Hungary

Essential values and fundamental principles

*Fundamental Law of Hungary (25 April 2011)*

'Article XX
(1) Everyone shall have the right to physical and mental health.
(2) Hungary shall facilitate the enforcement of the right referred to in Paragraph (1) by ascertaining that the agricultural sector is free of all genetically modified organisms, by providing access to healthy foodstuffs and potable water, by the protection of occupational health, by health care institutions and medical care, by supporting sports and regular physical exercise, as well as by ensuring the protection of the man-made and natural environment.'

- *Act CLIV on Health:*

  "1. § the purpose of this Act is to
  b) contribute to ensuring equal access to health care services for all members of society,"

  "2. § Fundamental principles (2) „It shall be required to enforce equity throughout the utilization of healthcare services.”

  "7. § Rights and Obligations of Patients; Right to Health Care (1) Each patient shall have a right, within the frameworks provided for by law, to appropriate and continuously accessible health care justified by his health condition, without any discrimination.”

  "36. § (1) Public health is responsible for monitoring and analysing the state of public health and its determinants, particularly: housing, work place, sports, recreation, education, food, wages, solid ecology system, sustainable resources, social justice and equity…

Hungary has recently undertaken a self-assessment exercise to identify the suitability of the policy environment for ensuring the rights of vulnerable groups to safe water and sanitation. The assessment explicitly addresses health-care facilities. The self-assessment is performed using the tool „Equitable Access Scorecard” which was developed under the aegis of the Protocol on Water and Health to the UNECE Convention on the protection and management of trans boundary waters and international lakes.

Primary care in the future in Hungary is planned to shift towards strengthening the tasks of definitive care, prevention and health education of the population, as well as the establishment of practice groups and the formation of practice communities. The changes also aim at strengthening equity of access to primary care. One of the first examples of this trend is the Primary Care Development Pilot in the northern and eastern region of Hungary made possible by a grant of Swiss Contribution.

The goal of the programme is to create practice communities and to bring prevention and health promotion into the focus of primary care. It aims to improve the health status of the local population and to widen people's health-related knowledge by life-style advices, screening activities and programmes of health promotion. The programme's special goal is to eliminate inequalities in access to healthcare and to involve disadvantaged groups, especially the Roma population. In the course of the programme 4 practice communities are established
in 14 settlements with the participation of 24 GP practices and other health professionals. The pilot operates from 2012-16 and may serve as a basis for the long-term renewal of primary care in Hungary. 1

Similarly, the reduction of social and economic inequalities is served by the supplementary monthly fee of HUF 100 000, which was introduced for all primary dental service providers in all settlements with underdeveloped social and economic infrastructure, or with unemployment rate much above the national average. 2

A new training programme called the „health promotion assistant” qualification programme started in Hungary in 2013, which aims to improve the health status of the population in the most disadvantaged micro-regions. The health promotion assistant plays a role in the motivation of the population to participate in prevention programmes and screenings. The programme is implemented by the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI), with the cooperation of County Employment Agencies. The training takes place in hospitals operated by GYEMSZI. The first phase of the programme started at the end of 2013 in eight hospitals of five counties (Békés, Baranya, Tolna, Hajdú-Bihar and Szabolcs-Szatmár-Bereg), with 141 participants. The hospitals’ qualified healthcare personnel were involved as trainers in the programme. The training consisted of a theoretical part (280 lessons) and a practical part (280 lessons). During the practical lessons, the participants familiarised themselves with the operation and tasks of the Mother and Child Healthcare services, the GP practice, a residential home and a hospital unit. The first course of training was completed by an examination in April 2014. From May 2014, the programme continues in 15 locations of eight counties with 31 participants from disadvantaged micro-regions.

During the earlier cervical screening model programmes the health visitors proved to be successfully educated in postgraduate courses, to reach, address and motivate women to take part in screenings, to do screenings and to take swabs of proper quality. The health visitor cervical screening brings screening closer to women, especially in the most disadvantaged regions and in small settlements. The health visitors already reached several women and motivated them to take part in screenings, who had not visited their gynaecologist in the last ten years or even longer. Until 2012, 285 health visitors voluntarily applied for the postgraduate courses and learned to do cervix screening. Nowadays nearly 200 health visitors are capable to do such screenings. The programme is going to be expanded by European support (TÁMOP 6.1.3/A). In doing so primarily those health visitors will gain competency through theoretical-, communicational-, and practical trainings, who work in the most disadvantaged regions, in settlements where less than 5000 inhabitant lives.

1 http://www.alapellatasimodell.hu/

The early childhood programme supports children’s optimal bio-psycho-socio progress from age 0-7, through developing the primary children health care in the following fields:

- support a healthy lifestyle from the early childhood and their successful start at school,
- follow up of the children’s development,
- helping to develop their abilities,
- exploring the risk factors, and
- straining children with different development.

In Hungary in the pediatric care 3800 health visitor and 3100 pediatricians provide services for about 600,000 children. The programme supports the professionals in the pediatric care mostly with improving and renewal of applied methodologies, especially in case of children and their families in the most disadvantages groups and special needs. Each child has to take part in ten screening between the ages of 0-7 which means, with the new screening package 1 Million screenings are done by year. In 2013 1654 child were screened.

**HAS THE COUNTRY INVESTED IN ACTIONS IN OTHER SECTORS WITH THE EXPLICIT AIM OF IMPROVING HEALTH?**

Since lifestyle factors play an important role in mortality and morbidity characteristics, it deserves special attention that there have been several changes in legislation in the past years aimed at the promotion of healthier lifestyles in Hungary. The public health product tax, a new type of tax that aims to limit the consumption of unhealthy foods and to increase healthcare revenues has been introduced in 2012. The taxed products are soft drinks, energy drinks, pre-packaged sweet goods, salty snacks, flavourings, flavoured beers, alcoholic refreshments and jams, if their sugar, salt or caffeine contents reach a determined level.³

To increase the revenues of the Hungarian Health Insurance Fund, another new tax was introduced in 2012: the accident tax composes the 30 percent of the fee of mandatory vehicle liability insurance. Since 2012 the government also motivates employers’ private health insurance by an exemption on the tax of such benefits.

