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# Introduction

The health indicators of the Hungarian population have been reflecting a particularly unfavourable tendency for a number of decades. Some of Hungary's morbidity and mortality statistics sadly qualify the country for the international vanguard. Morbidity and mortality conditions have not shown any improvement over the last decade either. Tumour-induced mortality deserves us the first place internationally. The weight of chronic, non-contagious diseases is decisive in early deaths and diseases. Average life expectancy at birth lags far behind the corresponding indicators of EU countries, with especially middle-aged men featuring high mortality rates.

The unfavourable health status of the Hungarian population is characterised partly by mortality and morbidity figures which are outstandingly high in international comparison, and partly by the high occurrence of risk factors.

The mortality history of the Hungarian population lends itself for division into three distinct periods: mortality shrank until the mid-1960s, rose in the period of 1968-1993, and has been decreasing again since 1994. The average life expectancy at birth in Hungarian men followed a downward tendency from the 1960s until the early 1990s, and has been growing since, while in women the tendency has been a slow but gradual increase over the past decades.

Infant mortality has been pointing downward in the past decades. In September 2001 there were only 6.0 infant mortalities for a thousand live births, as opposed to the EU average of 5.6. The value calculated for thousand live births dropped to 7.3 in 2003 from the 1993 value of 12.5.

Leading death causes have been the diseases of the circulatory system, tumours, violent deaths, and – since the early 1980s – chronic liver diseases.

The death cause matrix includes diseases of the circulatory system, tumours, diseases of the digestive system, respiratory system diseases, and accidents, poisonings, and violence as the most frequent death causes. Most external reasons include traffic accidents and other accidents, followed by fatal suicide attempts. The mortality rate for 100 thousand inhabitants was 94 in 1980, 64 in 1990, and 54 in 2003.

Summing up, one may claim that chances of life in the under-35 population have never been better than today, while survival chances in the 35-64 male age brackets has significantly worsened over the last three decades. Early death is particularly high, in terms of both number and ratio; 40% of all deceased men and 20% of all deceased women was younger than 65.

Life expectancy at birth has increased from 69.3 years in 1990 to 72.4 in 2002. That value is the highest in the almost hundred-year-long time series of life expectancy values, but it counts a low figure in international comparison.

## Risk factors

### Smoking

The ratio of smokers in the male population reduced in the early 1990s, but rose again toward the end of the decade to exceed 50%. The corresponding ratio for women has been rising constantly, to 31% by now.

Smoking is the single most important risk factor underlying avoidable and premature deaths; it qualifies as a grave mass disease from a public health point of view. The Hungarian Central Statistical Office (CSO) claims that the death of 28 thousand people annually in Hungary is attributable to smoking (2002).

**Alcohol consumption**

Patient turnover and mortality statistics clearly suggest that alcohol consumption among the Hungarian population is likewise a significant problem. Available research results indicate that the number of persons regularly consuming alcohol has increased to 89% in men, and to 64% in women. Every third 15-year-old boy, and every tenth girl of the same age consumes alcohol on a weekly basis.

The number of registered alcoholics dropped from 58.4 thousand in 1990 to 32.5 thousand in 2003. The actual number of alcoholics, in accordance with well-founded estimates and depending on the definition used ranges between half a million and one million; the CSO's last official estimate is 718 thousand (2003).

**Drug use**

The number of drug users treated in health institutions was around 12,700 in 1999; 12,000 in 2001, and almost 15,000 in 2003. The number patients treated included about twice as many men as women. The number of drug-induced deaths dropped from 339 in 1997 to 276 to 2002, and 257 in 2003. 29% of 16-year-old secondary school students have tried some kind of drug.

**Nutrition**

Obesity among men was nearly 50%, and among women 40% in 1994. The middle of the 1990s marks a favourable change in nutrition habits: the ratio of those consuming fruit, vegetables, poultry, increased, while the consumption of fat, bacon, and pork dropped. Despite favourable changes, consumption of animal fats is still too high, and that of fresh fruit and vegetables very low, especially among those with low qualification and low pay.

