*

⁸⁰ The government decree has been repealed as of 1 May 2004. The new decree in effect is *168/2004. (V. 25.) Korm.*

II.3. UPDATING OF CLASSIFICATION SYSTEMS FOR PAYMENT PURPOSES

The process of updating classification systems has been formalized for the purpose of payment and not for benefit definition. Nevertheless the detailed lists of services and ‘product categories’, which form the basis of the reimbursement of health service providers for instance, in the outpatient and acute inpatient care sectors, can be regarded as indirect benefit catalogues. While *Act LXXXIII of 1997* declares that all professionally justified curative services are included in compulsory social health insurance financing, there is no incentive for the providers to provide services which are not reimbursed. Therefore the updating procedure is relevant for the benefit basket and can be regarded as its indirect modification.

As we have briefly reviewed before, provider payment in Hungary is based on the output produced in the case of outpatient and inpatient care services. Outpatient specialist services are paid for by a fee-for-service point system, acute inpatient care by DRGs, while chronic inpatient care by bed days adjusted for the complexity of the case/service. The various services have been assigned certain number of points, and the number of points earned by a provider is converted into income by multiplying the total number of points with the monetary value of one point. Providers have to fill in a form on each patient treated. The information that has to be recorded includes the diagnosis and the services provided. The former is based on the International Classification of Diseases (currently ICD-10), while the latter is on the International Classification of Procedures in Medicine (ICPM). In the case of outpatient care, there is a list of services with ICPM codes and point values, while in the case of acute inpatient care cases are categorized into one of the 786 DRGs on the basis of the diagnosis as well as the procedures performed. Each DRG has a point value assigned to it, called the ‘DRG cost-weight’. In the case a chronic inpatient care, however, there is only a rough classification with 11 categories and various weights.⁸¹ The weights are used to multiply the number of patient days to adjust reimbursement to the complexity of the case.

The updating process of the various classification systems has been formalized in *Decree No. 6/1998. (III. 11.) NM of the Minister of Welfare on the Regulation of Updating Professional Classification Systems and Financing Parameters Used in Health Care.*⁸² The updating process includes the modification and extension of the two fundamental classification systems, as well as the list of outpatient specialist services and DRGs. The extension of the ICPM has special relevance for the benefit package, since those health care interventions, which are not listed in the (Hungarian version of the) ICPM have been excluded from social health insurance financing.

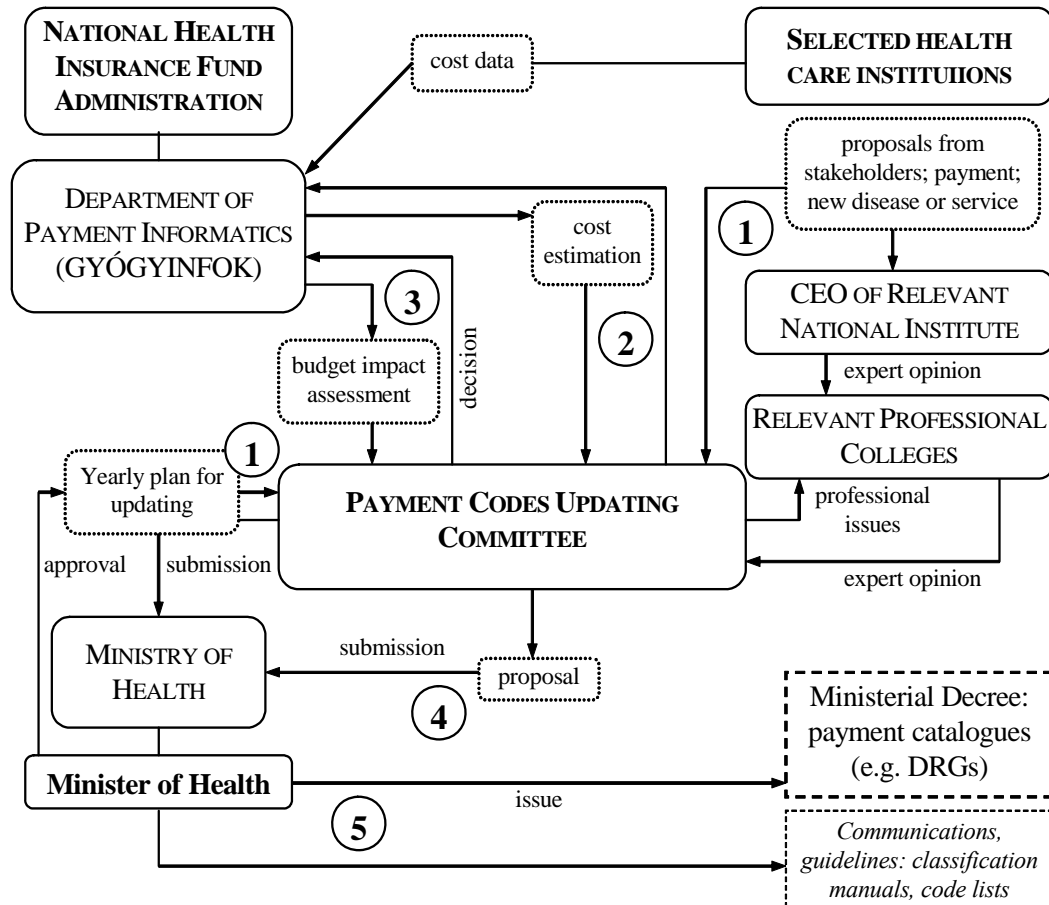
The key actors in the process are the Information Centre for Health Care (GYÓGYINFOK), which has recently been incorporated into the organization of the National Health Insurance Fund Administration as the Department of Payment

⁸¹ *Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services; Appendix 8.*

⁸² Before 1998, the updating process was carried out according to the traditional regulatory regime.

Informatics,⁸³ and the so-called Payment Codes Updating Committee, which is the advisory body of the minister of health in updating payment regulations. The list of outpatient specialist services and DRGs (as well as the day cases of curative care and the various forms of dialysis), and their modifications have always been issued as a ministerial decree.