In Hungary for the protection of non-smokers, an internationally acknowledged regulation came into force on 1 January 2012 extending earlier prohibitions. The extended legislation made public places, restaurants, bars and workplaces smoke-free. It is also prohibited to smoke in bus stops, underpasses used by pedestrians, in playgrounds, in schools, child welfare institutes and health service providers, including their courtyard.⁴ From the summer of 2013 the retail trade of tobacco products was limited by making it a state monopoly. This measure also aimed at reducing smoking among young people.

With funding support from the European Union the National Methodological Centre for Smoking Cessation Aid was established in the Korányi National Institute of Tuberculosis and Pulmonology in October 2012.

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³ Act CIII of 2011 on Public Health Product Tax

⁴ Act XLII of 1999 On the Protection of Non-Smokers and Certain Regulations on the Consumption and Distribution of Tobacco Products
The National Methodological Centre for Smoking Cessation Aid has a call centre where qualified psychologists and physicians give information and advice about smoking cessation and provide a cessation program services via telephone. The Centre’s services are available for free at the number +36 80 44-20-44. The Methodological Support Centre runs a homepage as well (www.leszokaspont.hu) for the purpose of broader public communication.

Since December 2013 smoking cessation consultation services are available nationwide in 86 pulmonology centres from European Union Funding. These pulmonology centres also engage in communication with local professionals and the public. At the same time personal cessation support services are offered as well in these centres, funded by the central budget. As a result of the recently launched programmes, the individual- and group consultation cessation support services will be available nationwide in the pulmonological centres. This will help to increase the number of people who quit smoking.

In February 2014, a new public health regulation came into effect to control the quantity of trans fats (unsaturated fats) in foods. From 20 February 2014, it is prohibited to sell foods in which 100 grams of the total fats contain more than 2 grams of trans fats. The regulation provides a 12-month grace period for those pre-packaged foods that were produced before the enactment of the regulation. The regulation applies to oils, fats and fat emulsions that are produced for consumption in themselves or as components of a food product. It does not apply to trans fats naturally found in animal fats. The reason for the measure was the acknowledged risk that trans fats pose risks to health, especially to the cardiovascular system.\(^5\)

Any other examples of actions toward improving health system and cross-sector investment for health?

Establishment and maintenance of early warning systems (Heat health watch warning system since 2005, Ragweed pollen alert system since 2012, UV alert together with National Meteorological Service since 2006, Smog alert since 2007, Air quality health index 2010)

Have formalised mechanisms been established to set health system goals and objectives?

Semmelweis Plan (2010) is a strategic policy framework of the Hungarian health government’s key strategies and action plans to rebuild the care and public health system. In Semmelweis Plan transparency is a key instrumental value in the operation of the health system, both from a professional and from an economic point of view. Those affected by the operation of health care (every citizen) have the right to know how resource allocation decisions are made, what criteria resource allocations are based on and how resources are used. Accordingly, the aim is to achieve that all decisions on resource allocation should be transparent and should be made on the basis of clearly defined criteria accessible to all, in a normative manner. Ensuring transparency and accountability is the best tool in the struggle against bias and corruption.

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\(^5\) Ministry of Human Capacities Decree 71/2013. (XI. 20.)
The introduction of regular health system performance assessment reports is underway and as part of this report target values and acceptability intervals will be set for the more than hundred indicators presented. Such limits and targets are set by the health system performance assessment working group which consists of the representatives of the central organizations of the health care administration. For more on that see 3.2.

There is also government regulation concerning the governmental strategic management which is described in 38/2012 (III.12.) Government Decree. As the described methodology is to be followed in all ministries for the process of strategic planning and execution therefore it also sets a framework for the Secretariat of Healthcare.

Related to the tasks of the National Health Insurance Fund, legislation in force specifies the following procedures for identifying objectives that should be implemented in the course of the provision of health services, the inclusion of services and service providers in the health insurance reimbursement list, in ensuring access to and improve quality of health insurance services:

**Rules for governmental strategic planning and setting of objectives**

Government Decree No 38/2012(III.12.) on strategic government administration specifies the circle of procedures and documents that should be prepared and implemented in order to set and reach strategic objectives. As regards the National Health Insurance Fund, the following documents should be respected:

- The Minister’s programme serving the implementation of overall governmental objectives, specifying medium term tasks for the Ministry, serving as a strategic planning document for the relevant governmental cycle, comprising:
  - the vision and objectives covering policy areas under the Minister’s responsibility;
  - the institutional strategy for the Ministry;
  - operational and developmental objectives for central government bodies and agencies under the direction and supervision of the Minister.

**Objectives, rules for health sector development**

Government Decree No 337/2008(XII.30.) for the implementation of Act 132 of 2006 on the development of the health care service, among rules for the inclusion of extra capacities in the health insurance reimbursement list, specifies that the National Health Insurance Fund prepares a proposal for priorities for the inclusion procedure for the Minister responsible for health and the approved list of priorities is published in a communication by the Minister. Rules governing the inclusion procedure, among others, specify that the Minister can identify priorities for the inclusion of new capacities or for the revision of included ones if

- the inclusion of new capacities is necessary for implementing new tasks,
- in case of certain profession(s), the inclusion of extra capacities becomes necessary due to changes in tasks or conditions,
in case of certain profession(s), the inclusion of new capacities becomes necessary to improve access to services.

Approved priorities are published in the Official Journal by the Minister in a communication. They are valid until withdrawal or until being modified by the Minister in a new communication.

