

# **Equity and health care reforms in Hungary: comments on the government's reform proposal**

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**SEMMELWEIS UNIVERSITY BUDAPEST  
HEALTH SERVICES  
MANAGEMENT  
TRAINING CENTRE**

# Outline

- Why focus on production efficiency?
- Where we by and large agree: problem diagnosis and the need for reform
- Where we disagree: is insurance competition a good idea?
- Constructive debate: an alternative option

- Production efficiency requires that whatever we produce do it at least cost
- Elimination of waste free up resources that can be used for any purposes, e.g. to decrease regional inequalities in access to care
- Proposals to increase production efficiency may have direct consequences on equity
- A significant problem in Hungary, but has relevance to all countries

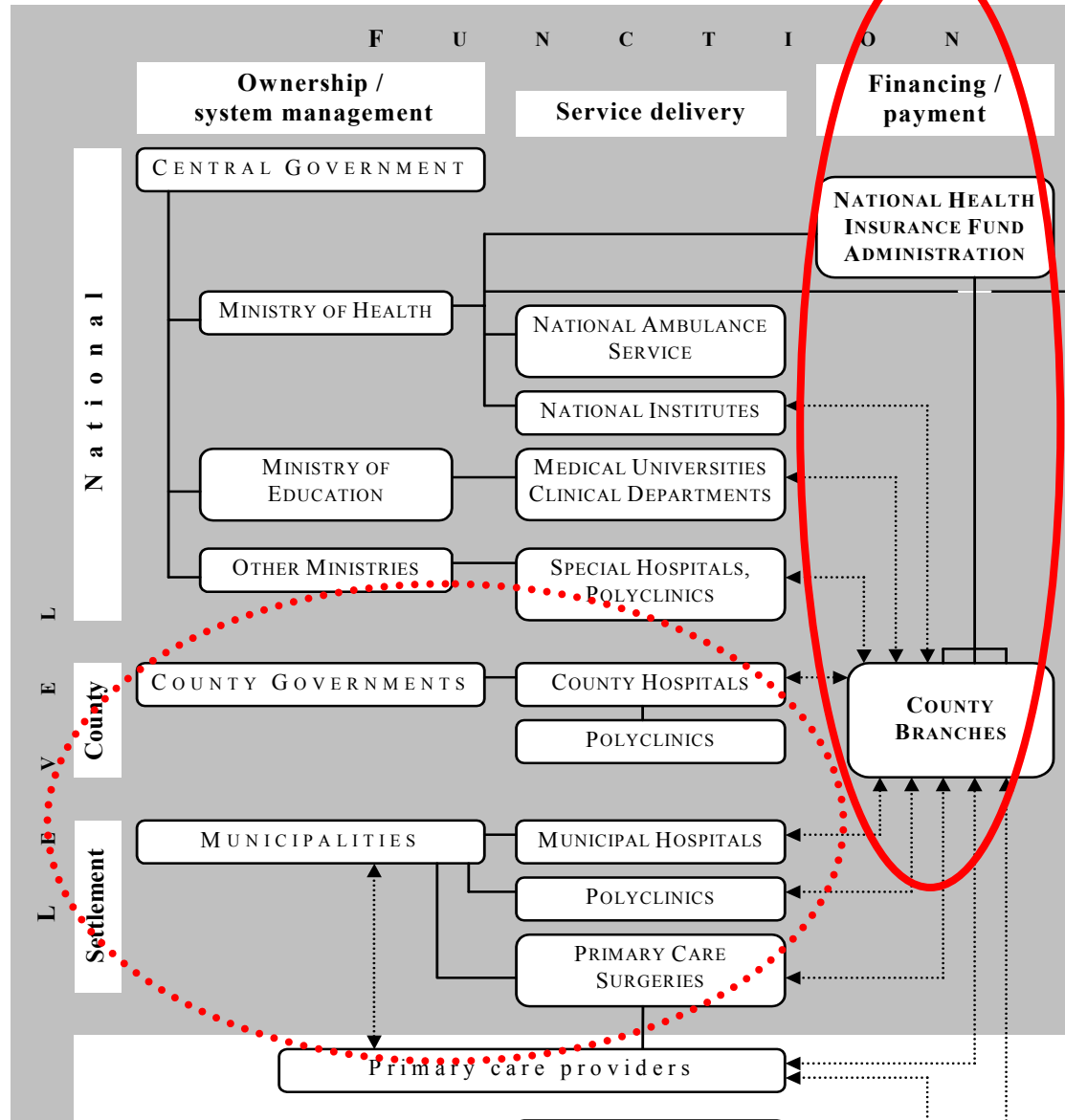
- Pure waste:
  - The use of ineffective and dominated technologies
  - Unnecessary services (Supplier Induced Demand)
  - Providing services at unnecessary high levels of care (e.g. hospitalization of patients, who could be treated in the outpatient setting)
- What is the evidence of waste in the Hungarian health care system?

# Problem diagnosis

- Brief introduction to the system
- Evidence of the provision of unnecessary services
- A more detailed analysis: payment reforms and production efficiency

- Financing:
  - social insurance with near comprehensive and universal coverage
- Service delivery
  - predominantly local-government owned delivery system
- Main features:
  - still dominantly publicly funded and provided health care, but
  - financing and service provision is separated (purchaser-provider split)

# The Hungarian system



- Identification number for each citizen (Social Insurance Identification Number)
- Specialist providers document services provided to each patient and report it to the NHIFA in each month on the basis of which they are paid



**Társadalombiztosítási Igazolvány**  
 név: *Kis István*  
 születési dátum: *1977-10-11*  
 Társadalombiztosítási Azonosító Jel:  
**037 276 965**