Figure II.3. Updating of Classification Systems for Payment Purposes



Source: Decree No. 6/1998. (III. 11.) NM of the Minister of Welfare; Procedure of the Payment Codes Updating Committee

The Payment Codes Updating Committee has 15 permanent members, out of whom the Ministry of Health, the chief executive officer of the National Health Insurance Fund Administration, the GYÓGYINFOK (Department of Payment Informatics of the NHIFA) and the Hungarian Hospital Association each delegates two members, the Hungarian Medical Chamber delegates one member, while the minister of health appoints 6 medical experts. Out of the 6 medical experts 2 have to represent the professional area of internal medicine, while surgical specialties, paediatrics, diagnostic specialties and rehabilitation are to be represented with 1 member each. There are temporary members as well, who are invited by the head of the Committee on an ad hoc basis from the Hungarian Chamber of Pharmacists, the national

⁸³ As of 16 January 2004.

institutes of health and the various professional colleges. The minister of health appoints the head of the Committee, whose work is supported by the secretary. The Department of Health Insurance of the Ministry of Health provides administrative support in the form of a civil servant, who assists the secretary of the Committee.⁸⁴ The Committee prepares its Procedure, a yearly workplan and a methodological document, on the basis of which the updating process is carried out.⁸⁵

The general division of tasks is that the GYÓGYINFOK is responsible for preparing decision support documents, including the collection and analysis of the necessary financing data, while the Payment Codes Updating Committee makes the decisions, which are formulated as proposals for the issuing of ministerial decrees. Of course, as it has been described before, the ultimate decisions rest with the minister of health.

The updating process includes all the classification systems, payment catalogues with relevant payment parameters, the rules of classification and the various forms of case reporting. The updating process of these components of the payment system can be initiated two ways. First, there is a workplan (to be approved by the minister of health), in which the regular updates are planned. According to the ministerial decree and the Procedure of the Committee there should be at least one meeting per month, whose proceedings have to be submitted to the minister of health in the form of a proposal for changes at least once a year.⁸⁶ Second, all the relevant stakeholders are allowed to initiate so-called unscheduled updates.⁸⁷

The various proposals for unscheduled updates first have to be submitted to the CEO of the relevant national institute, or directly to the Committee if there is no national institute concerned, and then, if the evaluation of the proposal requires medical specialist expertise, to the relevant professional college(s). On the basis of the expert opinion provided by the professional college(s) the Committee transfers the proposal to the GYÓGYINFOK, which first prepares a cost estimation and then, if there is a positive decision from the Committee, a budget impact analysis, usually on the basis of data provided by a sample of health care institutions, which nevertheless includes all those national institutes of health, which are involved in the provision of health services. The final proposal for changes are eventually submitted to the Ministry of Health, and the payment catalogues are issued as ministerial decrees, while various announcements, communications and guidelines are published to promote the lawful use of these catalogues.⁸⁸ Proposals for unscheduled updates have to be evaluated and answered within 30 days.⁸⁹ Regular updates have to be planned in accordance with the strategy of the Ministry of Health and the decisions to be made by the

⁸⁴ Procedure of the Payment Codes Updating Committee, Article 3.

⁸⁵ *Decree No. 6/1998. (III. 11.) NM of the Minister of Welfare on the Regulation of Updating Professional Classification Systems and Financing Parameters Used in Health Care*, Article 5, section (4).

⁸⁶ Article 5, sections (6-7) of the ministerial decree, and Article 4.4 of the procedure.

⁸⁷ Article 1, section (2) of the ministerial decree, and Article 2.4 of the procedure.

⁸⁸ Article 2, sections (2-4), and Article 7, section (1) of the ministerial decree.

⁸⁹ Article 2.4 of the procedure.

Committee have to take into consideration the criteria of public health impact and of the efficient allocation of resources.⁹⁰

II.3.A. SERVICE CATEGORIES AND BENEFIT CATALOGUES

HC.1.1. In-patient curative care

Hungarian category: acute inpatient care

Regulation: 4; 21 (Annex 3; Annex 8. for high cost high tech interventions; Annex 10. for course-type treatments)

Benefit catalogue: +

HC.1.2. Day cases of curative care

Hungarian category: one-day surgery

Regulation: 4; 21 (Annex 9.)

Benefit catalogue: +

HC.1.2. Day cases of curative care; special area: haemodialysis

Hungarian category: dialysis

Regulation: 4; 21 (Annex 11.)

Benefit catalogue: +

HC.1.3.2. Outpatient dental care

Hungarian category: dental care

Regulation: 4; 21 (Annex 12.)

Benefit catalogue: +

HC.1.3.3 All other specialized health care

HC.1.3.9 All other outpatient curative care

HC.2.3 Outpatient rehabilitative health care

HC.4.1. Clinical laboratory (performed in the outpatient setting)

HC.4.2. Diagnostic imaging (performed in the outpatient setting)

Hungarian category: outpatient specialist services (WHO point, or German point system)

Regulation: 4; 21 (Annex 2.)

Benefit catalogue: +

⁹⁰ Article 2.5 of the procedure.

HC.1.3.3 All other specialized health care; special area: chronic outpatient care

Hungarian category: chronic outpatient care
Regulation: 4; 21 (Annex 15.)
Benefit catalogue: +

HC.2.1. In-patient rehabilitative care

HC.2.2. Day-cases of rehabilitative care

HC.3.1. In-patient long-term nursing care, including special area: hospice care

HC.3.2. In-patient long-term nursing care

Hungarian category: chronic inpatient care
Regulation: 2; 20
Benefit catalogue: ?

II.4. INCLUSION OF MEDICINES INTO SOCIAL HEALTH INSURANCE FINANCING

The process of inclusion of medicines into social health insurance financing has recently been modified in accordance with the requirements of the European Union. Before 1st of May 2004, the process of inclusion was exactly the same as the process for therapeutic appliances, described in section II.2.

The essence of the modification is that the process of inclusion can be initiated on a case by case basis, either from the authorities, or from the owner of the distribution license of the medicine concerned (usually the pharmaceutical company),⁹¹ and that the process is very much formalized down to the level of decision-making criteria, which ensures the transparency of the inclusion process. It is important to note that beside safety and efficacy, cost-effectiveness has been incorporated as a criterion into the decision-making process.⁹²

The key actors in the process are the:

- National Health Insurance Fund Administration, particularly its:
 1. Transparency Secretary, and for the appeal procedures the Transparency Appeal Secretary,
 2. as well as its Department of Pharmaceuticals, and to a lesser extent – for medicines, which can be used in inpatient care only – the Department of Curative and Preventive Services; and
- the Ministry of Health, in particular the Department of Health Technology Assessment of its Health Strategic Research Institute (ESKI).

⁹¹ *Act LXXXIII of 1997*, Article 21/A, sections (1-3).

⁹² *Decree No. 32/2003. (IV. 26.) ESzCsM of the Minister of Health, Social and Family Affairs*, Article 3, section i).