List of priorities published in 2010 includes, among others:

- implementation of the National Programme for Infant and Child Health: development of perinatal care, extension of capacities in Perinatal Intensive Care Units (PIC II.);
- implementation of the National Cancer Control Programme: extension of capacities in mobile breast cancer screening units as well as colorectal screening units in gastroenterology centres;
- implementation of the National Programme for the Prevention and Treatment of Cardiovascular Diseases: in case of stroke centres: development of the overall spectrum of quality stroke care, as well as establishment of 2nd and 3rd level rehabilitation capacities;
- implementation of the National Mental Health Programme: extension of paediatric psychiatry rehabilitation capacities, as well as capacities for the drug treatment of the age group of 14-18;

Lists of priorities published in 2010 includes:

- extension of PET/CT capacities;
- developing telemedicine services (teleradiology, pathology, paediatric ophthalmology /for premature newborn/, infant and paediatric otorhinolaryngology /for premature newborn/, cardiology);
- extension of capacities for fertility treatment procedures;
- improving access to infant and early childhood development;
- extension of treatment of stroke related aphasia and dysphasia through the development of logopaedic outpatient specialist capacities;
- improving access to maxillofacial and dental surgery as well as parodontology outpatient specialist care.

In accordance with Decree No 28/2010 (V. 12.) of the Minister of Health on professional aspects and policy priorities for the inclusion in or revision of health insurance reimbursement of health technology applied in curative-preventive procedures, criteria, priorities specified by the Minister are also present among mandatory assessment aspects. Elements of the assessment process, based on a point system, are regulated in a transparent manner. The system, based on multiple criteria decision analysis is objective ensuring unified aspects for setting the order for inclusion, as well as for the posterior technology assessment and revision of reimbursed technologies.
HAVE PROCESSES FOR MEASURING AND REPORTING (PUBLIC) ON HEALTH SYSTEM PERFORMANCE BEEN SET UP?

The 36/2013 (V.24) ministerial decree of the Ministry of Human Capacities ordered the GYEMSZI to produce a Health System Performance Assessment Report every two year, interim report in the consecutive years and make the definition and up to date values of the included indicators available on its homepage. Also a working group has been established from the other central actors of the health care administration – including representatives of the National Health Insurance Fund (OEP), National Public Health and Medical Officer Service (ANTSZ), GYEMSZI and the departments of the State Secretariat responsible for Healthcare – to support and participate in the creation of the report and to approve its final form.

The operational rules of the working group and the format of the report have been regulated through the 19/2013 (V.24.) ministerial instruction about the Health System Performance Assessment Working Group. This instruction for instance guarantees that the working group holds meeting at least twice a year and also states the details that shall be included in the definition of each indicator.

The first report is to be published in 2016 considering the performance of the 2013-2014 period. It is to present indicators on a wide scale of issues from health status of the population, infrastructure of providers, efficiency and quality of care provided, patient satisfaction, etc. Heart attack and Tuberculosis infected patients’ treatment are special focal areas and therefore corresponding data will be analysed with special scrutiny and data will be made available at higher resolution and the analysis will be more scrutiny.

The performance assessment report also includes a chapter which suggests the introduction of new health policies based on the results of the report and in future reports this chapter shall also maintain the assessment of the effect of policies introduced on the basis of recommendations of earlier reports.

Measuring health system performance in support of system development decisions

Act 132 of 2006 on the development of the health care system specifies that development decisions, inclusion of extra capacities in reimbursement should always be made on the basis of health system performance measurements, on changes in health care demands.

The act provides for the following main rules:

Modification of capacity allocation:

Each third year, based on data from the previous calendar year, the Health Insurance Fund examines the utilisation of contracted capacities of specialist health service providers in a given health region and the necessity for capacity reallocations. Based on findings, the health insurer prepares a proposal for the reallocation, modification of capacities in each health
region and submits these proposals to the relevant health authority, as well as to the body entitled to form a professional opinion based on notification by Government. The health authority makes the decision on capacity rearrangements within 60 days, based on specific criteria and on the expert opinion.

Specific criteria include the following:

- At least 95% of the population should be able to reach the active inpatient health care provider in the basic specialities within less than 60 minutes. In case, as a result of capacity reallocation, active inpatient specialist care or inpatient care in a certain speciality is terminated in an institution, the nearest new services provider in the given speciality for the relevant catchment area should be reachable for the population within 60 minutes on road.
- Operability of national professional centres or institutions providing services for special circles of patients should be maintained.
- In case of decisions made on capacities for outpatient specialist care, at least 90% of the population concerned should be able to reach the service provider at least in the basic specialities within less than 30 minutes.

**Permanently unused capacities:**

In case of a permanent demand reduction, the maintainer, in consultation with the service provider concerned, initiates capacity reduction. The Health Insurance Fund continuously examines utilisation, and in case it observes permanently unused capacities it informs the maintainer on a case by case basis or at least once a year. If the maintainer does not take the necessary measures, the insurer informs the relevant health authority. It is the health authority who makes decisions on capacity reductions. Capacities becoming not contracted as a result of these decisions are regarded as reserves.

**Rules of capacity reallocation and modification:**

The health authority has the right to re-group specialist health care capacities, in part or as a whole, of a given provider to one or more other services providers, in case information received from the regional patient pathway manager or from the health insurer or data officially available support the necessity for reallocations.

**Legislation and processes concerning the regular evaluation of health system performance**

The Minister responsible for health regulates the process of evaluation, its participants, the publication of results covering the whole health care system, including publicly financed and private health care in Decree No 36/2013 (V. 24.), based on authorisation of Act 154 of 1997 on Health. The National Health Insurance Fund participates in the evaluation process.

**Continuous, overall measurement of the performance of health service providers through the financing system**
In Hungary, information is available in respect of each individual event of utilising publicly financed health care, in line with provisions of Government Decree No 43/1999 (III.3.) on detailed rules for financing health services from the Health Insurance Fund. Relevant public administration bodies, including state organisations responsible for the publication of statistical data receive regular information on performance data, in line with legislation in force on data collection and processing.