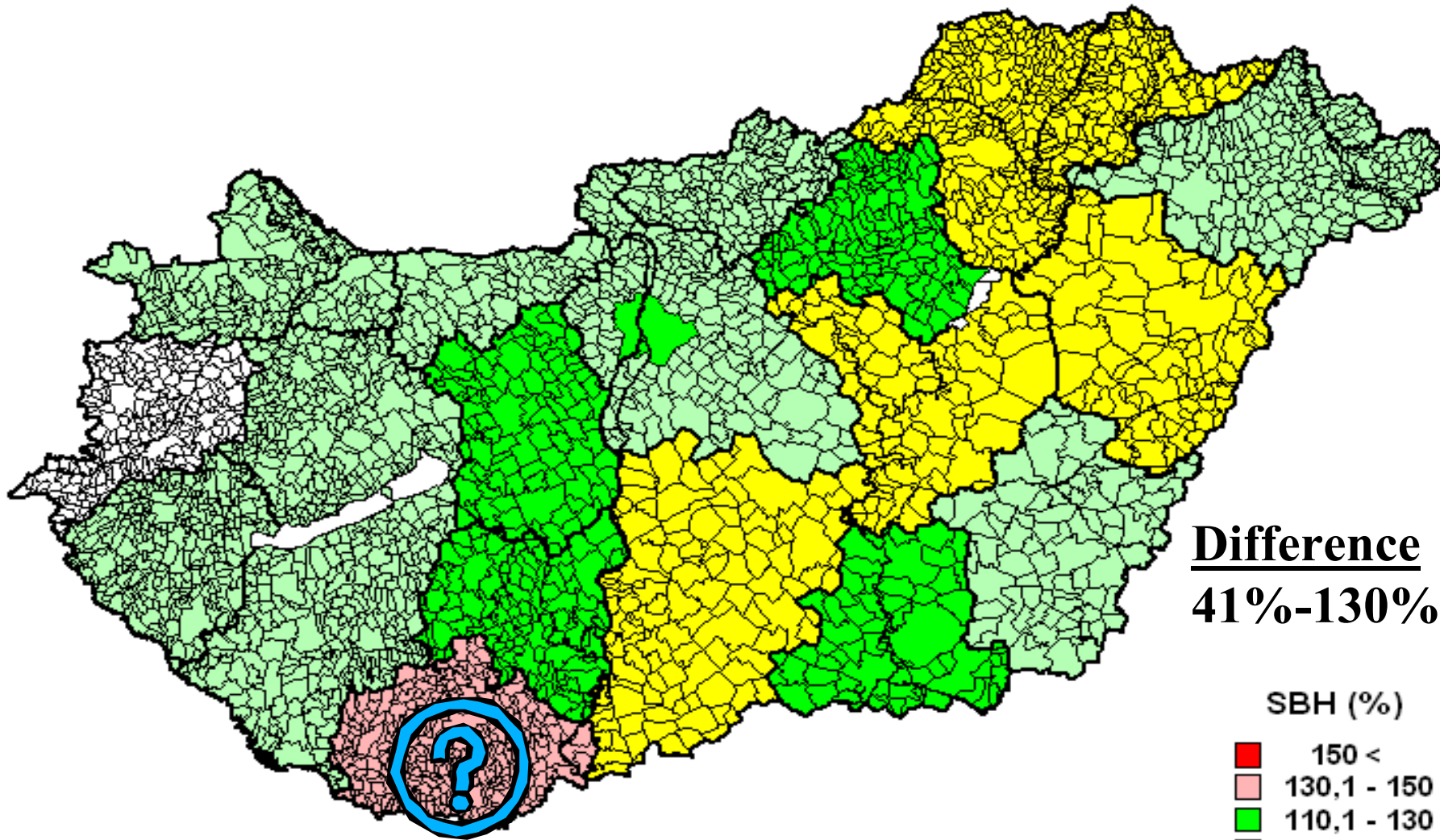
A kiállítás dátuma: *1995-10-05*

**Kőbányai Egészségügyi Szolgálat**  
 Kőbányai Egészségügyi Szolgálat  
 1106 Bp., Kerékpáros út 67.

**A választott orvos:**  
 neve: *Tel.: 2-628-295*  
 címe: *Dr. Bogdán József*  
 kódja: *AG.az.: 000* telefonszáma:  
 dátum: *1998 JAN 15* pH  
 aláírás

neve: \_\_\_\_\_  
 címe: \_\_\_\_\_  
 kódja: \_\_\_\_\_ telefonszáma: \_\_\_\_\_  
 dátum: ..... pH aláírás

# Geographical differences in the number of cases: Tonsillectomy 1997 Hungary



**Difference**  
**41%-130%**

**SBH (%)**

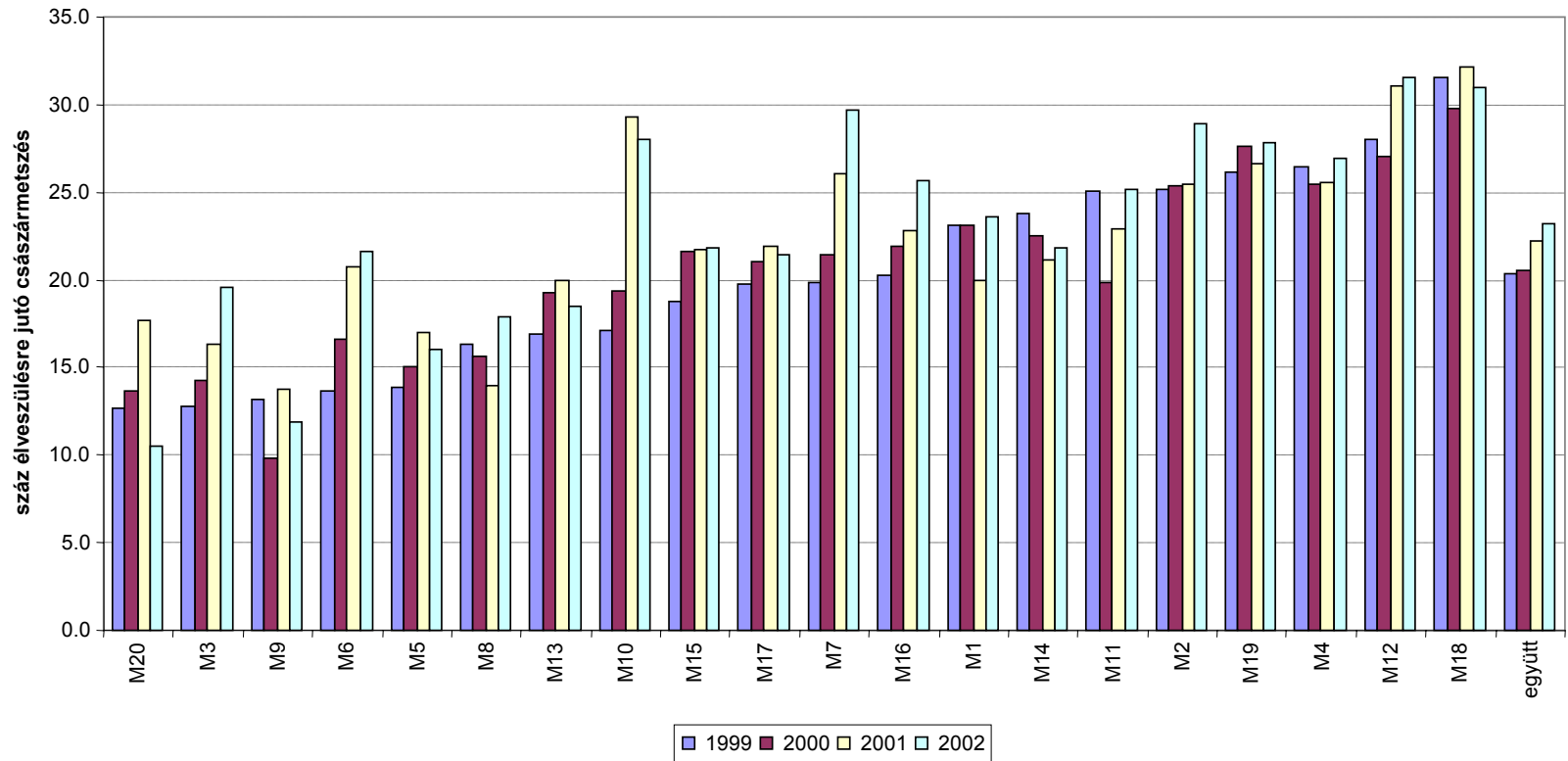
- 150 <
- 130,1 - 150
- 110,1 - 130
- 90,1 - 110
- 70,1 - 90
- 50,1 - 70
- 0 - 50