Other actors including the representatives of the Ministry of Finance, the Ministry of Economy and Transport, the Prime Minister's Office, the National Institute of Pharmacy, the Hungarian Chamber of Pharmacists, the Hungarian Medical Chamber, the Body of Presidents of Professional Colleges and other invited experts are also involved in the process.⁹³

In accordance with the rules and forms set by *Government Decree No. No. 217/1997. (XII. 1.) Korm.* and *Decree No. 32/2003. (IV. 26.) ESzCsM of the Minister of Health, Social and Family Affairs on the Rules of the Procedure for the Inclusion of Registered Medicines and Nutrients Satisfying Special Nutrition Needs in the Scope of Social Insurance and on the Modifications of Inclusion or Subsidy*, the owner of the distribution license of the medicine concerned has to prepare an application, which has to be submitted to the NHIFA. The Transparency Secretary is responsible for the administration of the decision making process from the registration of applications to the formulation of resolutions.⁹⁴ At the first level, the application is evaluated by the so-called Technology Assessment Committee (TÉB) and decision is made by the head of the Department of Pharmaceuticals (or Department of Curative and Preventive Services). Regarding the cost-effectiveness of medicines, the Department of Health Technology Assessment of ESKI has to be consulted.⁹⁵ If need arises, the relevant professional colleges and other external experts are also consulted.⁹⁶ At the second level the so-called Appeal Committee (FB) evaluates the application and the decision is made the CEO of the NHIFA.

The TÉB has to be set up by the NHIFA,⁹⁷ from the representatives of various stakeholders. The 11 members include the chair of the Committee, the representative of the Department of Pharmaceuticals, the representative of the Department of Curative and Preventive Services, the representative of the Department of Economics and Insurance Policy, two members delegated by the CEO of the NHIFA, the representative of the Hungarian Chamber of Pharmacists, the representative of the Hungarian Medical Chamber, the representative of the Body of Presidents of Professional Colleges, the representative of the Transparency Secretariat of the NHIFA (who is the secretary of the Committee), and the representative of ESKI. Nevertheless, the latter two members have no right to vote.⁹⁸ The TÉB have regular meetings, once a week.⁹⁹

⁹³ *Government Decree No. 217/1997. (XII. 1.) Korm.* Article 7, sections (8-9); *Decree No. 32/2003. (IV. 26.) ESzCsM of the Minister of Health, Social and Family Affairs*, Article 19; *Order No. 6/2005. (Eb. K. 3.) OEP of the Chief Executive Officer of the National Health Insurance Fund Administration*, point 4.

⁹⁴ *Order No. 6/2005. (Eb. K. 3.) OEP*, points 6, 57.

⁹⁵ *Decree No. 32/2003. (IV. 26.) ESzCsM*, Article 19, section 2; *Order No. 6/2005. (Eb. K. 3.) OEP*, points 26, 32.

⁹⁶ *Order No. 6/2005. (Eb. K. 3.) OEP*, points 33-35.

⁹⁷ *Decree No. 32/2003. (IV. 26.) ESzCsM*, Article 19, section 1; and *Order No. 6/2005. (Eb. K. 3.) OEP*, point 4.

⁹⁸ *Order No. 6/2005. (Eb. K. 3.) OEP*, point 7.

⁹⁹ *Order No. 6/2005. (Eb. K. 3.) OEP*, point 9.

of the NHIFA out of the 5 voting members of the FB. The Committee is convened by the chair as need arises.¹⁰¹

Each phase of the evaluation process is electronically recorded by the Transparency Secretariat.¹⁰² As it has been mentioned before, generally, the process is initiated by the owners of the licenses of various pharmaceuticals, but once a year the Department of Pharmaceuticals of the NHIFA has to review the complete list and initiate the necessary changes according to the process described before (yearly review).¹⁰³

The submitted application is first registered by the Transparency Secretariat, which, in consultation with the Department of Pharmaceuticals decides whether a normal or a simplified decision-making process is needed, and notifies the applicant about this.¹⁰⁴ The simplified process applies to pharmaceuticals with active ingredients, which have already been included in the benefit package, and its distinctive feature is that no evidence on cost-effectiveness and no need assessment have to be presented by the applicant. The normal process, with these latter requirements, applies to all pharmaceuticals with new active ingredients, to new indications, to new combinations and even to new formulae.¹⁰⁵ The owners of licences are also obliged to report any changes in the registration and licensing data of their medicines (notification obligation).¹⁰⁶ For the inclusion and exclusion process, the withdrawal of licences has special relevance, as it automatically incurs the removal of the medicines concerned from the benefit package.

The Transparency Secretariat also checks whether the submitted documentation contains all the required forms and attachments and that the required fee, set by *Decree No. 32/2003. (IV. 26.) ESzCsM*, has been paid. The Secretariat is responsible for obtaining the required expert opinions, first a review by the Department of Health Technology Assessment of ESKI. If need arises, the relevant Professional Colleges as well as other external experts are also consulted by the Department of Pharmaceuticals.

On the basis of these materials the department of Pharmaceuticals prepares a so-called preliminary opinion, which is presented in front of the TÉB. During the meeting of the Committee the representative of ESKI also presents the summary of its expert opinion, while other external experts can also be present in the meeting to summarize their findings and to be available for answering questions of regular members of the Committee. The TÉB are also allowed to ask for complementary information from the applicant, and can even initiate the hearing of the applicant, where the representative of ESKI has to be present. The hearing has to be organized

¹⁰¹ *Order No. 6/2005. (Eb. K. 3.) OEP*, point 15.

¹⁰² *Order No. 6/2005. (Eb. K. 3.) OEP*, points 27, 57.

¹⁰³ *Government Decree No. 217/1997. (XII. 1.) Korm.* Article 7, section (5); *Order No. 6/2005. (Eb. K. 3.) OEP*, points 53-54.

¹⁰⁴ *Order No. 6/2005. (Eb. K. 3.) OEP*, point 25.

¹⁰⁵ *Decree No. 32/2003. (IV. 26.) ESzCsM*, Article 22, section 2.

¹⁰⁶ *Decree No. 32/2003. (IV. 26.) ESzCsM*, Article 22, section 3.

by the Transparency Secretariat.¹⁰⁷ Then the TEB reviews the available materials and formulates a proposal, which is recorded in the proceedings of the meeting.¹⁰⁸

On the basis of this proposal the Transparency Secretariat prepares and submits a draft resolution to the head of the Department of Pharmaceuticals within 80 days of the date of application.¹⁰⁹ The head of the Department makes the decision and the resolution has to be posted by the Transparency Secretariat within 90 days of the date of application.¹¹⁰ This first level decision will only be effective after 15 days and in the case of a positive decision the financing of the pharmaceutical concerned has to begin no later than 365 days after this date.¹¹¹

In the case of an unfavourable decision, the applicant has the right to appeal against the resolution to the CEO of the NHIFA. The appeal is registered by the Transparency Secretariat and first forwarded to the Department of Pharmaceuticals. The Department reviews the appeal and can change its first level decision within its scope of authority, if the arguments presented by the applicant are convincing.¹¹² However, if the Department finds the claim unsubstantiated the whole documentation is forwarded to Transparency Appeal Secretariat. Then the Secretariat reviews the documentation, initiates the necessary consultation with external experts and presents the appeal to the Appeal Committee. The proposal of the FB is recorded in the proceedings of the meetings. On the basis of this proposal the Secretariat prepares a draft resolution, which is submitted to the CEO of the NHIFA, who makes the final, second level decision.¹¹³ The appeal procedure has to reach its conclusion within 60 days of the date of the submission of the appeal.¹¹⁴

The resolutions regarding the inclusion of pharmaceuticals into the benefit package have to be published monthly in the Health Insurance Gazette.¹¹⁵ The Department of Pharmaceuticals is responsible for maintaining the database of included pharmaceuticals, from which certain lists are generated and published regularly. Once a year (1 July in each year) the complete lists of included medicines is published in the Health Insurance Gazette, with the following information regarding each item:

- registration and licensing number,
- name,
- packaging,

¹⁰⁷ Decree No. 32/2003. (IV. 26.) ESzCsM, Article 20, section 4; Order No. 6/2005. (Eb. K. 3.) OEP, points 41.