**Ensuring conditions for transparency and accountability in the health financing system**

Each procedure, parameter of the financing of health care is determined by legislation, including the methodology and process of reimbursement fee parameters. Main areas of legislation include:

- rules for the regular up-dating of professional code systems and financing parameters /Decree No 6/1998 (III.11.) NM/;
- legislation on the definition of outpatient specialist services financed by the Health Insurance Fund, on conditions and rules for accounting as well as on performance based settling of accounts /Decree No 9/2012. (II. 28.) NEFMI/;
- rules for the coding and classification of curative-preventive health care services financed by the Health Insurance Fund on the basis of DRG financing /Decree No 10/2012. (II. 28.) NEFMI/;
- provisions on the DRG based financing of specific cancer therapies /Decree No 11/2012. (II. 28.) NEFMI/;
- rules on the application of the code list of dental care activities /Decree No 71/2011. (XII. 23.) NEFMI/;

**Introduction of financing systems necessary for the application of health technologies in relevant specific indications for (so called) therapies with specific itemised accounting**

**Ensuring transparency in the course of Health Insurance Fund allocations**

As specified by legislation, the National Health Insurance Fund provides information on reimbursed performance, payments, basic fees by individual forms of care, on a monthly basis. Data are published on the webpage of the National Health Insurance Fund.

**Ensuring the utilisation of health sector public data, unified rules**

The Health Insurance Fund makes available data on its webpage and allows access to public data in a regulated way, in line with legislation on data protection and data utilisation.

**Has an instrument for reviewing health system performance been implemented?**

As mentioned above, health system performance assessment is in progress. The responsible working group has already approved the structure of the report and the methodology of the
analysis. The recent phase consists of the formal definition of all indicators and the analysis of the data will be started next year.

**IT support, ensuring the relevant data basis in support of assessment**

In our response to previous questions, legislation in force has been described ensuring the availability of the whole spectrum of information on publicly financed health care in the relevant IT data bases, in a form appropriate for IT processing. The data allow for utilisation based analyses on territorial, age-group, service provider, disease related, procedure based dimensions.

**Methodological guideline for health technology assessment**

Certain analytical, evaluation methods are regulated by way of professional guidelines. For the first time in 2002, and afterwards in a revised form in 2013 the professional guideline on health-economic analysis of the Ministry of Human Capacities was published as the communication by the Ministry. Adherence to professional guidelines in assessments supporting health technology inclusion is compulsory by force of law.

**ANY OTHER EXAMPLES OF ACTIONS TOWARD IMPROVING TRANSPARENCY AND INCREASING ACCOUNTABILITY?**

Starting in 2013, several EU-supported eHealth projects have been implemented in Hungary that aim at the establishment of a standardized IT environment facilitating the cooperation of IT systems of different actors, a standard reporting system of the sector and a more databased decision support system.

**HR MONITORING SYSTEM**

The goal of the human resources monitoring system is to construct an integrated HR monitoring system and data warehouse serving the preparation and support of decisions on different levels (government, health sector, institution). It will support the development of a sectorial HR strategy and will allow for the tracking of sectorial HR features and trends.

**NATIONAL HEALTH MONITORING AND CAPACITY MAP DATABASE**

Establishment of a decision support system integrating and utilising the sector's more important sets of data, which provides efficient support and transparency to the evidence-based preparation and making of strategic decisions.

**DEVELOPMENT OF CENTRAL IT SYSTEMS ENSURING INTER-INSTITUTIONAL FLOW OF DATA**

The goal of the project is to ensure the free, though controlled flow of data, based on national standards, among health service providers of primary care, outpatient and inpatient specialist care for the sake of managing and providing care.

**DEVELOPMENT OF ELECTRONIC CERTIFIED PUBLIC RECORDS AND HEALTHCARE PORTAL**
A catalogue and register of certified public data in the health sector is created, which serves as a central and authentic source of institutional information, accounting and reporting systems, and as an instrument for reaching authentic master data in the health sector.

**LOCAL INFRASTRUCTURE DEVELOPMENTS NEEDED FOR THE CONSTRUCTION OF REGIONAL, FUNCTIONALLY INTEGRATED INTER-INSTITUTIONAL INFORMATION SYSTEMS**

The goal of the project is to modernise local infrastructure at all publicly financed outpatient and inpatient care institutions, carried out in parallel with the establishment of the central eHealth system.

Legislation on the management of healthcare and related personal data has been changed, taking into account the goals of monitoring the health status of patients and the promotion of effective treatment activities of providers.

From 2011, GPs have access to their patients’ data of healthcare provided under statutory health insurance through electronic data query from the National Health Insurance Fund. From 2013, the legislation allows also the pharmacist to have access to medication data of the patient redeeming a prescription provided under the statutory health insurance within one year. From 2014, the patient's attending physician can also use this option.6

**Demand assessment, unified, transparent support of reallocation decisions in contracting care capacities, as well as of the transparent publication of available information on publicly financed health service providers and capacities**

Legislation specifies further guarantees to demand assessment and transparency, including the following provisions:

- The Office of the Chief Medical Officer operates a publicly available registry of specialist health care capacities as well as of territorial care obligations (catchment areas) of individual health service providers.
- In the course of procedures related to health service provision (e.g. decisions on the inclusion of extra capacities, identification of professional priorities), joint decisions of the Minister responsible for health and the Minister of National Economy are published in the Official Journal.
- Health authority decisions related to the health care system are published by the relevant health authority (the Office of the Chief Medical Officer), they can be appealed by those concerned before entering into force (e.g. in case of modifications of catchment areas for care obligations, local authorities have the right of appeal, based on provisions of the law on public administration procedures).

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6 Act XLVII of 1997 on the handling and protection of health data and related personal data
Transparency of health care services to be provided on the basis of waiting lists

A critical issue of health service accessibility is ensuring the relevant order of patient treatment in case of certain specific forms of care. In Hungary, it has been compulsory for service providers to operate waiting lists since 2007, however earlier validation, proper transparent publication, control of these lists could not be guaranteed. Since 1 July 2012, the National Health Insurance Fund operates an on-line, real-time system, with daily control and monthly co-ordination with data provided for performance reimbursement accounting. When entering the waiting list, the patient receives a national identification code in line with the relevant order, ensuring anonymity, and allowing him/her to continuously control his/her own position.

Are there specific examples of actions taken to make systems and services more responsive to citizen’s needs, preferences and expectations?