**Standardized procedure ratios SBH (%)**

**Total number of cases: 43 266**

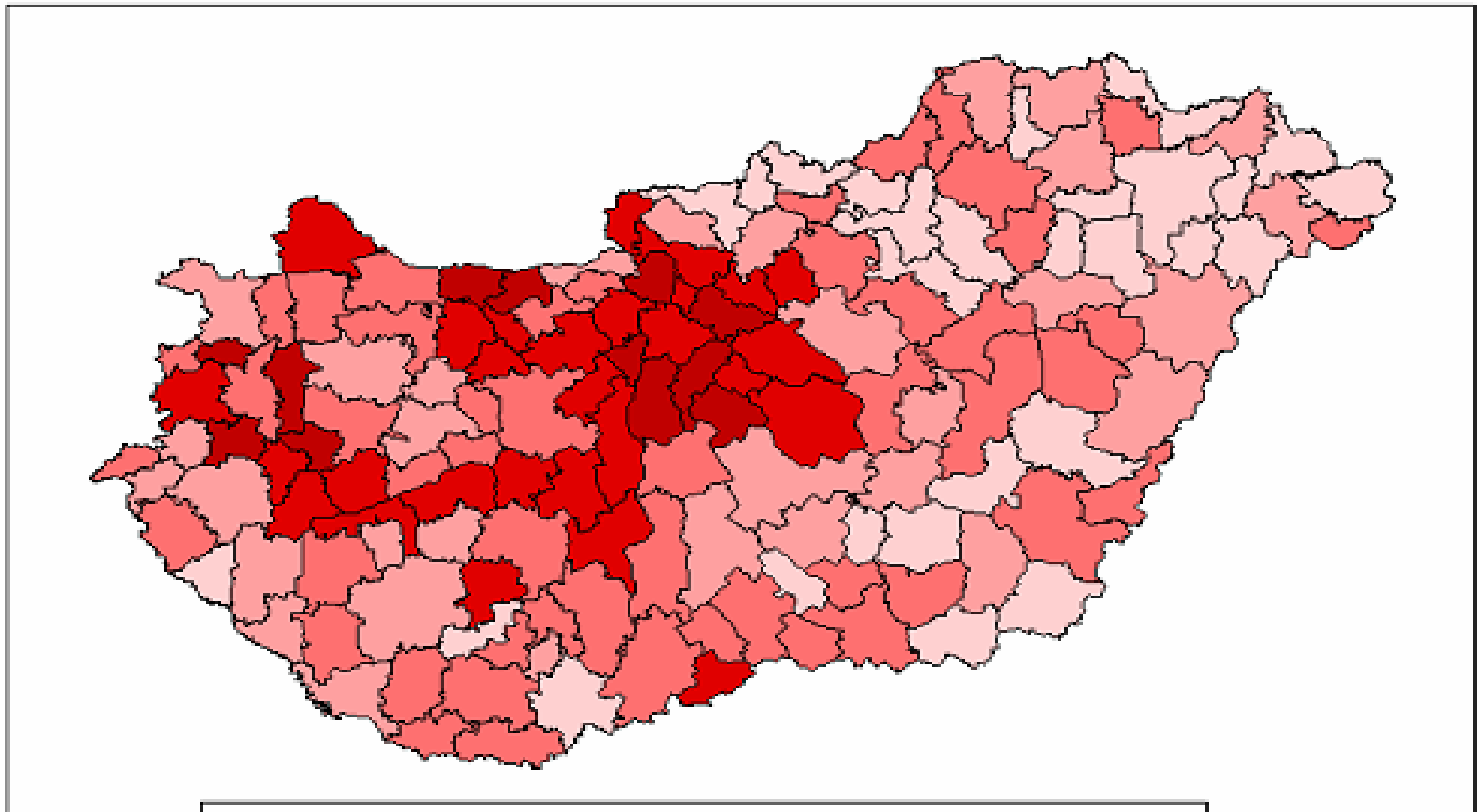
*Source: Éva Belicza*

# Variations in the rate of Caesarian section in county hospitals (1999-2002)



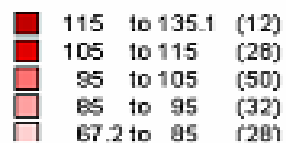
Source: Belicza, 2004

# Variation in use of prescription drugs for diabetes



Gyógyszerrel kezelt diabeteszesek aránya az országos színhez képest (%), 2002/2003