¹⁰⁸ Order No. 6/2005. (Eb. K. 3.) OEP, point 36.

¹⁰⁹ Order No. 6/2005. (Eb. K. 3.) OEP, point 38.

¹¹⁰ Government Decree No. 217/1997. (XII. 1.) Korm. Article 7, section (2); Order No. 6/2005. (Eb. K. 3.) OEP, point 39.

¹¹¹ Government Decree No. 217/1997. (XII. 1.) Korm. Article 7, section 7.

¹¹² Order No. 6/2005. (Eb. K. 3.) OEP, point 47.

¹¹³ Order No. 6/2005. (Eb. K. 3.) OEP, points 48-49.

¹¹⁴ Government Decree No. 217/1997. (XII. 1.) Korm. Article 7, section 8.

¹¹⁵ Government Decree No. 217/1997. (XII. 1.) Korm. Article 7, section 8.

- producer price,
- gross consumer price,
- extent and amount of subsidy,
- consumer price (co-payment),
- starting date of financing.

Nevertheless, to keep the interested parties informed, the NHIFA is also obliged to publish the list of changed items (including the excluded ones) quarterly, i.e. on the first day of each calendar quarter.¹¹⁶

To ensure the transparency, accountability, predictability and publicity of the decision-making process, the decisions have to be made according to “objective and accountable” criteria.¹¹⁷ The inclusion and exclusion criteria are specified in *Decree No. 32/2003. (IV. 26.) ESzCsM* and *Order No. 6/2005. (Eb. K. 3.) OEP*.¹¹⁸ The ministerial decree defines certain principles, which the decision-making process has to comply with:

- registered medicines with scientifically proven safety and effectiveness,
- budget impact and financial sustainability: the decision-making process has to take into account the planned budget of the Health Insurance Fund, and the budget impact of the inclusion has to be predictable, foreseeable,
- health needs,
- cost-effectiveness,
- equity and accessibility.¹¹⁹

The order of the CEO of the NHIFA further specifies the criteria according to which the committees have to make their decisions.¹²⁰ Regarding health needs, the public health importance of the pharmaceutical has to be considered, while the order talks about the concept of maximising societal health gain, which is most probably the interpretation of the cost-effectiveness criterion at the system level. Nevertheless, the equity criterion has not yet been defined, neither it is clear how the various criteria have to be taken into account, especially if there are conflicts among them.

In general, Annex 1 of the decree lists the extent of subsidy achievable in the various indication groups (the so-called ATC groups; e.g. H₂ receptor antagonists, or liver protective medicines, or anti-TB antibiotics).¹²¹ This list also indicates the

¹¹⁶ *Government Decree No. 217/1997. (XII. 1.) Korm.* Article 7, sections (10), (12).

¹¹⁷ *Government Decree No. No. 217/1997. (XII. 1.) Korm.* Article 7, section (7); *Decree No. 32/2003. (IV. 26.) ESzCsM*, Article 3, points c-f).

¹¹⁸ *Government Decree No. 217/1997. (XII. 1.) Korm.* Article 7, section (13).

¹¹⁹ Article 3, sections a), b), h), i); Article 4, section (1).

¹²⁰ Point 37.

¹²¹ If there is a new medicine, which can not be classified into any of the existing groups, the applicant has to request the addition of the new group into the list. In this case, the minister of health consults the NHIFA and the relevant professional colleges, and, in agreement with the minister of finance, the new indication group has to be published in a ministerial decree (*Government Decree No. 217/1997. (XII. 1.) Korm.* Article 7, section (16)).

categories, where public tendering is required (see also section II.2). Certain exclusions are also stipulated in the decree:

- the medicine has no valid license,
- there is substantial evidence regarding the ineffectiveness of the medicine,
- the budget impact is disproportionately higher than the achievable health gain (nevertheless what should be considered disproportionate is not specified in the decree),
- the cost-effectiveness of the medicine can not be proven,
- if the owner of the license violates the rules of advertising at least twice within a one-year period,
- the medicine has not been marketed for more than 6 months,
- the license of the medicine has been withdrawn,
- exclusion has been requested by the owner of the license.¹²²

II.4.A. SERVICE CATEGORIES AND BENEFIT CATALOGUES

HC.5.1.1. Prescribed medicines (excluding very expensive, special medicines)

Hungarian category: prescribed medicines

Regulation: 4 (Article 21/A); 5; **22**; 29; 30

Benefit catalogue: + (includes all pharmaceuticals)

¹²² Decree No. 32/2003. (IV. 26.) ESzCsM, Article 18.

III. BENEFIT CATALOGUES

The benefit catalogues have already been summarized in section II, where the decision-making process, and the decision-making criteria (if formalized) have also been described. We have also provided examples for simple benefit lists with few items. In this section we summarize these pieces of information with a focus on the various benefit catalogues and explore only the more complicated benefit catalogues in detail.

Referring to the dilemmas raised in section I, it is important to note that we consider only those lists, which specify services beyond broad functional categories. The list of chronic inpatient care services is probably the borderline case in this respect, nevertheless it is included in this section as an illustration for the difficulties of the definitional issues discussed before.

III.1. IN-PATIENT CURATIVE CARE

OECD category:	HC.1.1.
Hungarian category:	acute inpatient care
Document(s):	21

- (21) *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services, Annex 3.*

Date passed:	2 April 1993
Decision-maker:	minister of health
Updating:	regular, according to the workplan of the Payment Codes Updating Committee
Last update:	6 August 2004
Original purpose:	payment
Method of classification:	itemized by service
Taxonomy:	26 main groups (major diagnostic categories) altogether with 786 items
Decision-making process:	updating of classification systems for payment purposes

III.1.A. HOMOGENOUS DISEASE GROUPS: THE HUNGARIAN VERSION OF DRGS

The essence of the DRG based hospital payment is that it pays a standard fee for discharged acute hospital cases and not for individual service items, like laboratory tests, hospital days, drugs or procedures. In the DRG system cases are classified into manageable number of categories, the so-called Diagnosis Related Groups. The principles of creating these groups are: (i) that they should be medically meaningful, and (ii) that in each group resource use should be the same or at least similar (homogenous resource use). A relative weight is assigned to each group. The

weight describes how costly the certain DRG cases are on average compared to other DRGs. Cost weight 1.00 represents the average cost case. A certain DRG with a weight 2.30 is more costly than another group with a weight 0.63. It is important to note however that actual hospital cases which are classified into the same DRG maybe different in terms of actual resource use (there could be less and more severe cases of the same disease), the weight of the group corresponds to the average cost of 'all' cases in the group. When DRGs are used for hospital payment purposes, the monetary value of cost weight 1.00 has to be set, and the income of the hospital can be calculated by the sum of all cost weights the hospital 'produced' by treating patients in a given period multiplied by the monetary value of 1.00 DRG weight. This latter is referred to as base fee or base rate.