Responding to population demands when determining territorial care obligations (catchment areas), in utilisation of service providers

In Hungary, law prescribes territorial care obligations (catchment areas) for service providers. Further on, as described earlier, legislation specifies, for example, maximum timeframe for being able to reach the service provider or provides possibilities for local authorities to initiate the rearrangement of territorial care obligations, based on population demands.

Making available for the public texts of draft legislation to allow for a wide societal consultation. Government publishes the texts of draft legislation on its webpage (www.kormany.hu) in the course of administrative coordination procedures, making possible for everyone who is interested to receive information and form opinion.

Responding to population demands in the course of health technology inclusion

Health insurance financing inclusion procedures described earlier take into consideration population health care demands, the number of those concerned, population preferences (QALY), as well as support to finding solutions to public health problems.

Has this led to specific actions, legislation, regulations, etc.?

Developing the institutional system for patient rights

With the aim of strengthening patient rights, the Government approved Decree No 214/2012. (VII. 30.) on the National Centre for Patients’ Rights, Rights of Beneficiaries, Children’s Rights and Documentation. Based on the decree, a central office (the National Centre for Patients’ Rights and Documentation) was established being responsible for the effective protection of patient rights, as well as for the protection of rights of beneficiaries in social institutions and children’s rights.

In the course of its activities to represent the protection of rights, the institute pays special attention to providing information on the rights of those concerned, on access to services, the enforcement of the right to get acquainted with patient documentation, to support the exercise
of right to complaint, explore and solve systematic errors. In the course of its procedures, it intermediates in the swift and mutually satisfying settlements of disputes between the service provider and the claimant out of court. During their work, the representatives of the protection of rights keep contact with a wide circle of service operators, maintainers, authorities, professional organisations.

**Establishment and development of patient representation organisations**

Decree No 50/2012. (XII. 19.) EMMI on the National Patients’ Forum regulates the operation of the umbrella organisation covering patient and civil interest representing organisations. In case of certain diseases, like oncology, psychiatry, cystic fibrosis, haemophilia, it is characteristic that patients organise groups for the protection of their interests, regularly preparing proposals for health policy bodies, organisations concerning their health care demands and frequently enter into direct consultations. The National Patients’ Forum, which was joined by more than 200 patient organisations, acts as the counselling body of the Ministry of Human Capacities and participates in the elaboration of public health programmes, health sector draft legislation and of professional standards.

**Any other examples of actions toward increasing responsiveness of health systems?**

**Making information available for the population on actual questions concerning the use of health services**

Webpages of the National Health Insurance Fund and other bodies of public administration make information directly available for the population, also on the use of health services, by operating specific population pages.

**Control by population, access to data on personal health service utilisation**

Insured persons, following specific procedures, can directly access their own health care related data.

**Engagement of stakeholders**

Please provide one or more examples from your country on how the engagement of stakeholders, and a participatory governance approach, has been an explicit part of policy development and implementation processes?

**Please provide any examples of progress that your country has made in engaging in a dialogue with stakeholders, both within and outside the health sector, towards strengthening the health system and / or in respect of the development of specific policies.**

Expert and NGO consultation process of the 2nd National Climate Change Strategy
Have citizens been involved in such dialogue, and if so in what way?

It is important to involve wide range of stakeholders in planning and implementation of the programs e. g.: the public, NGOs, professional bodies, universities etc. The social consultation (which is part of the process of the consultation of public administration) creates occasion and opportunity for everyone to give informed opinion. Furthermore, for specific projects, the periodic and continuous dissemination of the results generated is important. Plan and implementation of the policy programs also open the opportunity for the highlighted and important themes to be widely consulted e. g.: smoking prevention, decrease alcohol consumption, prevent chronic non-communicable diseases.

Fostering cross-country learning and cooperation

Please provide one or more examples from your country on what has been done to foster cross-country learning and cooperation.

Has there been an explicit role for learning and cooperation from other countries in the design and implementation of health system reforms at national and sub-national levels in your policy development processes?

The Health System Analysis Division at National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) analyses the main components of health systems (resource creation, resource allocation, health services and regulation), and presents them in an international perspective. The beginning of the system analysis work of the Division can be traced back to 2004. In processing international literature the Division prepares a series of country studies, mostly from the EU countries, paying special attention to innovative approaches that provide efficient and adaptable answers to the challenges of health systems. The Division also conducts international comparative thematic analyses on issues that have relevance for Hungarian health policy. The results of the research are publicly available on the website of GYEMSZI, on the platform of up to date information on international health systems. From 2011 the Division - with the analysing of international literature and best practices- participated in several projects that aimed to develop the Hungarian healthcare system.

Regional organisation of healthcare provision

From 1 May 2012, healthcare delivery takes place in a system that is built upon special healthcare regions (eight regions has been established). The task of optimal organisation and supervision of healthcare taking place in the regions, as well as the management of patient pathways are performed by GYEMSZI, a professional institute which belongs to the Ministry
responsible for health. The new capacities for inpatient care and the connected areas operate from 1st July 2012, taking regional borders into consideration. Before this regional organization model in healthcare delivery system was introduced, Hungary examined several international best practices in health organizing. The Danish and Norwegian examples were the most beneficial to the Hungarian aims taking into consideration the Hungarian features. We successfully contacted a Norwegian regional leader who visited Hungary and studied the new Hungarian model (which is based on the Semmelweis Plan) and with whom Hungary still cooperates.

When Hungary studied the Danish model, a delegation of Hungarian health experts visited a Danish health region and built a promising collaboration with them.

**Integrated Care Models**

Experts from the Ministry of Human Resources, Secretariat for Health attended the Expert Seminar on Integrated Care Models in Health Care System in the Visegrad Group (V4 countries). The purpose of this event was to share the countries’ experiences between each other regarding the integrated models in healthcare systems.