***Obesity*** is a top-priority problem of public health also in Hungary, concerning over 1.5 million people. Another 2.7 million people suffer from overweight. Obesity is highly typical of men under 40, almost half of the men of this age are overweight. The number of obese people over 65 significantly declines, but it is only a seemingly favourable phenomenon since due to obesity related illnesses the obese people reach old age in fewer numbers than those who do not suffer from obesity.

**Physical exercise**

One of the reasons of the bad state of health of the population is lack of physical fitness. According to the relevant surveys, only 21% of men and 14% of women in the 15-64 age brackets do regular exercise in Hungary. The physical activity indicator drops fast with the increase of age. While 25% of the 20-29 year-old answered that they exercised regularly, that indicator dropped to 15% among 30-39 year-old, and to 10% among those in the higher age groups.

**Environment**

The air is polluted in 13% of the country's area, home to almost half of the population. 3% of the population is confined to drink impure water.

Food safety standards in Hungary are high; food products are subject to regular inspection.

488 occupational diseases were recorded in 2002 in Hungary; this number had been almost double ten years earlier.

**Progress**

The establishment of health manager training institutions and university faculties constituted a major step forward. Training has led to the familiarization of the health institution managers with the essential concepts of more independent financial management, and large groups of the medical profession have welcomed new knowledge concerning the economical operation of institutions.
Performance-based funding has been introduced in major areas of care provision; free choice of doctors and hospitals has been declared; (quality) competition has emerged among the service providers; the institutions concerned acquired partial independence and privatization has started.

In the area of health preservation, steps toward healthier nutrition, drug-prevention actions, anti-smoking programmes etc. all promote a healthier lifestyle.

# 1. Health insurance

**Health insurance**

## International comparison

The health systems of the economically developed countries are usually divided into three basic categories. One includes public health services funded from tax. That is the so-called Beveridge model, to be found e.g. in the United Kingdom. The other group is that of health services powerfully relying on social security systems supplemented by private insurance. This is called the Bismarck model, existing, for example, in Germany. The third group includes systems characterised by weak social security and strong commercial private insurance, as the one in the United States.

The Hungarian social security system presently operates a one-insurer pattern supplemented by optional membership in not-for-profit health funds and commercially operated insurance companies. There is no independent accident insurance branch yet, but plans already exist.

In 2006, the Government set the objective of overhauling the health system, and transforming the social security as part of the same effort. The reform concepts so far released for debate suggest a multi-insurer arrangement under the social security. The new actors operating the social security compete in a regulated fashion at two levels: funds race for the prospective insured persons, and thereby force health providers also to compete. There may be no competition in the level of contributions and in the compulsory care services (these must be provided by each fund, and continue to be under statutory regulation). Competition may unfold in regard of the extra services offered by the funds (services in addition to those that the funds must compulsorily provide, patient collection routing, supporting pharmaceutical prices, etc.). Competition is expected to greatly improve the quality of services.

The main task of the compulsory health funds to be formed would be the delivery of statutory health insurance services, in particular, the organisation of care services and funding. Private investors may acquire a 49% stake in the funds, and the state would have 51%. State majority would be an unchangeable given.

Insurance is compulsory. The principle of compulsory insurance deprives funds of the right to select among patients. Those who do not choose a fund for themselves will be insured on a statutory basis by the geographically competent fund. That is rigorously controlled by the Health Insurance Supervisory Authority.

Three packages have been devised for care provision: a) the basic package, b) the insurance package, and c) whatever is beyond, i.e. services not available for funding by the social security (extra package).

Insured persons continue to pay contribution proportionately to their earnings. That is collected by the state, and it constitutes the revenues of the single Health Insurance Fund. The Health Insurance Fund pays a quota per insured to the funds.

Funds must generate reserves, and ensure cover funds in order to provide financial guarantees for their operation.

Health providers, and/or pharmaceutical and medical aid manufacturers and distributors may not acquire ownership; at the same time the law does not prohibit the newly establishing health funds to acquire stakes in health service providers (but they may not, even in that case, operate a provider themselves).