In Hungary the DRG system was introduced countrywide in 1993 after a long period of data collection in 28 hospitals of a pilot project started in 1987. The US DRG system was adapted to the local situation using the cost data collected. Detailed analysis of expenditures was carried out for about 500,000 cases to determine the weights which reflect the Hungarian conditions. The National Information Centre for Health Care (GYÓGYINFOK) within the Ministry of Health was established to administer the program and to run the system. Since then the GYÓGYINFOK (currently one department of the NHIFA) has been responsible for the continuous refinement of the Hungarian DRGs (referred to as Homogenous Disease Groups or HDGs) which reflects in the number of new versions developed so far.

The current version is HDGs 5.0 which has been in effect from the 1st of February 2004, but since then it has already been modified once. The many times modified *Decree No. 9/1993. (IV.2.) NM of the Minister of Health* describes the HDGs including certain group specific parameters which have important effects on how hospitals are paid for a given case. The 786 HDGs are classified into 26 main groups, referred to as major diagnostic categories, which are shown in Table III.1. For classifying a patient into DRGs, certain characteristics of the case are considered including the principal diagnosis of hospitalization, co-morbidity, medical interventions performed and the patient's age.

Table III.1. Major Diagnostic Categories of HDGs

Major diagnostic categories	Number of HDGs in major categories
01 Diseases of the nervous system	72
02 Eye diseases	20
03 ENT diseases	31
04 Diseases of the respiratory system	37
05 Diseases of the circulatory system	91
06 Diseases of the digestive system	57
07 Diseases of the liver and pancreas	24
08 Diseases of the muscular system and connective tissues	107
09 Breast and skin diseases	25
10 Endocrine, nutrition and metabolism diseases	28
11 Kidney and urinary diseases	31
12 Male reproductive system diseases	19

Major diagnostic categories	Number of HDGs in major categories
13 Female reproductive system diseases	23
14 Pregnancy, birth, childbed	23
15 New-born babies	22
16 Blood and blood-forming system diseases	15
17 Myeloproliferative diseases	25
18 Infectious diseases	12
19 Mental diseases	17
20 Mental and organic diseases caused by alcohol and drug addiction	5
21 Injuries, poisonings	21
22 Burns and chilblains	12
23 Signs and symptoms	1
24 AIDS	1
25 Operations in polytraumatic state	11
26 DRGs without main category*	56
Total	786

Notes: * 12 DRGs are without cost-weight, because different reimbursement is applied

The first step is to determine the major diagnostic category. Within a major diagnostic category, the main diagnosis and/or the interventions can be a principal classification criterion, which are further modified by co-morbidity and age. Once the final diagnosis related group is selected for a given case its cost weight (or point) is also known, because these are listed in the aforementioned ministerial decree. For instance in the major diagnostic category 14 (pregnancy, birth and childbed) there are three groups of classifying factors: the type of pregnancy (w/o complications, pathological pregnancy), the type of delivery (Caesarean, vaginal, vaginal with operation, vaginal with epidural anaesthesia) and the conditions of delivery (high risk, other co-morbidity). Table III.2 provides a few examples of HDGs and cost weights in the major diagnostic categories 05 and 14.¹²³

Table III.2. Examples of HDGs in Major Diagnostic Category 05 and 14

#	Examples of HDGs in category 05 and 14	Cost weight (HDG point)
05M 2050	AMI (Acute Myocardial Infarction) treated with thrombolytic therapy	2.71050
05M 2060	AMI with temporary pacemaker implantation	2.52839
05M 2070	AMI without special treatment	1.82023
05P 2081	AMI treated with PTCA and one or more stent(s)	7.14697
05P 2082	AMI treated with PTCA, without stent	4.84391
05M 2220	Angina pectoris with complex non-invasive diagnostic procedure	0.96748
05M 2230	Angina pectoris, atherosclerosis, other circulatory diseases	0.56686
14P 671A	Caesarean section	1.29933
14P 671B	Caesarean section after a pregnancy with complication	3.57493

¹²³ Nevertheless the cost weight is only one, though important factor in determining how much hospitals are in fact paid.

#	Examples of HDGs in category 05 and 14	Cost weight (HDG point)
14P 672A	High risk vaginal delivery	0.84518
14P 672B	High risk vaginal delivery after a pregnancy with complications	3.70151
14M 673A	Normal delivery	0.62474
14M 673B	Vaginal delivery after a pregnancy with complications	2.72986
14M 673C	Vaginal delivery with epidural anaesthesia	0.69926
14M 673D	Vaginal delivery with epidural anaesthesia after a pregnancy with complications	2.73109
14M 674A	Vaginal delivery with operation	0.69622
14M 674B	Vaginal delivery with operation after a pregnancy with complications	2.95130
14P 6780	Extrauterin gravidity operated by laparoscopy	0.99520
14P 6790	Extrauterin gravidity operation (open laparatomia)	1.00425

III.2. DAY CASES OF CURATIVE CARE

OECD category: HC.1.2.
Hungarian category: one-day interventions
Document(s): 21

- (21) *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services, Annex 9.*

Date passed: 2 April 1993
Decision-maker: minister of health
Updating: regular, according to the workplan of the Payment Codes Updating Committee
Last update: 6 August 2004
Original purpose: payment
Method of classification: itemized by service
Taxonomy: Altogether 227 items in two lists. The first list contains 194 elective surgical procedures (Annex 9, section I), while the second list contains 33 other (so-called “clinical”) interventions (Annex 9, section III).
Decision-making process: updating of classification systems for payment purposes

III.3. DAY CASES OF CURATIVE CARE; SPECIAL AREA: HAEMODIALYSIS

OECD category: HC.1.2.
Hungarian category: dialysis
Document(s): 21

(21) *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services, Annex 11.*

Date passed:	2 April 1993
Decision-maker:	minister of health
Updating:	regular, according to the workplan of the Payment Codes Updating Committee
Last update:	2 March 2001
Original purpose:	payment
Method of classification:	itemized by service
Taxonomy:	6 items: (1) haemodialysis, haemofiltration, haemodiafiltration; (2) haemodialysis, haemofiltration, haemodiafiltration under 18 years old; (3) peritoneal dialysis; (4) haemoperfusion; (5) haemodialysis with reusable dialysator; (6) mobile treatment.
Decision-making process:	updating of classification systems for payment purposes