**PLEASE PROVIDE EXAMPLES OF WHERE YOU COUNTRY HAS OFICIALY SUPPORTED A COLLABORATIVE APPROACH WITH OTHER MEMBER STATES**

Hungary officially and successfully applied for being a pilot country in WHO’s EVIPNet Europe network. The participation will help Hungary to establish a country team in 2015, which will promote policy development and implementation through the use of available scientific evidence. Successful collaboration will also enable Hungary to become future mentors and EVIPNet champions in the WHO European Region.

Within the frame of the reflection process on modern, responsive and sustainable health systems - established by the EU Working Party on Public Health at Senior level on 10 October 2011 - Hungary headed subgroup 2 (Defining success factors for the effective use of Structural Funds for health investments) and participated in subgroup 4 (Measuring and monitoring the effectiveness of health investments). The latter work resulted in a resolution to set up an EU level expert group to support national level health system performance assessment pursuits.

Hungary participates, along with 8 other EU-countries, to the HoNCAB project on cross border care. The aim of the project is to evaluate the operational and organisational challenges of international cooperation between hospitals, and to develop solutions as to seamlessly providing care for EU citizens insured in a different member state.

The PARENT cross border patient register initiative is a joint action of EU member states’ public authorities for the development of a database on rare diseases. Hungary is actively
taking part, along with 8 other member states. The epSOS project also intends to facilitate cross border health care, through developing a pilot for sharing electronic patient data across different providers in different member states.

Hungary is contributing to the **SCOOP project on common European pharmacovigilance.** The project aims at improving the cooperation among EU member states in order to successfully manage the common pharmacovigilance database in place since 2012. Hungary is leading the work package on quality management systems.

The **eHealth Governance Initiative** is a Europe-wide project on coordinating the e-health programmes and efforts of the European Commission and member states. It develops a common platform on e-health projects improving health care interventions and facilitating health policy decision making.

A **reflection process on modern, adapting and sustainable health care systems** was launched during the Hungarian presidency of the Council of the EU in 2011. Hungary led the working group on how to best use structural funds for investment in health care. The project terminated in 2013.

**ANY OTHER EXAMPLES OF ACTIONS TOWARD FOSTERING CROSS-COUNTRY LEARNING AND COOPERATION**

Comparison of the Hungarian and Australian DRG systems

The Hungarian DRG classification system was innovative when it was introduced, but now it is getting old fashioned so Hungary seeks methods to streamline it. The Australian DRG Classification System is among the best recognised and most highly regarded systems, therefore Hungary would have liked to use it for research purposes, so Hungary contacted the Independent Hospital Pricing Authority in Australia in order to compare and contrast the two systems, specifically the procedure list and the procedures’ definitions. Hungary and Australia made a contract to evaluate the Australian DRG Classification System. The evaluation lasted for 6 months and now Hungary intends to publish this research nationally and internationally in due course, focusing on the Hungarian system.

**Experience in health systems strengthening**

In this section please include any additional elements of your country’s work over the last six years to strengthen the health system. For guidance purposes only consider the following key areas:
Health care services are financed by the National Health Insurance Fund (managed by the National Health Insurance Fund Administration). Since 2008, there were measures performed to improve the balance of Fund and to achieve a sustainable income-expenditure relation.

**Main sources of National Insurance Fund income:**

**Contribution**
- health care contribution (by employees)

**Direct Government transfers from the Central Budget**

**Other incomes**
- incomes from pharmaceutical companies
- accident tax (since 2012)
- public health product tax (since 2012)

**Main estimates of Fund expenditure:**

**Cash benefits**
- sickness benefit,
- pregnancy-confinement benefit
- work accident sickness benefit
- child care fee

**Benefits in kind**
- general practitioners
- dental care
- nurses
- laboratory
- patient transport
- outpatient care
- hospital care
- pharmaceuticals and medical devices
The main change, hospitals are state owned and the National Institute for Quality- and Organizational Development in Healthcare and Medicines and it’s the maintainer and middle management body since 2012. These measures helped to observe better the operation of hospitals, and propose and take action and measures if these become necessary.

A pay-for-performance model is applied in inpatient service presently. State owned hospitals are paid by a DRG classification. One unit of financing currently equals 150.000 HUF. Financing for health care provided is calculated as a product of 150.000 HUF and a multiplier derived from the DRG classification of the main diagnosis. In addition, there are income flows to hospitals for outpatient care, chronic care, laboratory care and wages. In regard to outpatient care, providers are financed by a pre-determined point value of the care provided. These pre-determined point values are based on the overall average cost of that particular care provided. One point equals 1.5 HUF. Chronic care is financed by a daily fee. Wages transfers are calculated by a monthly request of providers and it’s financed by the National Health Insurance Fund Administration.

At the present, in our health care system, outpatient service providers are financed by a pre-determined point value of the care provided. These pre-determined point values are based on the overall average cost of that particular care provided. One point equals 1.5 HUF.

There were a plenty of incentive actions accomplished were improved the outpatient and inpatient health care services since 2008:

- transformation of the structure (2012)
- hospitals are state owned since 2012
- hospital debt managing measures (constantly, under the current budgetary framework)
- continuous waiting list reduction programs (since 2012)
- improvement in remuneration of health workers from 2012 (in more steps), improvement in finance of primary care, home medical care, home care on-duty medical services, school medical care, nursing care, dental care and dental attendance (for example: subsidy family doctors to settle in vacant zones where vacant posts exist more than 12 months)
- continual support of patient transport and rescue financing

*Human resources for health e.g. health professional curricula, policies on migration/retention of health workers, changed conditions for health professionals (incentives to work in under-served areas)*

“In the recent 4 years, the Government has taken measures aiming at maintaining – both on short and long terms – an appropriate level of well-trained human resources in the health sector.
These actions comprise on the one hand institutional and on the other hand such changes that would improve the overall professional – including financial – situation of health care professionals.

Main points of the measures are the following:

One-off income supplement for health workers
In 2011, partly financed by the revenues from the public health tax on foodstuff, a one-off bonus, which equals approximately three months’ allowance base, was paid to health care workers in positions with higher risks and greater workload. This one-off payment is due to all health care workers, irrespective of the employer. Altogether 68,100 health care workers received 36, 120 or 150% allowances. As a result of this measure, totally 5,6 billion HUF was paid to health care workers in two phases.