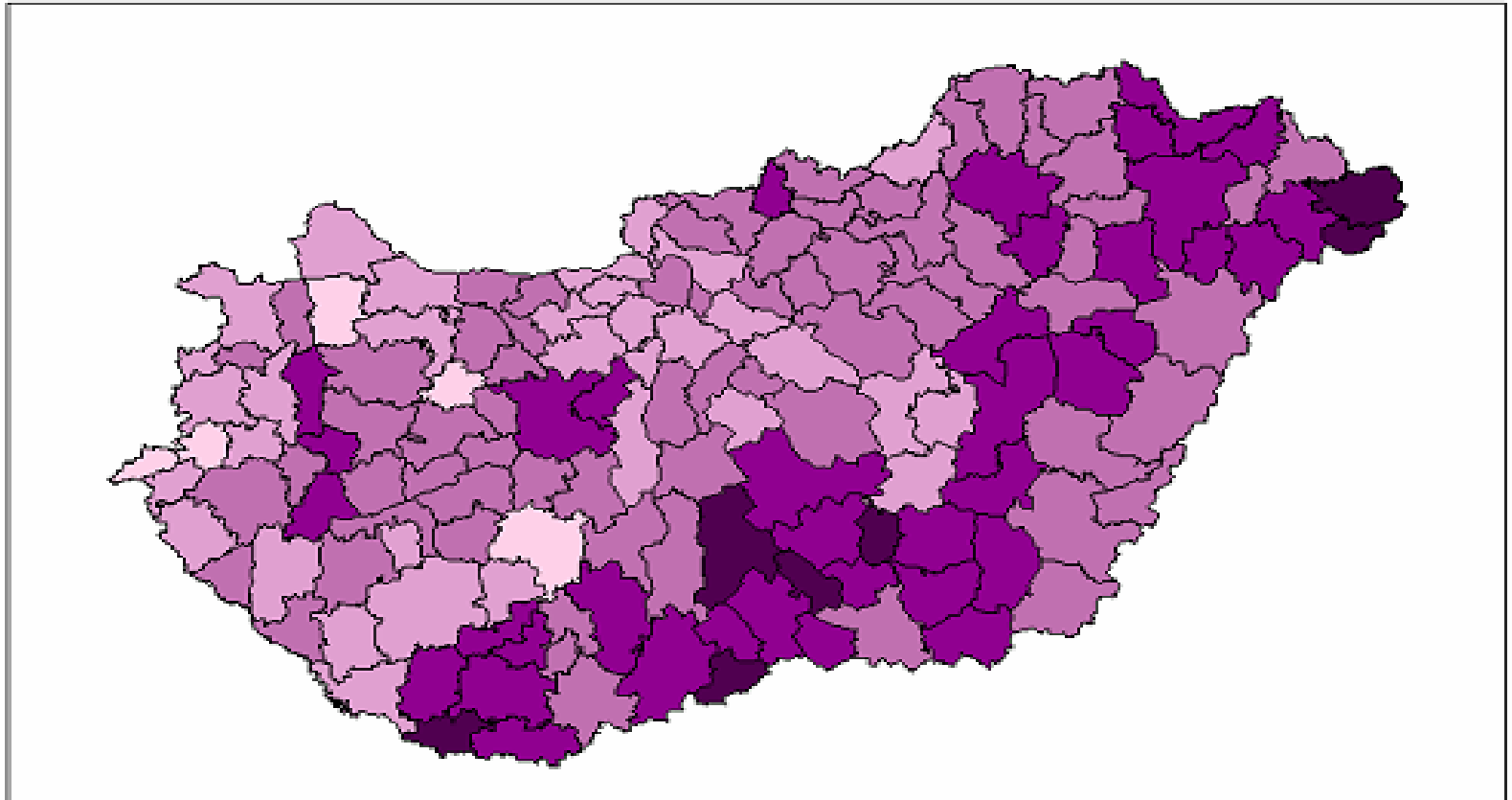
Kor és nem szerinti indirekt standardizálással



Source: Belicza, 2004

# Variation in use of antibiotics

(age and sex standardized, 2002/2003)



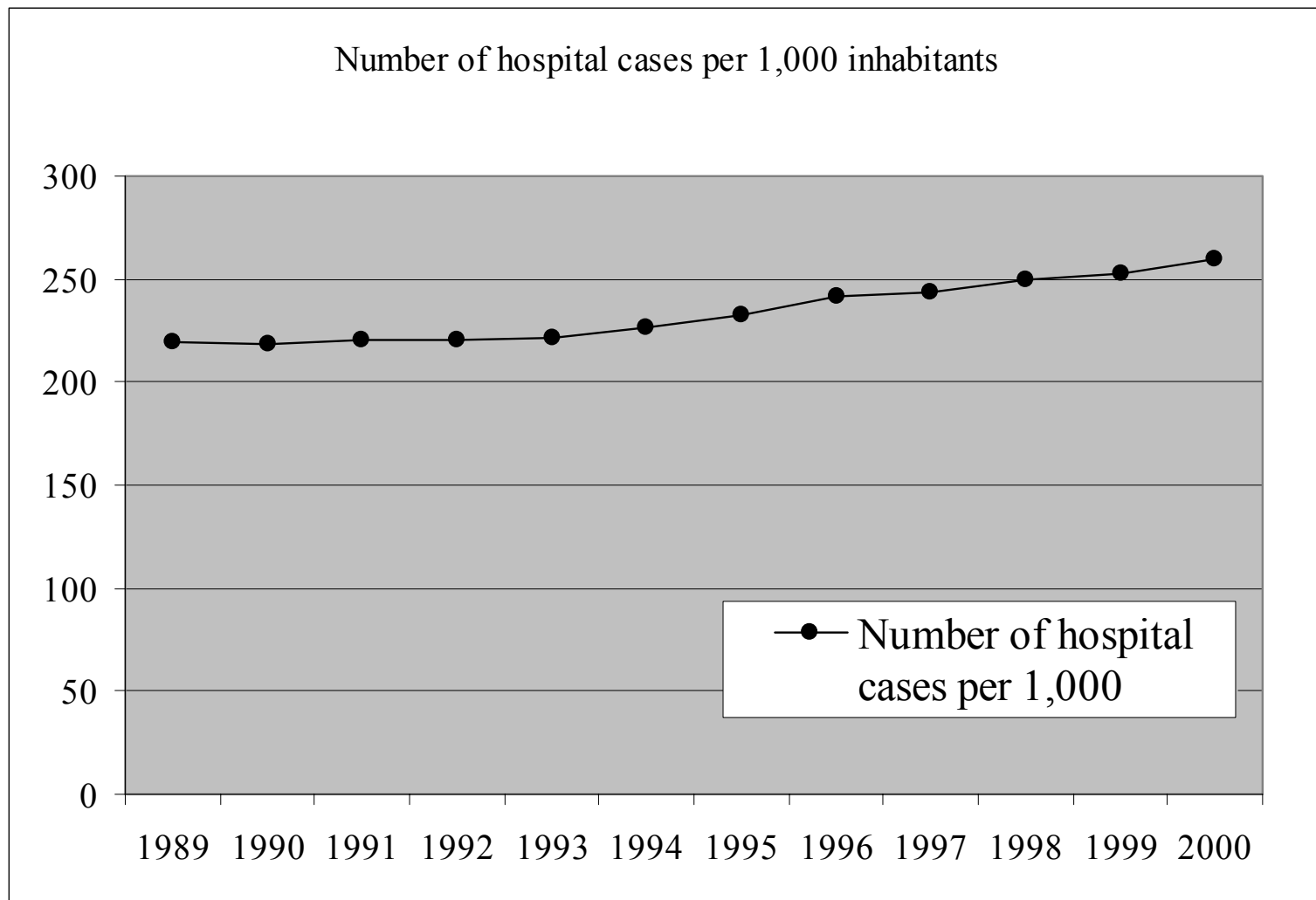
Systemás fertőzésellenes szereket receptre kiváltók aránya az országos gyakorisághoz képest (%) kistérségenként, 2002/2003  
Kor és nem szerinti indirekt standardizálással

115 to 121	(7)
105 to 115	(38)
95 to 105	(67)
85 to 95	(33)
81.2 to 85	(151)