III.4. OUTPATIENT DENTAL CARE

OECD category:	HC.1.3.2.
Hungarian category:	dental care
Document(s) #:	13; 21; (4 (Article 23, a,c), 7 (Annex 1, 1,2) – co-payment)

(13) *Decree No. 48/1997. (XII. 17.) NM of the Minister of Welfare on Dental Services which Can Be Utilized in the Frame of the Compulsory Health Insurance*

Date passed:	17 December 1997
Decision-maker:	minister of health
Updating:	ad hoc
Last update:	1 November 2001
Original purpose:	definition of entitlements
Method of classification:	itemized by service
Taxonomy:	3 main groups: (1) dental screening, with 7 items in 3 subgroups; (2) dental emergency services with 10 items; (3) dental primary and secondary care, defined as the payment list, detailed in a separate decree (21);
Decision-making process:	traditional regulatory regime

(21) *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services, Annex 12.*

Date passed:	2 April 1993
Decision-maker:	minister of health
Updating:	regular, according to the workplan of the Payment Codes Updating Committee
Last update:	11 March 2003
Original purpose:	payment
Method of classification:	itemized by service
Taxonomy:	125 items in 10 groups: (1) examinations, documentations with 9 items, (2) prevention with 5 items, (3) x-ray with 5 items, (4) anesthesia and prescription of medications with 5 items, (5) tooth preserving services and endodontia with 12 items, (6) oral diseases and parodontology with 11 items, (7) dental surgery with 24 items, (8) dental prosthetics with 26 items, (9) child, school and youth dental services with 13 items, (10) orthodontia with 15 items;
Decision-making process:	updating of classification systems for payment purposes

III.5. OUTPATIENT SPECIALIST SERVICES

OECD categories:	HC.1.3.3 All other specialized health care
	HC.1.3.9 All other outpatient curative care
	HC.2.3 Outpatient rehabilitative health care
	HC.4.1. Clinical laboratory (performed in the outpatient setting)
	HC.4.2. Diagnostic imaging (performed in the outpatient setting)
Hungarian category:	outpatient specialist services
Document(s):	21

(21) *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services, Annex 2.*

Date passed:	2 April 1993
Decision-maker:	minister of health
Updating:	regular, according to the workplan of the Payment Codes Updating Committee
Last update:	27 August 2004
Original purpose:	payment
Method of classification:	itemized by service

Taxonomy:	The so-called WHO point, or German point system is based on the 1978 International Classification of Procedures in Medicine of the WHO (ICPM), but the original list have been frequently modified ever since it has been introduced as the basis of payment in the outpatient specialist setting. The list contains 3166 (and together with the dispensary specific services 3204) items, with no apparent classification structure.
Decision-making process:	updating of classification systems for payment purposes

III.6. ALL OTHER SPECIALIZED HEALTH CARE, SPECIAL AREA: CHRONIC OUTPATIENT CARE

OECD category:	HC.1.3.3.
Hungarian category:	chronic outpatient care (provided by dispensaries for skin and sexually transmitted diseases, oncology, pulmonary diseases, psychiatric diseases and addictology)
Document(s):	21

(21) *Decree No. 9/1993. (IV. 2.) NM of the Minister of Welfare on the Social Insurance Financing of Specialist Services, Annex 15.*

Date passed:	11 May 2004
Decision-maker:	minister of health
Updating:	regular, according to the workplan of the Payment Codes Updating Committee
Last update:	-
Original purpose:	payment
Method of classification:	itemized by service
Taxonomy:	Altogether 120 items in 5 main groups according to the 5 main areas: (1) skin and STD with 29 items; (2) oncology with 26 items; (3) pulmonology with 25 items; (4) psychiatry with 19 items and (5) addictology with 21 items. Nevertheless there is a considerable overlap with the list of Annex 2 (outpatient specialist services), leaving only 38 items that are listed in Annex 15 (services of chronic outpatient care).

Decision-making process: updating of classification systems for payment purposes

III.7. ALL OTHER OUTPATIENT CURATIVE CARE; SPECIAL AREA: BALNEOTHERAPY

OECD category: HC.1.3.9.
Hungarian category: balneotherapy (“therapeutic service”)
Document(s): 11 (within the frame of medical rehabilitation), 18

(11) *Decree No. 5/2004. (XI. 9.) EüM of the Minister of Health on Balneotherapy for Medical Rehabilitation that can be Utilized with Social Insurance Subsidy*

Date passed: 9 November 2004
Decision-maker: minister of health
Updating: ad hoc
Last update: -
Original purpose: definition of entitlements, regulation of prescription, utilization, and professional requirements
Method of classification: itemized by service; indications and contraindications
Taxonomy: Annex 1. list of balneotherapy services, 10 items; Annex 4. list of physiotherapy services, 13 items; Annex 5 and 6. indications and contraindications.
Decision-making process: traditional regulatory regime

(18) *Decree No. 56/2003. (IX. 19.) ESzCsM of the Minister of Health, Social and Family Affairs on the Subsidies of Balneotherapy, which can be Prescribed with Social Insurance Subsidy*

Date passed: 19 September 2003
Decision-maker: minister of health
Updating: regular
Last update: -
Original purpose: definition of entitlements
Method of classification: itemized by service
Taxonomy: 3 groups with the same 10 items; subsidy (co-payment) is different for spas, which have national, regional and local qualification;
Decision-making process: price negotiations

III.8. SERVICES OF CURATIVE HOME CARE AND REHABILITATIVE HOME CARE

OECD category: HC.1.4, HC.2.4.
Hungarian category: specialist home care
Document(s) #: 23

- (23) *Decree No. 20/1996. (VII. 26.) NM of the Minister of Welfare on Home Care, Annex 1.*

Date passed: 26 July 1996
Decision-maker: minister of health
Updating: ad hoc
Last update: 9 June 1999
Original purpose: specification of professional requirements
Method of classification: itemized by service
Taxonomy: 13 service categories, 22 items (includes hospice at home)
Decision-making process: traditional regulatory regime

III.9. CHRONIC INPATIENT CARE

OECD category: HC.2.1. In-patient rehabilitative care
HC.2.2. Day-cases of rehabilitative care
HC.3.1. In-patient long-term nursing care, including special area: hospice care
HC.3.2. In-patient long-term nursing care
Hungarian category: chronic inpatient care
Document(s): 20

- (21) *Government Decree No. 43/1999. (III. 3.) Korm. on Certain Aspects of the Social Insurance Financing of Health Services, Annex 8.*

Date passed: 3 March 1999
Decision-maker: central government
Updating: regular, according to the workplan of the Payment Codes Updating Committee
Last update: 28 April 2004
Original purpose: payment
Method of classification: itemized by major service categories
Taxonomy: 11 items, 9 service categories
Decision-making process: updating of classification systems for payment purposes

III.9.A. CHRONIC INPATIENT CARE CATEGORIES

Annex 8 of the government decree lists 9 service areas:

1. long-term nursing care (care provided at long-term nursing care wards; long-term nursing care provided at nursing wards with mixed profile),
2. chronic care,
3. rehabilitation,
4. intensive rehabilitative care,
5. hospice care (and hospice care included in the frame of tendering),
6. rehabilitation of alcohol, drug addicts and other addictological patients,
7. care provided for patient with four paralyzed limbs (quadriplegia),
8. special rehabilitative care (patients with skull, brain and backbone damage, septic patients),
9. respiratory rehabilitation (machine).