## Legislative background

## Eligibility for health services of domestic resident Hungarians

### 1) Eligibility for health services of domestic resident Hungarians

Essentially, the insured is eligible for in-kind health services and financial provisions. The law sets out the list of those entitled to insurance. Insured persons are entitled to all health insurance services. Some persons not listed under the insured are only entitled to in-kind health services. Such persons include, in addition to Hungarian citizens studying at day-time courses of a secondary training or education institution or a higher education institution, also foreign citizens who are party to a pupil or student legal relationship based on international agreement or scholarship granted by the Ministry of Education and Culture.

The following are also entitled to health services: recipients of sick pay; of pregnancy and confinement benefits; child-care fee; accident-related sick-pay; accident-related benefits; pension on own right; survivor's pension; old-age benefit; incapacity benefit or widows'/widowers' benefit or increased-amount old-age benefit, incapacity benefit, or widows'/widowers' benefit; temporary benefits; regular social benefits; health impairment allowance; disability support; invalidity benefit; national nursing fee, war veteran's care, miner's pay supplement; child-care aid; pension from a church or a congregation; regular social aid; benefits for the elderly; nursing fee; child-raising support; income supplement of unemployed persons; persons with changed (min. 50%, certified by the competent authority) working capability; support for persons having reached pension age and earning below 30% of the minimum wages; persons recognized as socially indigent by an official certificate issued by the mayor of a local government; persons entering into an agreement for receiving health insurance services; persons obliged to pay health service contribution; persons with a monthly earning generating a contribution base lower than 30% of the minimum wages and acting as a foster parent, provided that the persons concerned qualifies as resident Hungarian.

For the purpose of the following titles, under the law, domestic resident Hungarians are Hungarian citizens living in the territory of the Republic of Hungary; persons in immigrant or permanent resident status or recognized as refugees; persons within the scope of the *Act on the Entry and Stay of Persons With the Right of Free Movement and Residence,* provided that they have a registered place of residence in accordance with the *Act on Keeping records on Personal Data and Address of Citizens,* or if the person concerned is stateless.

Under specific conditions, persons of minor age having a place of residence in the territory of the Hungarian Republic are likewise entitled to health services, as well as persons placed in

a residential social institution providing personal care (except foreign citizens); young adult recipients aged 18-24 in follow-up care in the child protection system, and foreign minors placed temporarily by the competent Hungarian authority or put into temporary or permanent home-providing care, as well as prisoners and homeless persons.

All insured persons are entitled to full accident-related care, i.e. accident-related financial provisions on top of accident-related health care. Persons eligible for some types of social security services under the applicable legislation have more restricted access. In addition to insurance policy holders, individual or collective entrepreneurs pursuing "supplementary activity" are also entitled to accident-related care. A private entrepreneurs or member of a partnership qualifies as person pursuing a supplementary business activity if he performs the activity as pensioner on own right.

Pupils of institutions of education and training and of higher education, of schools, or trainees provided practical training outside the school system (except for foreign citizens), mental patients treated in socio-therapeutic institutions, addicts, persons apprehended, preliminary detainees, detainees, persons serving a prison sentence who suffered an accident or health damage, particularly in the course of life saving, accident and/or disaster rescue operations or blood donation, or perform public interest (voluntary) work are entitled to accident-related benefits.

**Eligibility for health services of foreigners**

Foreign citizens may stay in Hungary temporarily or on a permanent basis, i.e. to live their life there. In the latter case, the foreign citizen transfers his place of residence to Hungary to work or study there, or to live there as a pensioner, a financially dependent close relative of a Hungarian worker (policy-holder), or perhaps as a refugee, asylum seeker or stateless person. Foreign citizens with a residence permit and a permanent place of residence in Hungary qualify as domestic residents from a social security point of view, and the circle of foreigners includes, in addition to those of foreign citizenship, persons who cannot be regarded as residents, that is, also Hungarian citizens with no permanent place of residence in the country.