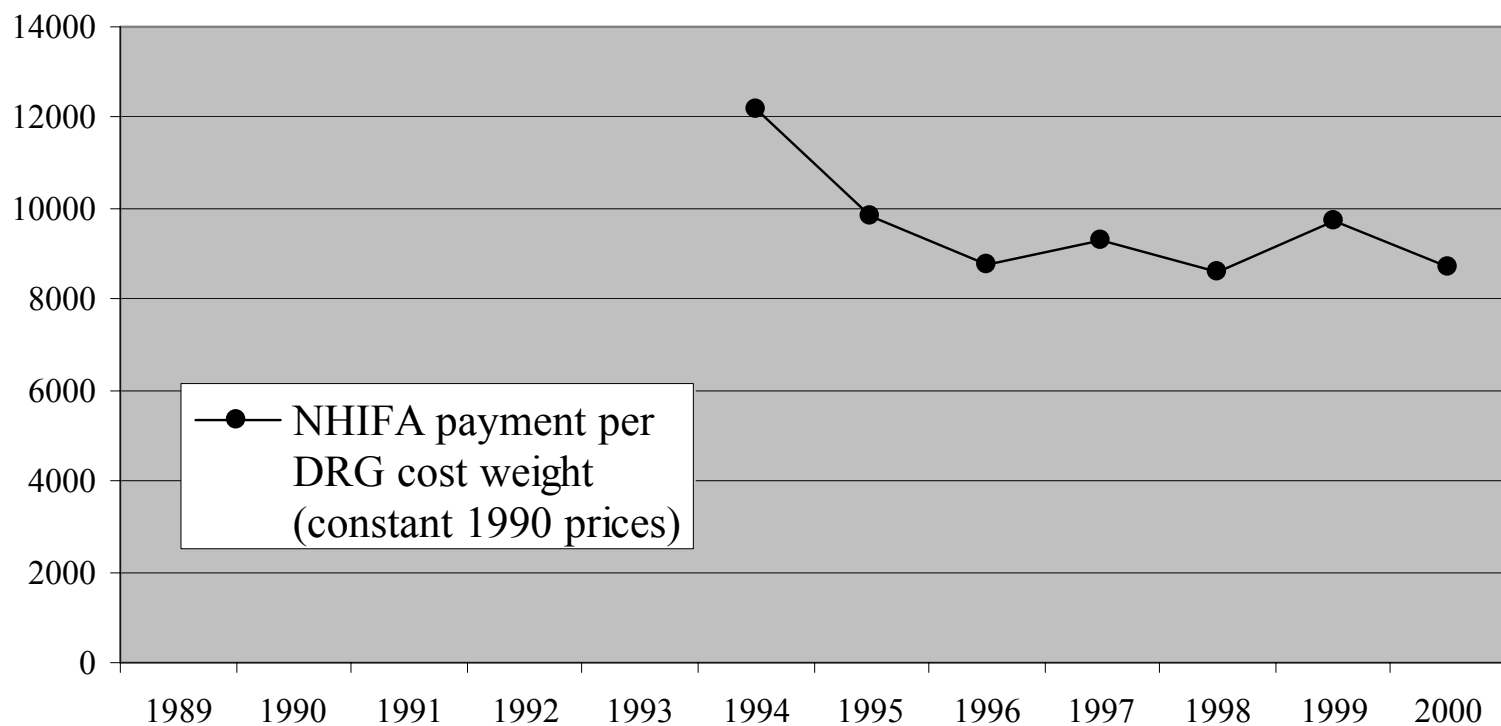
Source: Belicza, 2004

# New payment methods and their consequences

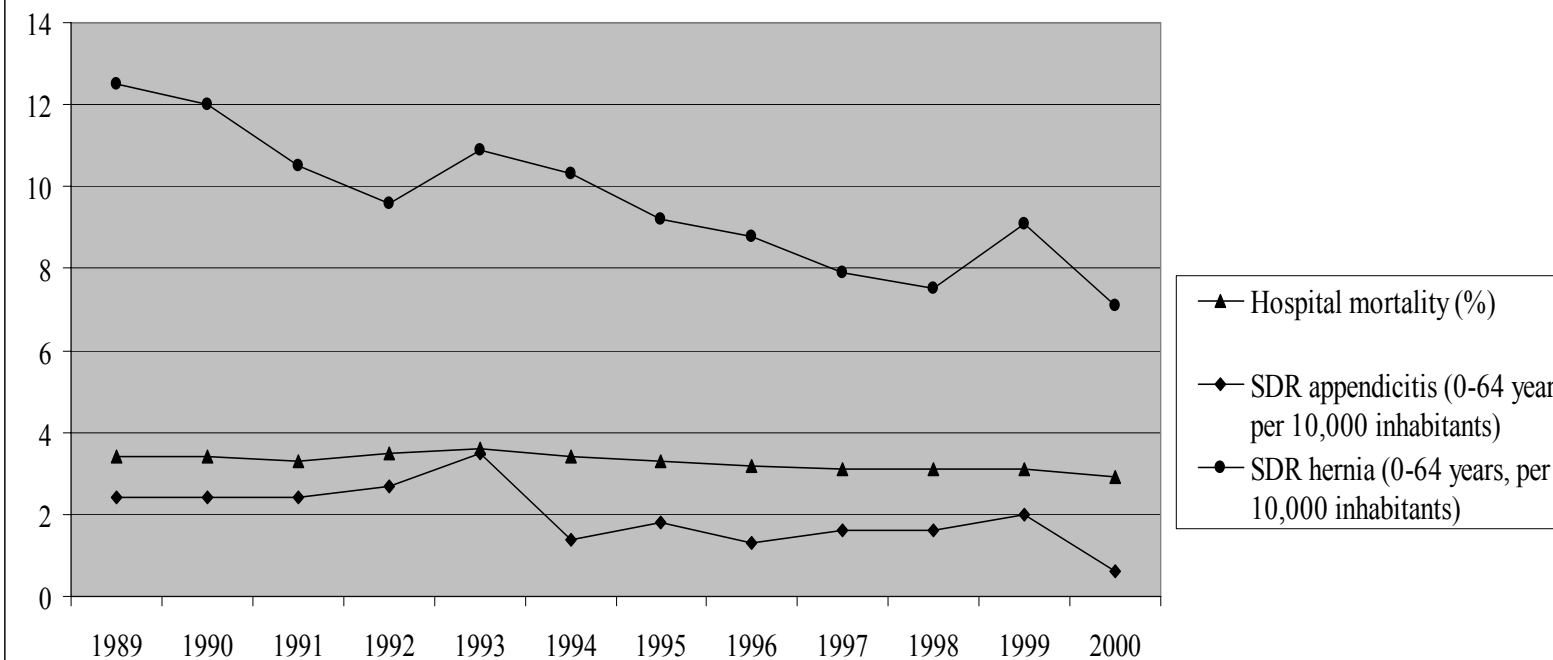
- Primary care: capitation (introduced in 1992)
  - High rate of referral to specialists
- Outpatient specialist care: fee for service (introduced in 1993)
  - Entrance to hospital inpatient care (most polyclinics are attached to hospitals)
- Acute inpatient care: DRGs (introduced in 1993)
  - No incentives to treat patients at lower levels of care
  - Within hospital efficiency gains are mostly exhausted by the incentives built in the DRG payment system