III.10. INPATIENT REHABILITATIVE CARE, SPECIAL AREA: SANATORIUM

OECD category:	HC.2.1.
Hungarian category:	treatment in sanatoria in the frame of medical rehabilitation
Document(s) #:	12

(12) *Decree No. 20/1995. (VI. 17.) NM of the Minister of Welfare on the Treatment in Sanatoria in the Frame of Medical Rehabilitation, Annexes 2, 3, 4*

Date passed:	17 June 1995
Decision-maker:	minister of health
Updating:	ad hoc
Last update:	3 May 1996
Original purpose:	regulation of utilization
Method of classification:	indications and contraindications
Taxonomy:	Annex 2. adult rehabilitation: 3 groups (cardiovascular diseases – 11 indications, locomotor disorders – 4 indications; lung diseases and endocrine diseases – 6 indications; sanatoria are also specified); general and specific contraindications Annex 3. child rehabilitation: indications and contraindications are specified by the 3 sanatoria Annex 4. outpatient rehabilitation: 3 groups (cardiovascular diseases; locomotor disease, other diseases
Decision-making process:	traditional regulatory regime

III.11. PRESCRIBED MEDICINES

OECD category: HC.5.1.1.
Hungarian category: included medicines
Document(s): 22

- (22) *Decree No. 1/2003. (I. 21.) ESzCsM of the Minister of Health, Social and Family Affairs on the Medicines which can be Prescribed with Social Insurance Subsidy and on the Amounts of Subsidy, Annex 4.* (valid until 1 July 2005; then the list will only be published as an Announcement in the Health Insurance Gazette of the NHIFA)

Date passed: 21 January 2003
Decision-maker: National Health Insurance Fund Administration (previously minister of health)
Updating: regular (quarterly for the changes, yearly for the whole list)
Last update: 1 April 2005
Original purpose: definition of entitlements (the list includes all the included medicines, but certain items are not subsidized either because they are available free of charge only for the socially indigent (co-payment exemption scheme- KÖZGYÓGY), or because they are used in inpatient care only)
Method of classification: itemized
Taxonomy: items are listed in alphabetical order
Decision-making process: inclusion of medicines into social health insurance financing; partly price negotiations (very expensive special medicines)

III.12. THERAPEUTIC APPLIANCES AND OTHER MEDICAL DURABLES

OECD category: HC.5.2.
Hungarian category: medical aids and prosthesis, therapeutic appliances
Document(s): 19

- (19) *Decree No. 19/2003. (IV. 29.) ESzCsM of the Minister of Health, Social and Family Affairs on the Medical Aids and Prostheses which can be Prescribed and Rented with Social Insurance Subsidy, on the Amount and Extent of Subsidies and on the Professional Requirements of Prescription, Distribution, Renting and Repair, Annex 1.* (Annex 2. – 100% subsidy; Annex 3. – 85% subsidy, Annex 4. rentable items)

Date passed: 29 April 2003

Decision-maker:	minister of health
Updating:	regular
Last update:	23 November 2004
Original purpose:	definition of entitlements
Method of classification:	itemized by service
Taxonomy:	6 (7) level classification system based on ISO codes
Decision-making process:	price negotiations

III.12.A. TAXONOMY OF THE BENEFIT CATALOGUE FOR THERAPEUTIC APPLIANCES

The Decree has three itemized lists in appendix. Annex 2 lists all the included therapeutic appliances according to the ISO classification:

- ISO number,
- name of the therapeutic appliance,
- unit of quantity (pc/couple/box/meter),
- agreed net price (HUF/unit),
- extent of subsidy,
- net amount of subsidy (HUF/unit),
- nominal duration of use,
- maximum quantity that can be prescribed,
- availability in the frame of the co-payment exemption scheme,
- production ceased.

In Annex 1, items are listed with its general extent of subsidy, but for special indications and for special prescription (prescribed by for instance particular specialists), it is possible to have particular items with higher subsidy. Annex 2 lists those items, which patients with certain diseases are eligible for free of charge (i.e. 100% subsidy), while Annex 3 lists the items, which can be obtained with 85% subsidy for special indications, provided that the therapeutic appliances are prescribed the authorized physicians specified in these lists.

Annex 1 has two main parts. It begins with a “table of content”, which provides an overview of the product categories up to the third hierarchical level. The second part of Annex 1 is a table, which lists all included therapeutic appliance items in accordance with the classification system presented before, but of course with all six (seven) levels, where the sixth (seventh) level category is the product itself. There are 8 major (first level) categories:

1. bandages (ISO code 02), with 13 sub-categories,
2. therapeutic and practicing equipment (ISO code 03), with 10 sub-categories,
3. orthoses and prostheses (ISO code 06), with 7 sub-categories,
4. appliances of personal care and protection (ISO code 09), with 9 sub-categories,

5. appliances of personal motion (ISO code 12), with 6 sub-categories,
6. household appliances (ISO code 15), with 1 sub-category,
7. furniture and adaptation equipment for home and other use (ISO code 18), with 1 sub-category,
8. contacting, communication and signaling equipment (ISO code 21), with 2 sub-categories.

For instance in category 8, there are two sub-categories (second hierarchical level):

1. visual aids, and
2. hearing aids.

Within the sub-category of hearing aids there are 9 sub-sub-categories (third hierarchical level), including:

1. hearing aids in the ear,
2. hearing aids behind the ear,
3. hearing aids built in spectacles frame using air transmission,
4. boxed hearing aids attached to the body,
5. hearing aids built in spectacles frame and other hearing aids using bone transmission,
6. appliances for treating tinnitus,
7. hearing aids accessories (personalized ear-attachments)
8. hearing aids batteries and their accessories,
9. other accessories and other hearing aids.

Table III.3 and Table III.4 provide examples for the other hierarchical levels.