**Residents (domestic persons) and aliens (foreigners) from a social security point of view**

The following qualify as aliens (from a social security point of view):
All the natural persons who shall not be regarded as residents shall qualify as aliens.

The following shall qualify as residents (from a social security point of view):

- Hungarian citizens living in the territory of the Republic of Hungary
- Immigrants
- Persons having a settlement permit (settlers)
- Persons recognized as refugee
- Persons under the effect of the Act *on the entry and stay of persons with the right of free movement and residence*, who exercise the right of free movement and stay in excess of three months in the territory of Hungary, and have a registered place of residence there in compliance with applicable legislation. The persons concerned include:
  - EEA citizens (citizens of an EEA Member State), as long as they have an EEA residence permit, and registration certificate,
  - Family members accompanying an EEA citizen (as long as the have a residence card and/or registration certificate issued by the Hungarian alien control authority)

- Family members of non-Hungarian citizenship accompanying a Hungarian citizen (as long as they have a residence card)
- Dependants of a Hungarian citizen or a person of EEA citizenship with a Hungarian residence permit, or those having shared a household with such a person for at least one year, or those under the personal care of the Hungarian/EEA citizen for serious health reasons, if the Hungarian alien control authority given permission for the immigration and stay of that person as family member
- Those enjoying the same legal status as the citizens of the EEA member countries, but are citizens of a non-EEA member country, provided that they have a residence permit,
- Stateless persons

**Entitlement to health services of EEA citizens**

**Characteristics of the regulation co-ordinating the social safety systems of EU member countries**

The community social policy of the EU, built on action programmes, was not designed to create a uniform European social safety law whose immediately applicable provisions would represent a uniform European Social Code replacing the different national social security laws currently prevailing in the twenty-five Member States. So there is no common EU social security legislation applicable to all citizens of all EU Member States; the individual member countries will abide by their respective national legislations. Each state will decide freely what social security scheme to operate, what services to provide under what conditions, how much contribution to collect, etc.

The guaranteed free movement of workers is one of the basic freedoms of the EU. That entails that all workers who are citizens of any member country are entitled – subject to the derogations applicable to the new Member States –to move to any other Member State to perform a gainful activity, i.e. to engage in employment there.

As social security regulations concerning employment are different in the Member States, the EU must ensure that differences among the various systems should not inhibit the workers in moving about freely.

Thus the EU's social security legislation focuses on co-ordination rather than harmonization. The Union tries to ensure that citizens and their families exercising the free movement of persons, moving about the Member States, should be entitled to health care/services also in other Member States, i.e. in the course of migration. The legal sources of co-ordination are Council Regulations (EEC) Nos. 1408/71/EEC and 574/72/EEC.

**The co-ordination legislation**

The social security system of the EU is determined in line with the above principles by Council Regulation (EEC) No. 1408/71/EEC and Regulation No. 574/72/EEC concerning its implementation (hereinafter, collectively: the Regulation). The Regulation has been amended a number of times since its creation, and currently it ranks among the most complicated ones in the EU.

The Regulation on the social security of migrant workers contains such provisions for the assessment of insurance obligation and health insurance services as are to be executed in

Hungary by the National Health Insurance Fund. Of course, the Regulation applies not only to Hungarian citizens working in other European Union (hereinafter: EU) Member States, and non-Hungarian EU citizens working in Hungary, but it is also an outstanding piece of legislation with reference to health services to tourists and students coming from other Member States of the EU, and Hungarian insured persons spending their holidays in an EU Member State, and applies also to so-called commuting citizens (persons moving back and forth to a neighbouring country to work).

*Basic principles:*

1. The 'non-discrimination' principle: citizens of EU Member States hold equal rights and share equal duties from a social security point of view in another Member State with the citizens of that Member State. In short: Member States must not discriminate against the nationals of another Member State.

2. The 'applicable legislation' principle: as a general rule, a person is subject to the legislation of one Member State only at any one time, and workers are normally subject to the legislation of the State in which they work.

3. The 'aggregation' principle: entitlement built up in one Member State should be recognised when calculating benefit entitlement in another. In short: entitlement acquired in the home country shall be recognized in another Member State, too.