Supporting career starter general practitioners in purchasing practice
300 million HUF were available for launching a call for application for career starter general practitioners. The National Institute of Primary Care based on an agreement with the Ministry of National Resources launched the call for application in the first half of 2012. General practitioners could apply for financial support to purchase a practice as well as equipment necessary for the operation of the practice. In return, they have to commit themselves that they will work as general practitioners in the given practice for a period of time proportional to the magnitude of the grant.

Resident scholarship programme
Resident doctors can receive (after an application procedure) a tax-free scholarship with a sum of 100 000 HUF (cc. 330 euro) per month. For receiving the scholarship they have to agree that they will work for the Hungarian public healthcare system after specialisation training for the equal time than their scholarship period (5 years in most of the cases), and they do not accept any informal payments.

CDP courses
In line with Decree No. 63/2011 (XI.29.) of the Minister of National Resources amending relevant legislation in force, as of January 2012:
- compulsory further theoretical training of medical doctors and health workers will be entitled to state financial support,
- working abroad as well as further training completed abroad shall be recognized, and through that contributing to the integration of medical doctors returning to the Hungarian health care system,
- to decrease administrative burdens, the electronic record system of further training of health workers shall be established.

Changes in vocational education
In line with the conception approved by Government on vocational training, the overall transformation of the vocational training system has been started in 2011. Act CLXXXVII of 2011 on vocational training entered into force on 1 January 2012. Government Decree No. 150/2012. (VII. 6.) on the National Training Registry entered into force on 1 September 2012. Main points of the new vocational school system:

- shorter duration of training, except the training system of nurses (3 years). In Hungary the legislation is in accordance with the recognition of professional qualifications on the European Parliament and the Council's 2005th Directive 2005/36/EC of 7 September Article 31 (3).
- practice orientated training.
- following the vocational training (4 years) he/she is get a leaving certificate.

Measures for increasing the social appreciation of health professionals

The birthday of the famous Hungarian doctor, Ignac Semmelweis (1 July) has become a legal holiday for health professionals since 2011. 19 February was declared as the Day of the Hungarian Nurses in 2014.

Renewal of the residency training system

- more flexibility and transparency
- continuous access to specialist training by MDs
- support to cover material costs: 100 000 HUF per year (~350 EUR/year), following at least 12 month resident education.

Wage increases

Actions targeted at solving the human resources crisis continued in 2012 with measures that intended wage-corrections for health professionals. More than 95 thousand health professionals (including physicians, nurses, pharmacists, etc.) received salary increases in the public sector. The average salaries increased by 15.5% in 2012 compared to 2011, and an increase to a similar extent was implemented in 2013.”

In addition to ageing, a general tendency in Europe, the migration of doctors and health care workers also imposes a high burden on the situation of healthcare human resources in Hungary. Measures have been taken for years in order to retain the skilled health workforce migrating abroad in the hope of better income opportunities and more favourable general working conditions.

In 2011 scholarship grant programmes have been launched in order to support the retention of young doctors. Specialist residents and specialist pharmacist candidates can ask for a net extra remuneration of 100 000 HUF per month on condition that they take a job in the publicly funded health system and reject informal payments. Paediatrician residents who take a job in a vacant GP practice can receive a net monthly allowance of 200 000 HUF.

From 2013 on, scholarship programmes for residents are completed with a scholarship programme for emergency medicine specialist residents. The residents who provide
emergency care on a location defined by the Hungarian National Ambulance Service, and do not accept informal payments, can receive a net monthly allowance of 200 000 HUF.

After extensive consultations with the advocacy groups, the Hungarian Government made a legislative commitment to improve the earnings of health professionals. Legislation referred to health workers working as employees at publicly financed health care providers owned by the state, a municipality, a church or a higher education institution. The regulations covered the employees of the outpatient and inpatient institutions, as well as ambulance, patient transport and blood supply providers specified in the implementation regulation.

In 2011, nearly 71 000 healthcare workers received a one-time subsidy of totally HUF 5.6 billion. In 2012, 90 000 healthcare workers got a retrospective and ongoing wage increase of totally HUF 30 billion. In 2013, wage increase affected 95 000 healthcare workers and amounted to nearly HUF 50 billion. In 2013, the wage increase was 10-11% on average for doctors (following an increase of 20% in 2012) and 8% for healthcare workers (following an increase of nearly 16% in 2012).

In October 2013 and February 2014, the government provided HUF 16 billion of additional funding for primary care. In the fall of 2013, GPs, primary care duty services, dental care centres, MCH nurse and school health services received an increase of their monthly funding, provided retroactively to January. The monthly funding of GPs increased in average by HUF 45 000 (about 4.5%). To support the employment of allied health professionals by GPs in their practices, a supplementary fee was introduced in 2014. The employment of additional health professionals, resident doctors and specialist doctors is supported by raising degressive point limits. There was an increase in the fees for indicator-based care (performance bonus) and GP on-call care. The remuneration of GP practices increased altogether by HUF 70-80 000 per month (about 7-8% of practice financing). The funding of workers in district MCH nurse services increased on average by HUF 30 000 per month in each service.