Table III.3. Example of the taxonomy of the benefit catalogue of therapeutic appliances: Hearing aids

ISO number	Category / name	U	Net price (HUF)	Subsidy		ND	MP	CE	P
				ext.	HUF				
21	CONTACTING, COMMUNICATION AND SIGNALING EQUIPMENT								
21 45	HEARING AIDS								
	<i>Note:</i> when prescribed the side has to be indicated								
21 45 03	HEARING AIDS IN THE EAR								
	<i>Indication:</i> improving hearing impairment								
	<i>Prescription right:</i> audiology specialist								
21 45 03 03 09	In-ear, analogue module appliances equipped with “D” class amplification (recommended for grave hearing impairment)								
21 45 03 03 09 39	Group C								
21 45 03 03 09 39 001	Phonak Unica	pc	48,947	85%	41,605	60	1	K	
21 45 03 06 03	In-ear, analogue module appliances equipped with not “D” class amplification (recommended for mild hearing impairment)								
21 45 03 06 03 06	Group B								

ISO number	Category / name	U	Net price (HUF)	Subsidy		ND	MP	CE	P
				ext.	HUF				
21 45 03 06 03 06 001	Starkey Intra B 20	pc	40,375	85%	34,319	60	1		X
21 45 03 06 03 06 002	Starkey Intra B 25	pc	40,375	85%	34,319	60	1		X
21 45 03 06 03 09	Group C								
21 45 03 06 03 09 001	Starkey Intra B 28	pc	42,925	85%	36,486	60	1	K	
21 45 03 06 03 09 002	Starkey Intra B 23	pc	42,925	85%	36,486	60	1	K	
21 45 03 06 03 09 003	Viennatone 431	pc	42,925	85%	36,486	60	1	K	
21 45 03 06 03 09 004	Siemens Cosmea Modul 12 A	pc	51,775	FIX	34,420	60	1		X
21 45 03 06 03 12	Group D								
21 45 03 06 03 12 001	Starkey Intra B 44	pc	42,925	85%	36,486	60	1	K	
21 45 03 06 03 12 002	Phonak Unica EH	pc	64,688	FIX	36,486	60	1		
21 45 03 06 03 12 003	Puretone C2006	pc	42,925	85%	36,486	60	1	K	
21 45 03 06 03 12 004	Puretone C2007	pc	62,700	FIX	36,486	60	1		

Notes: U = unit of quantity; pc = piece; HUF = Hungarian forints; ND = Nominal duration of use in months; MP = Maximum quantity that are allowed to be prescribed; CE = available in co-payment exemption scheme; P = Production has been ceased.

Table III.4. Example of the taxonomy of the benefit catalogue of therapeutic appliances: Manual inhalators

ISO number	Category / name	U	Net price (HUF)	Subsidy		ND	MP	CE	P
				ext.	HUF				
03	THERAPEUTIC AND PRACTICING EQUIPMENT								
03 03	EQUIPMENT OF RESPIRATION THERAPY								
03 03 06	INHALATORS								
03 03 06 09	MANUAL INHALATORS FOR INHALATION MEDICINES								
	<i>Indication:</i> mucoviscidosis, acute bronchitis, chronic bronchitis, bronchiectasia, asthma bronchiale, pseudocroup								
	<i>Prescription right:</i> internist, ENT specialist, pulmonologist								
03 03 06 09 03	Manual inhalator for Pulmicort powder								
03 03 06 09 03 001	Pulmicort nebulizer	pc	829	85%	705	36	1		X
03 03 06 09 06	Manual inhalator for Cromolyn capsules								
03 03 06 09 06 001	Cromolyn	pc	359	85%	305	36	1		X
03 03 06 09 09	Manual inhalator for Intal capsules								
03 03 06 09 09 001	Intal spinhaler	pc	559	85%	475	36	1		X
03 03 06 09 12	Manual inhalator for other anti-asthmatic medicines								
03 03 06 09 12 001	Inhalator M (Atrovent, Berodual, Berotec)	pc	1,322	85%	1,124	36	1		X

Notes: U = unit of quantity; pc = piece; HUF = Hungarian forints; ND = Nominal duration of use in months; MP = Maximum quantity that are allowed to be prescribed; CE = available in co-payment exemption scheme; P = Production has been ceased.

III.13. MATERNAL AND CHILD HEALTH; FAMILY PLANNING AND COUNSELING, SPECIAL AREA: INFERTILITY TREATMENTS

OECD category: HC.6.1.
Hungarian category: infertility treatments
Document(s): 14

- (14) *Decree No. 49/1997. (XII. 17.) NM of the Minister of Welfare on Infertility Treatments which Can Be Utilized in the Frame of the Compulsory Health Insurance*

Date passed: 17 December 1997
Decision-maker: minister of health
Updating: ad hoc
Last update: 28 December 2001
Original purpose: definition of entitlements
Method of classification: itemized by service
Taxonomy: see section II.1.B
Decision-making process: traditional regulatory regime

III.14. PREVENTION OF NON-COMMUNICABLE DISEASES

OECD category: HC.6.4.
Hungarian category: prevention and early detection of diseases (screening)
Document(s): 17

- (17) *Decree No. 51/1997. (XII. 18.) NM of Minister of Welfare on Health Services for the Prevention and Early Detection of Diseases, which Can Be Utilized in the Frame of the Compulsory Health Insurance and the Certification of Attendance Annex*

Date passed: 18 December 1997
Decision-maker: minister of health
Updating: ad hoc
Last update: 16 June 2004 (inclusion of breast cancer and cervical cancer screening)
Original purpose: definition of entitlements
Method of classification: itemized by service
Taxonomy: 3 sections: (1) compulsory screening, (2) optional screening, (3) "public health" screening, further subdivided by age.

Section 1: two age categories (1) 0-6 days with 4 items, (2) at the age of 1 month, 3 months, 6 months with 7 items;

Section 2: six age groups (1) at the age of 1, 2, 3, 4, 5, 6 years with 8 items, (2) 6-18 years with 5 items, (3) 18-25 years with 5 items, (4) 25-45 years with 4 items, (5) 45-65 years 4 items, (6) 65+ years with 5 items;

Section 3: currently 2 items (1) 25-45 years cervical cc screening, (2) 45-65 breast cc screening.

Decision-making process: traditional regulatory regime

IV. DISCUSSION

In summary the above discussion shows, that Hungary has a near comprehensive benefit basket, with few exclusions, and generally few cases of substantial co-payments except for pharmaceuticals and therapeutic appliances. The general opinion in Hungary is that the explicit priority setting with more exclusions or more significant co-payments would not be accepted by the majority of the society and therefore politicians are reluctant to touch the issue of rationing and priority setting explicitly. On the other hand, the financial pressure on the system is high and indirect, implicit rationing does occur, for instance through informal payments. It is a question how long this schism can be uphold, especially in light of the challenges (threats) the new freedom of joining the European Union poses to the country, and in particular to the health sector.