4. The 'export' principle: benefits are payable without reduction or modification outside the national territory if the person concerned resides in another Member State .

*Personal scope of the Regulation*

The Regulation applies essentially to the following:
1. the employed,
2. the self-employed,
3. civil servants and public servants, and
4. family members of all three categories indicated above, and
5. refugees, stateless persons residing in the territory of the Member States on a permanent basis and their family members, and
6. students and their family members.

As for the territorial scope of the Regulation, "co-ordinated" social security benefits within the EU are available – on the basis of the effective text of the Regulation – to citizens of EU Member States plus of Norway, Iceland, Liechtenstein. In addition to the citizens of the aforementioned countries, citizens of non-EU member countries (so-called "third countries") may also acquire entitlement provided that they have a permanent place of residence and a valid insurance in an EU Member State.

For the purposes of the Regulation,

*employee, self-employed person* means '…all persons who have an unbroken insurance on a compulsory or voluntary basis for one or several contingencies that are within the scope of the various branches of the social security system for employees and self-employed persons';

*family member* means 'any person defined or recognised as a member of the family or designated as a member of the household by the legislation under which benefits are provided' and, furthermore, 'if, under the aforementioned legislation. a person is considered a member of the family or member of the household only if he/she lives in the same household as the insured person or pensioner, this conditions shall be considered satisfied if the person in question is mainly dependent on the insured person or pensioner'. Of course, the concept of "family member" varies by country; in this regard, the national legislation of the state where the family member resides shall be indicative (that is, the "family member" status of a relative living in France of an insured residing in Belgium shall be determined in accordance with the relevant French provisions.)

**Material scope of the Regulation**

The Regulation co-ordinates the following social safety systems amongst EU Member States:

1. sickness and maternity benefits,
2. invalidity benefits,
3. old-age benefits,
4. survivors' benefits,
5. benefits in respect of accidents at work and occupational diseases,
6. death grants,
7. unemployment benefits, pre-retirement benefits
8. family benefits.

The Regulation shall not apply to social aid, and to other agreements between social partners and/or supplementary pension funds.

**Bilateral social security agreements following accession:**

The Regulation contains provisions concerning the further destiny of bilateral social security agreements concluded by the Member States among themselves. As a general rule, it repeals the agreements concerned, but if they provide a relatively higher level of protection to citizens, then it maintains their effect in regard of the articles concerned. Thus some provisions of Hungary's agreements with present EU Member States or states having joined the EU in the same round as Hungary – establishing additional protection in comparison with those under the Regulation –will remain in effect.

**Employment – Determination of the applicable legislation**

The Regulation establishes the general and special rules for determining which country's legislation should be applied to identify the social security benefits of an employed/self-employed person who moves about within the EU.

*As a general rule,* the employed person shall be ensured in the state where he/she pursues his/her earning activity (principle of *lex loci laboris*).

According to the general rule under the Regulation, a person is subject to the legislation of only one Member State, as follows:

- a person employed in the territory of a Member State is subject to the legislation of that State;
- a self-employed person carrying out his/her business activity in the territory of a Member State is subject to the legislation of that State;
- a person employed on board a vessel flying the flag of a Member State is subject to the legislation of that State;
- civil servants are subject to the legislation of the Member State to which the administration employing them is subject;
- a worker called up or recalled for service in the armed forces or for civilian service of a Member State retains the status of worker and is subject to the legislation of that State;
- retired persons are subject to the laws of the Member State in which they reside.

These general rules shall be applied unless Articles 14-17 of the Regulation provide otherwise.

*Special rules:*

The Regulation establishes special rules for the following forms of employment:

1. Posting:
   A person posted to the territory of another Member State to perform work there by an employer, or a self-employed person conducting his/her independent business activity in the territory of another Member State shall continue to be subject to the legislation of the first Member State despite performing work in another Member State. The duration of such posting shall be 12 months, extendable on one occasion, by another 12 months. The form (E 101) designed to certify the posting prove to the competent authority of the country competent by place of work that the worker continues to be insured in the sender state, and that he/she is exempt from contribution payment in the country of work.

