



**Hungary 2007**

## **Access to care and health status inequalities in a context of healthcare reform**

**Short Report**



On behalf of  
**European Commission**  
DG Employment, Social Affairs and Equal Opportunities



The Peer Review was held in Budapest (Hungary) on 17-18 January 2007 and hosted by the Hungarian Ministry of Health. In addition to the host country, nine peer countries took part: Austria, Bulgaria, the Czech Republic, Estonia, Finland, France, Luxembourg, Portugal and Slovenia. Also participating were stakeholder representatives from the European Federation of National Organisations Working with the Homeless (FEANTSA) and the European Association of Paritarian Institutions of Social Protection (AEIP), together with representatives of the European Commission's DG Employment, Social Affairs and Equal Opportunities, and DG Health and Consumer Protection.

This was the first Peer Review on healthcare issues. Its main purpose was to take stock of the reforms currently underway in the Hungarian healthcare system. At the same time, it examined wider European developments. Throughout the EU, there have been huge health improvements, but major divergences in living and working conditions, differences in health related behaviour, and differences in the way individuals access and use health care services are also causing differences in health status among and within Member States. For example, life expectancy varies greatly both between Member States and within each country. Studies show that within every EU country, those on higher incomes are likely to have a better health status than those with limited means. In some cases, a vicious circle can arise. For example, the relationship between ill-health and homelessness is two-way – each can contribute to the other. The differences are mainly related to variations in chronic conditions, communicable diseases and accident injuries. Working on these three areas, it is possible to reduce the life expectancy gap. In this context, healthcare systems do have a role notably in reducing preventable and amenable/treatable mortality of the whole population but also in reducing the gap between socio-economic groups. Treatable causes of mortality are mainly related to infant mortality, cardiovascular diseases and testicular cancer. But there are also preventable causes of mortality. These include lung cancer, cirrhosis of the liver and traffic injuries. In general, treatable mortality is highest in the Central and Eastern European countries.

Under the subsidiarity principle, the organisation of healthcare is a national matter. However, through the open method of coordination, the EU Member States have agreed to look together at the three objectives of universal access, high-quality service and sustainability notably through the work of the Social Protection Committee. The Commission is also proposing that health inequalities should be highlighted in the EU's new Health Strategy. The Seventh Framework Programme provides opportunities for funding research on health inequalities. And the structural funds, for the first time, are making it easier for countries and regions to invest in health as part of their economic development package.

In the view of the Hungarian government, the country's healthcare system has to change for a number of reasons, notably the country's high morbidity and mortality rates; the existing conflicts between the intentions of macro health policy and institutional interests; the lack of financial and professional transparency in the system, as manifested by widespread "under-the-table payments" for healthcare; and changing needs, due amongst other things to a rapidly ageing population. So major reforms are currently underway:

- Health service network restructuring.
- A new public health focus, with priority going to areas such as oncology, cardiology, children's health and medical emergencies. All the public health activities will be organised around the most important causes of mortality and morbidity in Hungary.
- A Supervisory Authority, which will combine the functions of consumer protection, healthcare market surveillance and enhanced quality control of the Hungarian health insurance and service provision system.
- The integration of long-term care with healthcare.
- Adjustments to hospital bed capacity. Hungary currently has 80,000 beds, of which 60,000 are for acute care. The intention is to have about 40,000 acute care beds, while the number of long-term care beds will have to increase.
- Improved geographical accessibility. The principle is that everybody will be within 50km of a hospital centre, 30km of a general hospital, 20km of an outpatient clinic and 15km of an ambulance.
- Some new forms of co-payment. These are the most controversial aspect of the reforms. The government argues that they will help to adjust care provision to the real needs of the population. Critics say that they will reduce healthcare access by people who most need it, and that the cost of administering the co-payments will in any case seriously reduce the revenue that they will produce for the system. Moreover, peer countries have expressed their doubts regarding co-payments ability to reduce unnecessary use of care. Note, however, approximately four million Hungarians, out of a total population of ten million, will be exempt from paying the charges. The basic amount of the co-payment will be a little over one euro per visit, or per day in hospital.

At the time of the review, no decision had yet been taken on another important issue – the future structure of Hungarian health insurance. A possible option is a multiple insurance system, with different insurance companies competing. A number of peer reviewers expressed doubts about this. One objection is that, in countries where health insurance is market-based, administrative costs consume up to 20% of the total healthcare budget, whereas under a single-insurer system, the corresponding figure is as low as 1.5%. However, the Hungarian Secretary of State anticipated that the administrative burden would represent only about half of the savings made through the introduction of co-payments and, possibly, multiple insurance. Participants also wondered if price competition might not reduce the content of the basic health insurance package and if companies might not engage in “risk selection” by turning down the applicants who were most likely to require healthcare. The Secretary of State replied that all insurers would be required to offer a government-defined basic package and to accept all applicants.

The reforms favoured by the government are not the only options to have been tried in Hungary. Participants were also told of a pilot project based on the concept of a care coordination organisation (CCO), which can only be a care provider. For an adjusted capitation payment, this CCO assumes responsibility for almost the whole spectrum of services to the population signed up for primary care via GPs in a given geographical area.

Discussions between the participants were a valuable source of information during the seminar. For example, Bulgaria, the Czech Republic and Estonia have already implemented extensive healthcare reforms, from a starting point that was in some ways similar to that of Hungary. So they were able to point to some of the pitfalls. While the Budapest seminar did not adopt any formal conclusions, it did raise a number of points and questions which will be brought to the attention of the Social Protection Committee.

What emerged quite clearly is that true equality of access to healthcare entails more than simply ensuring equal treatment for all. Within each country, account will have to be taken of the different needs of different population groups. Age, gender, income, socio-economic status, ethnicity and geography are just some of the factors involved. So how can the needs of the different groups be met? What forms of outreach can get to the people who tend to remain outside the healthcare system? How can geographical disparities be reduced, whether between regions, between urban and rural areas or between richer and poorer areas? What can be done to counter the effects of the “inverse care law”, a perverse relationship between the need for health care and its actual utilisation, which in essence says that those who most need medical care are least likely to receive it, while those with least need of health care tend to use health services more (and more effectively)? How can we tackle the situation where care capacity is developed where it is the least needed, whilst there remain serious limitations with regards to accessibility and quality of healthcare services provided where the needs are the greatest?? Can the market help? What role might be played by co-payments and financial incentives? Is co-payment an effective “gatekeeper”, reducing unnecessary healthcare use and waste, or does it discourage people from consulting doctors and dentists in good time, thus making expensive interventions more likely further down the line? What could be the role of care coordination? In healthcare policy formulation, where should the line be drawn between stakeholders and lobbyists? How can services be reorganised to strengthen prevention? What potential does technology offer? How can waiting times be reduced? How can education, awareness and information be strengthened? How can data collection and monitoring be improved on health status, access and use by population groups? What should be the links to policies in other sectors – for example, on reducing unemployment and social exclusion? As some of the biggest healthcare provision gaps in Member States happen to be in border areas, is cross-border healthcare cooperation one possible solution? How can structural funds be used for health promotion and for filling infrastructure gaps in cohesion regions?

The debate has just begun.