NHIFA payment per DRG cost weight (constant 1990 prices)



## Crude quality indicators



- Conclusions:
  - smaller budget
  - more patients (and DRG points) in 2000 than in 1994
  - cost per case (DRG point) substantially decreased (appr. 30%) with no dramatic decline in clinical quality
- However this does not mean each patient was treated at the lowest possible costs – the interface between primary and secondary care:
  - The effectiveness of the ‘gate-keeping’ function of family doctors is dubious
  - Between 1990 and 2000:
    - non-diagnostic referrals increased by more than 60%
    - hospital referrals per 1,000 patients attended increased by almost 30%
- There is no incentive in the system to provide definitive care at the lowest possible level of specializations

# Options for the reform

- Original idea (before the elections): strengthening the purchasing function of the NHIFA
- Current idea (after the elections): introduction of the competitive insurance model
- A forgotten idea: the Care Coordination Pilot

- Assumption:
  - ⇒ competition forces insurance companies to eliminate unnecessary services, so care coordination is in the interest of an insurance company, but
- risk selection and cream skimming:
  - ⇒ revenue-oriented management
- risk of under-treatment
- costs of administration

- What does competition will mean for providers?
  - multiple contracting
  - multiple reporting requirements
  - multiple control
  - different payment methods
  - multiple price negotiations
  - prior approval of diagnostic and therapeutic interventions
  - prior approval of reimbursement

- What does this mean at the level of the system as a whole?
  - Multiplication of administrative costs
  - Increased marketing costs
  - profit (return on investment)
- Administrative costs:
  - Insurance competition: 10-20%
  - NHIFA: 1.5%
- The first 10-20% of efficiency savings is adsorbed by the increased administrative costs.

# Managed care and fundholding

- Integration of financing and provision, purchaser and provider at the same time
- Managing revenue collection and budgets (managed care)
- Capitation payment to fundholder: managing the budget, but not revenue collection (fundholding)
- Contracting with other providers to purchase care (managed care: if necessary)
- Micro level management of resource allocation
  - Managing the patient pathways in the delivery system
  - Gate keeping function at lower levels of care

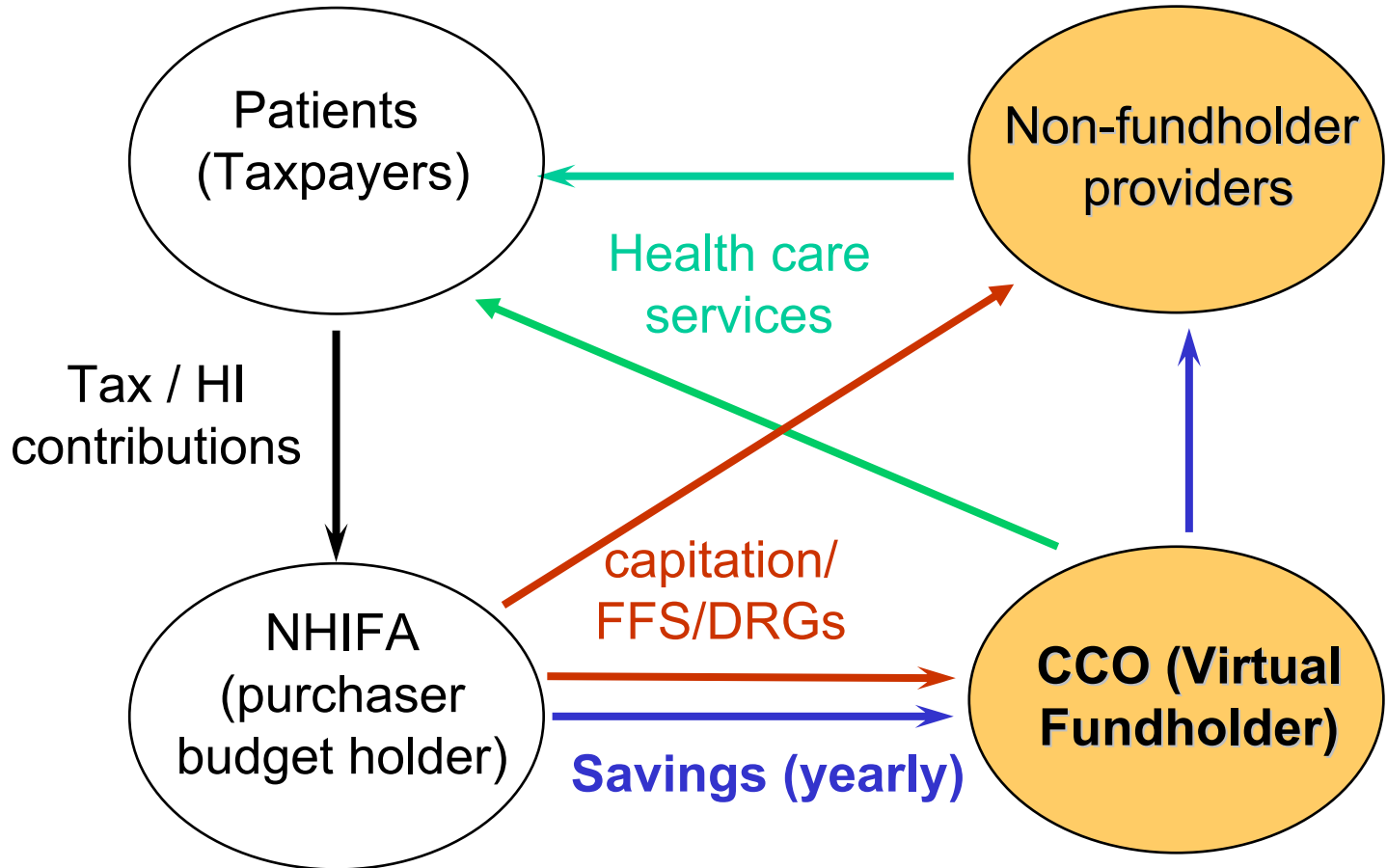
# The Hungarian experiment

- The care coordination organization (CCO) can only be a health service provider
- For an adjusted capitation payment it assumes responsibility for virtually the whole spectrum of services (from primary to tertiary care) of a population signed up for primary care (family doctors) in a geographic area of concern
- The budget calculated on the basis of the capitation payment is not transferred to the bank account of the care coordinator organization
- They provide care and can collaborate with other providers to optimize the treatment of their patients
- All health care providers are paid for according to the general payment techniques
- Balance is calculated at the end of each year; savings are transferred to the CCO and can be used for remuneration and investment purposes