2. Pursuit of activities in two or more Member States:
   2/a. A person who normally pursues an activity as an employed person in two or more Member States shall be subject to the legislation of the Member State of residence if he/she pursues a substantial part of his/her activity in that Member State. That rule is applicable, *mutatis mutandis*, also to self-employed persons.
   2/b. If the person in question performs work in several Member States, but has no permanent place of residence in any of these, then the indicative law shall be that of the country in which the employer has his registered seat or where the business has a registered office.
   2/c A self-employed person shall be subject to the legislation of the Member State where he/she pursues a substantial part of his/her independent entrepreneur's activity.
   2/d A person who is employed in one Member State and, simultaneously, self-employed in another Member State shall be subject, as a general rule, to the law of the State where he/she is employed under an employment relationship. In some special cases double contribution payment is also allowed.

On the basis of Article 17 of the Regulation, two or more Member States and/or their competent authorities may agree to depart from the above provisions in the interest of certain persons or certain groups of persons. In Hungary the competent authority is the National Health Insurance Fund.

**Health care benefits**

The Regulation provides for persons within its scope to be able to receive "co-ordinated" social security benefits from the competent authority of another Member States as well, under the same conditions as the citizens of that State.

*1. Workers and their family members*

As a general rule, a person working in another EU Member State and his/her family members may receive health care benefits in the country where they are insured, in accordance with the rules of that country. (e.g. a Belgian citizen working in Hungary will be entitled to benefits according to the Hungarian rules.)

*2. Tourists*

However, the Regulation covers not only workers who undertake employment in another Member State, but also tourists who, as EU citizens, qualify as insured in one of the Member States. Tourists are entitled to the health care services medically required to restore their health and to avoid lasting health damage in the light of the duration of their planned stay and their health status. They are entitled to these benefits under the same conditions as persons insured in the host Member State. The service may be claimed from the Member State's health insurer or one of the service providers holding a contract with the Member State's health insurer. The costs of the service shall be covered by the insurer where the person concerned is insured. For that, however, the person concerned should have a European Health Insurance Card testifying that his/her insurer undertakes in advance to provide cover for the incurred expenses. If the person concerned does not carry a European Health Insurance Card, then he/she must pay for the services on the spot, and may reclaim part of the costs following his return home.

Note that in this case the person concerned will not be reimbursed on all the costs, but only those that his/her insurer would have been obliged to pay if the European Health Insurance Card had been used upon claiming the services. (In the event of services taken without the European Health Insurance Card, the service provider shall ask the same price as is covered by the insurers for other persons insured locally; without the card, on the other hand, there is no equal treatment obligation and thus the provider will apply the corresponding "market price").

*3. Pensioners*

The Regulation requires that pensioners, too, be provided appropriate social security protection. That applies not only to migrant employees having reached pension age in the territory of a Member State different from their permanent residence, but also to those who have never left their home as employees, but would like to stay/settle down in a different Member State as pensioners. Pensioners living in the other Member State are, in the meaning of the Regulation, entitled to the full set of health benefits even if they have never been insured in the Member State of their stay. In that case, all the cost of the benefits are borne by the state that provides their pension. Of course, as with all benefits, it is necessary to claim these, too, by using the dedicated forms (E 120, E 121).

*4. Commuting workers and their family members:*

Workers and their family members commuting from one Member State to another represent a category of their own in the application of the Regulation. As a special entitlement, they may claim health care services in both Member States involved, even though – in lack of an agreement to the contrary – in the state where the insured performs his/her work, the family members are only entitled to such services to the extent deemed necessary medically. On the other hand, the commuter worker and his/her family members are entitled to health services "at home", that is, in the country of their residence, under the same conditions as if they were insured there. Of course, cash benefits will be disbursed to the insured in such cases by the insurer competent by his/her place of work. (The entitlement of commuters to health services shall be certified on form E 106.)