PUBLIC HEALTH POLICY E.G. TRAINING IN PUBLIC HEALTH, IMPROVING, PUBLIC HEALTH SERVICES AND CAPACITIES

Key areas of public health policy in the last six years:

- **smoking**: is prohibited to smoke in all enclosed public places from January 1, 2013; tobacco products packaging with health warnings; help to stop smoke:

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8 Government Decree 138/2012 (VI.29.)
9 National Health Insurance Fund Communication on the basis of Government Decree 40/2014. (II. 24.)
http://www.oep.hu/pls/portal/docs/PAGE/LAKOSSAG/OEPHULAK_HIREK/SAJTOSZOB/TA B60675155/ALAPELLATAS_KOZLEMENY_VEGLEGES.PDF
- **alcohol:** the Policy Program of Alcohol Problem is completed and now it is before the public consultation

- **nutrition – obesity:** the introduction of public health product tax; regulate the amount of trans-fatty acids; regulating the communal feeding to make child feeding more healthy

- **physical activity:** full range school health promotion e.g.: physical education five times a week

- **the fight against cancer:** organized system of public health screenings: breast screening, cervical screening – nurse program, Vaccination against HPV, colorectal cancer; Occasional screenings; revised National Cancer Control Programme; management of National Cancer Registry and National Screening Registry; Joint action- European Partnership Action Against Cancer (EPAAC)

- **other programs:** establishment of Health Promoting Offices and Centre for Health Communication; assessment of oral health; Swiss-Hungarian Cooperation Programme

**Smoking cessation aid**

With funding support from the European Union the National Methodological Centre for Smoking Cessation Aid was established in the Korányi National Institute of Tuberculosis and Pulmonology in October 2012. The National Methodological Centre for Smoking Cessation Aid has a call centre where qualified psychologists and physicians give information and advice about smoking cessation and provide a cessation program services via telephone. The Centre’s services are available free of charge at the number +36 80 44-20-44. The Methodological Support Centre runs a homepage as well (www.leszokaspont.hu) for the purpose of broader public communication.

Since December 2013 smoking cessation group consultation services are available nationwide in 86 pulmonology centres from European Union Funding. These pulmonology centres also engage in communication with local professionals and the public. At the same time personal cessation support services are offered as well in these centres, funded by the central budget. As a result of the recently launched programmes, the individual and group consultation cessation support services will be available nationwide in the pulmonological centres. This will help to increase the number of people who quit smoking.

**Swiss-Hungarian Cooperation Programme**

The primary health care organizational model programme, with focus on public health issues, will be established with Swiss support. Within this framework four group practice has been established consisting of 24 primary health care practices in North Hungary and in the North Great Plain region (centres are Berettyóújfalu, Jászberény, Borsodnádasd, Heves). During the programme approx. 50,000 people will take part in a complex screening (for more than 20 parameters) accompanied by life-style counselling. The programme improves in access to and quality of the primary health care services, especially among the Roma population. The implementation of the programme started in June 2012 and is expected to reach its conclusion on the 30th of June, 2016.
Health Promoting Offices (HPO’s)

The establishment and operation of Health Promoting Offices (HPOs) are novel elements of the Hungarian health promotion framework. This is the first time in Hungary, that a health promotion and disease preventing institution which operates on a sub-regional level among local communities has been established. The fundamental objective of the HPOs is to improve individuals’ health through the prevention of cardio-vascular and tumorous diseases and the promotion of lifestyles that influence early and avoidable mortality. The offices aim to improve the health care system’s preventive activities by involving clients (people in need of lifestyle change advised by the family doctor, outpatient- or inpatient care services or seeking change on their own initiative) in lifestyle change programmes and following up their participation. The HPOs offer new services free of charge and without the need of referral. Each HPO operates in a sub-region. 59 beneficiaries are starting their operation from European Funds throughout the country in 2013 - 18 of them in the most disadvantaged areas of Hungary.

Health Communication Centre

In order to promote health communication, the Health Communication Centre was established in the second half of 2013. The Centre’s aim is, through quality information service, to be a trademark and a trustworthy, focal point in the fields of healthy lifestyle and disease prevention. To achieve these goals, the Centre runs a homepage (www.egeszseg.hu) with thematic headings, organises nationwide campaigns, as well as maintains interactive communication connections with the public via social media. Furthermore it establishes and runs public health action groups that realises innovative communication programmes (e.g. flash mobs, community action programmes, performance, sit-in etc.) to achieve public health initiatives. Thematic fields are: smoking cessation, healthy diet, physical activity, harmful use of alcohol, responsible practice of responsible drug use- and patient adherence, screening programmes etc.

Cervix screening programme provided by health visitors

During the earlier cervix screening model programmes the health visitors proved to be able to successfully educate the postgraduate courses, to reach, address and motivate women to take part in screenings, to do screenings and to take swabs of proper quality. The health visitor cervix screening “brings screening closer to women, especially in the most disadvantaged regions and in small settlements. The health visitors already reached several women and motivated them to take part in screenings, who have not visited their gynaecologist in the last ten years or even longer. Until 2012, 285 health visitors voluntarily applied for the postgraduate courses and learned to do cervix screening. Nowadays nearly 200 health visitors are capable to do such screenings. The programme will be expanded from European support (TÁMOP 6.1.3/A). In doing so primarily those health visitors will gain competency through theoretical-, communicational-, and practical trainings, who work in the most disadvantaged regions, in settlements where less than 5000 inhabitant lives.

Pilot colon screening programmes
The family practice pilot colon screening programme is realized in three counties (Győr-Moson-Sopron, Heves, Nógrád) between 2013 and 2014 with the voluntary participation of 95 GPs. The target groups are men and women between ages of 50 and 70. In 2014 with European Fund support the same pilot programme starts in Csongrád County.

**Early childhood programme**

The programme supports children’s optimal bio-psycho-socio progress from age 0-7, through developing the primary children health care in the following fields:

- support a healthy lifestyle from the early childhood and their successful start at school,
- follow up of the children’s development,
- helping to develop their abilities,
- exploring the risk factors, and
- straining children with different development.

In Hungary in the pediatric care 3800 health visitor and 3100 pediatricians provide services for about 600,000 children. The programme supports the professionals in the pediatric care mostly with improving and renewal of applied methodologies, especially in case of children and their families in the most disadvantages groups and special needs. Each child has to take part in ten screening between the ages of 0-7 which means, with the new screening package 1 Million screenings are done by year. In 2013 1654 child were screened. The implementation of the programme started on the 1th of October 2012 and is expected to reach its conclusion on the 31th of May 2015.

**Examination of oral health status**

The implementation period of the programme is between May 2013 and the end of June 2014 and its aim is to examine the oral health and health behaviour of 1800 children between the ages 6 and 12 in 17 locations.