# The Hungarian experiment

- Yearly budget
  - capitation according to size of population, adjusted for age structure
  - Virtual, i.e. not transferred to the CCOs' account
  - CCOs are not real, but „virtual fundholder”
- Expenditure
  - payments made by the NHIFA to all providers, who provided services for the CCOs' population
  - transferred to providers on a monthly basis
  - available for each individual patient (social insurance identification number)
- Savings = Yearly budget – Expenditure
  - transferred to the CMOs' account at the end of each year

# The Hungarian experiment



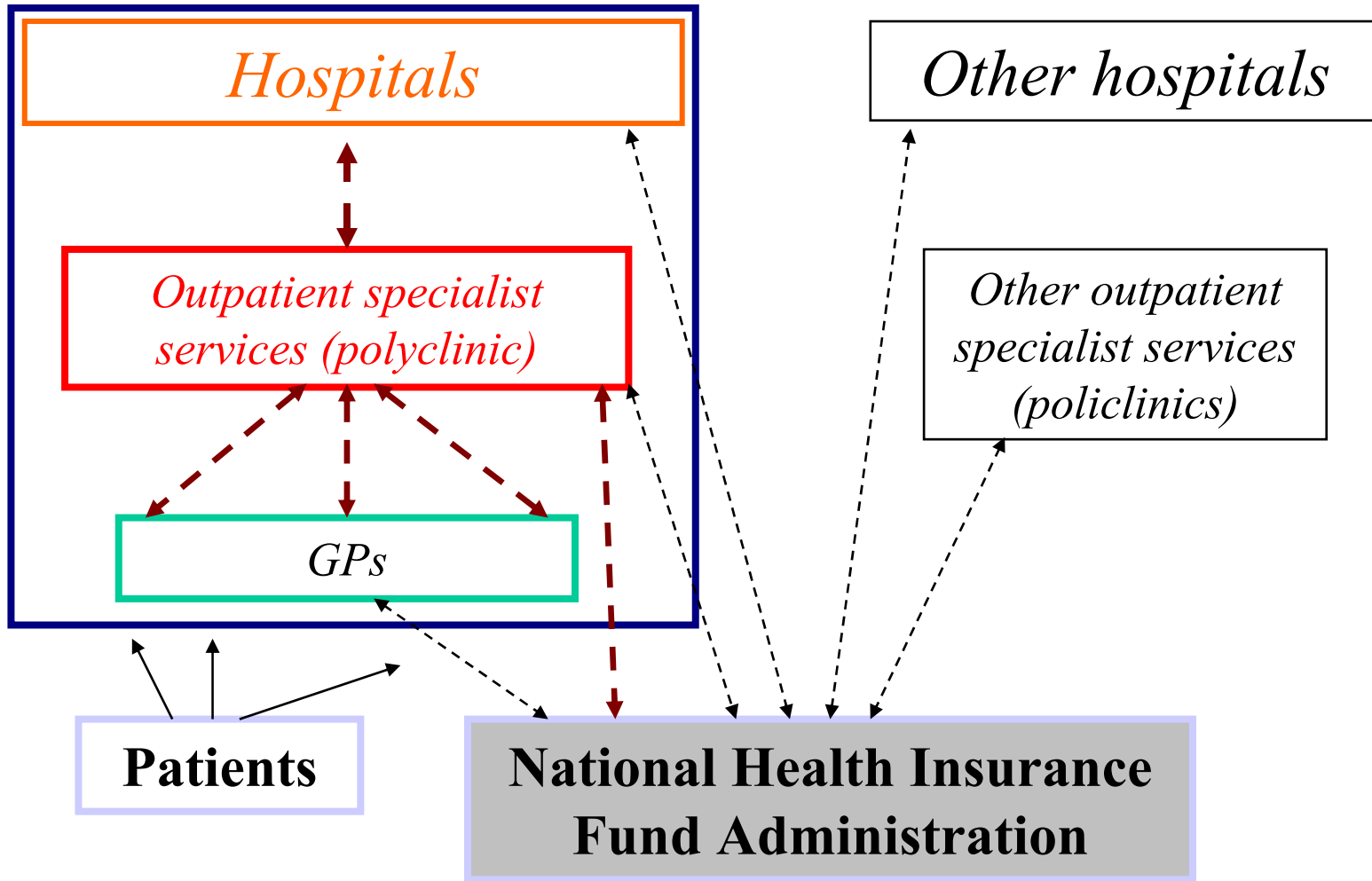
# The Hungarian experiment

- Different types of CCOs:
  - ⇒ group of GPs (family doctors)
  - ⇒ polyclinics (outpatient specialist service provides)
  - ⇒ hospitals
- How is the population of the CCO determined?
  - ⇒ group of GPs: people on the practice lists
  - ⇒ polyclinics, hospitals: obliged to contract with local GPs, but GPs can refuse to take part in the experiment

# Polyclinic CCO model

*Providers IN the model*

*Providers OUT of the model*



# The Hungarian experiment

- How can the CCOs coordinate care and influence other providers?
  - financial motivation: share the savings
  - professional and ‘legal’ motivation: analyze utilization data, provided by the NHIFA on the basis of the social insurance identification number of patients
- The Hungarian pilot does NOT
  - Change the ownership structure of the system
  - Reduce patient choice
  - Change the payment systems for providers

# Main conceptual differences

- The CCO does not manage revenue collection
  - Does not decide on insurance premium levels
  - Does not collect contributions
  - Does not decide on the package of the services covered
- The CCO does not hold a real budget („virtual fundholder”)
- The CCO does not purchase services
  - does not contract for service provision
  - does not set prices
  - does not pay for service provision
- The CCO carries out only the care coordination function:
  - Managing the patient pathways in the delivery system
  - Gate keeping