**Foreign citizens staying in Hungary temporarily, for a short period**

**Intergovernmental health care agreements**

Based on the principle of reciprocity and on various inter-state agreements, the parties to these agreements mutually grant various entitlements to their citizens for the period of their stay abroad.
Foreign citizens arriving from countries which are party to such agreement and not insured in Hungary are entitled to health care services (covered by their health insurance policies on the basis of different accounting methods) during their stay to the extent absolutely necessary, in case of acute illnesses or emergency. The benefits concerned cover primary (basic) medical service, outpatient care, and inpatient care (hospitalization).

**Foreigners undertaking work in Hungary**

As a general rule, foreign citizens arriving in Hungary to undertake employment count as insured from the date of the commencement of their employment by an employer qualifying as domestic resident Hungarian and paying the relevant contributions. On that basis, the employee concerned acquires entitlement to all services provided by the health insurance system.

**Close dependent relatives of the above persons**

Close relatives of foreigners insured in Hungary may become entitled to health services on the basis of an agreement concluded with the county health insurance fund.

**Foreign citizens studying in Hungary**

The following rules are indicative for the entitlement to health benefits of persons of Hungarian or foreign citizenship studying in Hungary:

Hungarian citizens who are full-time students in a higher education institution and foreign citizens who are students based on an international agreement or a grant awarded by the minister responsible for education are entitled to the in-kind benefits of the Hungarian social security system.

A foreign citizen who does not meet the above conditions (he/she has no grant provided under international agreement or awarded by the minister responsible for education) shall be entitled to health services in Hungary according to the following:

a) Entitlement to health services of EEA citizens with student legal relationship in a Hungarian higher education institution

   aa) Persons arriving from a Member State of the European Economic Area (EEA), if entitled to health services in their home country, may claim the services deemed necessary in the light of their planned period of stay, and their state of health if they show up their European Health Insurance Card issued by their respective competent insurers.

   ab) If an EEA citizen who is the student of a Hungarian tertiary education institution has no entitlement to health benefits in his/her home country, but has a residence permit in the EEA, then he/she will qualify as Hungarian resident from a social security point of view. Hungarian residents must pay a monthly contribution corresponding to 16% of the minimum wages following registration with the directorate of the Hungarian Tax and Financial Authority (APEH) competent by their place of residence. Through contribution payment, these persons acquire entitlement to health services, which they can claim by showing up the so-called TAJ [social security identification number] card issued upon request by the county health insurance fund geographically competent on the basis of their residence. The monthly contribution corresponds to 9% of the minimum wages after 1 April 2007.

b) Entitlement to sickness and health benefits of non-EEA (third country) citizens with student legal relationship in a Hungarian higher education institution

   ba) If Hungary has an effective bilateral social policy/social security agreement with the state of which the person is a citizen, he/she may claim sickness and health benefits in Hungary in accordance with the provisions of that agreement. At present, Hungary has an effective social policy agreement with the following countries: Angola, North Korea, Iraq, Jordan, Serbia, Montenegro, Macedonia, Cuba, Kuwait, Mongolia, and the Former Soviet Republics with the exception of Estonia, Latvia, Lithuania, and Uzbekistan. Given the fact that entitlement based on such agreements is acceptable as proof of the financial coverage of the health service, citizens of these states are entitled to claim emergency care in Hungary by showing up their passports. Presently, Hungary has an effective social security agreement based on clearance with Croatia, whereby Croatian insured persons may be provided emergency care in Hungary by using the HR/HU 111 form.

   bb) Citizens of countries not parties to an effective agreement with Hungary, possessing a residence permit in Hungary and having established a student legal relationship at a day-time course of a Hungarian tertiary educational institution, may conclude an agreement with the county health insurance fund geographically competent by their place of residence in order to acquire entitlement to health care benefits. Monthly contribution corresponds to 30% of the minimum wages ever. The beneficiary is entitled to emergency care in Hungary in the first six months following the conclusion of the agreement, but if he/she pays contribution due for the first six months in one sum upon concluding the agreement, he/she will acquire entitlement to the full range of social security benefits in kind from the date of concluding the agreement. Such agreement may be concluded by persons with a permanent residence permit who are citizens of a country party to a bilateral agreement with

Hungary, who wish to have more extensive insurance in Hungary than just emergency care.

bc) A third-country citizen with permanent residence permit in Hungary qualifies as domestic resident from a social security point of view, and hence the obligation to pay contribution corresponding to 16% of the minimum wages ever shall apply.