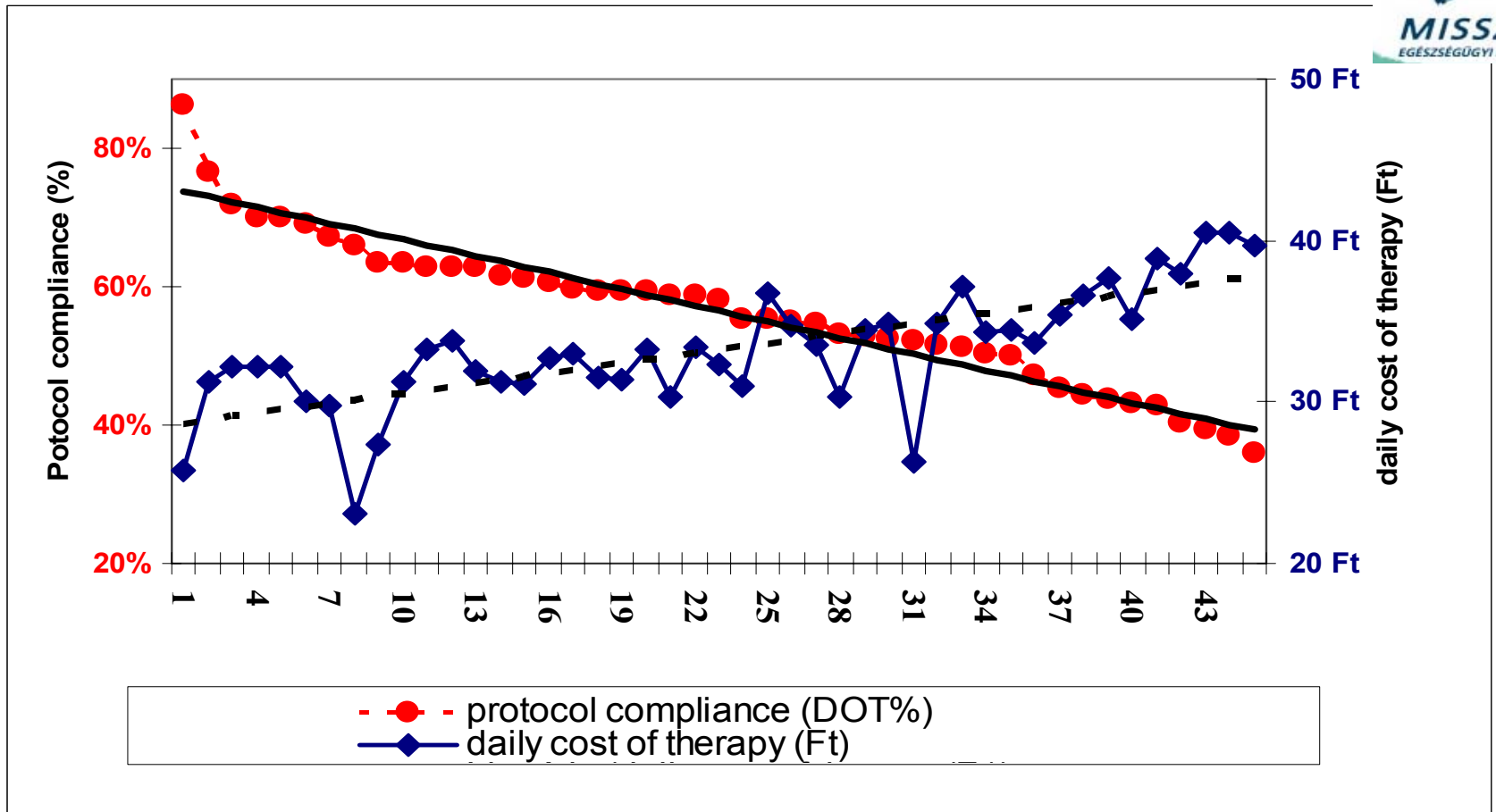
- Revenue collection does not distract the focus of the organiser from care coordination (elimination of risk selection and cream skimming)
- if the care coordinator organisation fails, patient will still be cared for (elimination of the risks associated with insurance bankruptcy)

- Efficiency gains can be realized if savings stem from the elimination of unnecessary services
- Savings can also be realized:
  - ⇒ if capitation payment does not reflect health needs of the local population (virtual budget could be based on actual costs)
  - ⇒ under-treatment (incentive structure), underdeveloped capacities

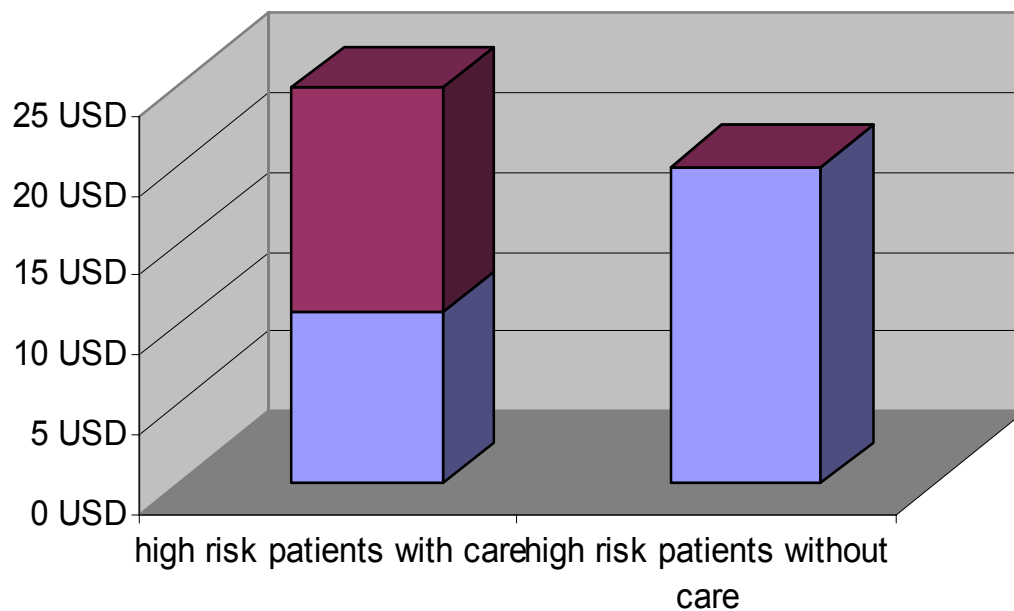
- Elimination of unnecessary services is in the interest of CCO and collaborating providers:
  - income from unnecessary services = NHIFA payment – actual cost of service
  - income, if unnecessary service not provided = NHIFA payment (saving)
- Limits to under-treatment:
  - providers have to generate enough income to survive until the end of the year, when savings are actually transferred to the CCO
  - the CCO (and the collaborating providers) has no incentive to deny care for patients, because patients can choose other providers freely, whose service provision is not under the control of the CCO
  - if care is denied, patient will cost much more later on,
  - sensible to build on the sense of duty of providers
  - face directly the consequences of ruthless cost saving

- The experiment separates the care coordination function from other purchasing functions, revenue collection and the pooling function
- The experiment assigns various functions to the actor, which can implement the function at the lowest possible transaction cost (i.e. where the function can be realized most efficiently):
  - revenue collection, pooling, budget holding, contracting and payment: **CENTRALIZED**
  - care coordination: **DECENTRALIZED**
- The theory of functional deconstruction

# Protocol compliance of GPs and cost of therapy



# Costs of inpatient care among the high risk patients



- cost of revascularisation
- other cardiological costs