A Hungarian citizen studying in a foreign higher education institution operating in Hungary, but not subject to a student legal relationship and not insured under some other title, shall pay contribution as defined under the applicable legislation.

The same applies to an EEA citizen having an EEA residence permit and studying in a foreign tertiary education institution operating in Hungary, or to a third-country citizen holding a permanent residence permit, unless they have a certificate of entitlement based on the co-ordination regulation or defined by international agreement (European Health Insurance Card, form).

A third-country citizen with Hungarian residence permit, pursuing studies in a foreign tertiary education institution operating in Hungary, may conclude an agreement with the county health insurance fund competent by his/her place of residence; in this case, the monthly contribution amount corresponds to the minimum wages.

**Pensioners of foreign citizenship settling down in Hungary**

Pensioners of foreign citizenship settling down in Hungary, and having a permanent residence there, and provided pension debited to the social security agencies of the Republic of Macedonia (Skopje), the Republic of Croatia, Serbia or Montenegro, and their family members entitled to benefits are provided hospital care under the same terms as pensioners of Hungarian citizenship, provided that the foreign agency disbursing their pension benefits issues a certificate to that effect.

Given the large number of Yugoslav pensioners having moved to Hungary, persons receiving pension exclusively from a Yugoslav social security agency, and having a permanent place of residence in Hungary, shall be provided health care benefits according to the relevant Hungarian regulations, to the debit of the Hungarian insurer.

Hence entitlement to free benefits in Hungary may be established if the claimant has an identity card and his/her pension is transferred to Hungary in accordance with the agreement. As the Yugoslav pension insurer does not transfer pension abroad at the moment – in spite of the provisions of the agreement –, the Hungarian party is willing to overlook the fact that the pension is not transferred to Hungary as long as an authenticated translation is presented of the pension awarding statement testifying that the person concerned receives pension in Yugoslavia.

Pensioner foreign citizens having settled down in Hungary and not within the scope of mutual agreements concluded with any of the above-mentioned countries may claim health care benefits in Hungary at a charge or they may, of course, conclude an agreement to receive health insurance services.

**Title of foreigners to health services based on agreement**

Foreign citizens staying for a longer period in the territory of Hungary may, if Hungary has no valid social security agreement with their country and if they are not entitled to health benefits under another legal relationship, conclude an agreement with the health insurer to provide for themselves by undertaking to pay a pre-defined contribution amount. Hungarian citizens qualifying as aliens for the purposes of the social security system (including the people who cannot have a valid Hungarian ID) shall fulfil the same conditions.

A child living in the household of a foreigner concluding such an agreement may also be provided entitlement to the health care services.

Foreigners may initiate the conclusion of the agreement giving them entitlement to the services concerned at the county health insurance fund competent by their place of residence, and the foreigner is provided a form certifying entitlement to health services at the same place. Entitlement is certified at the place of payment or at the MEP (county health fund).

Contribution payable by foreigners based on agreement:

Foreign citizens of major age may acquire entitlement to health services by paying the minimum wages in effect on the day of the conclusion of the agreement, and a child younger than 18 years of age and foreigners studying at a day-time course of a Hungarian institution of education by paying an amount corresponding to 30% of the minimum wages.

Contribution due for the first month must be paid upon concluding the agreement, and later on it is payable monthly, in advance, no later than the 12$^{th}$ day of the month preceding the month of entitlement.

The agreement is valid from the first day of the month following the first payment (i.e. the conclusion of the agreement), but in the first six months, it provides title to limited services only.

The beneficiary of the agreement becomes entitled to health services supported by social security as of the first day of the sixth month following the conclusion of the agreement, with the proviso that he/she shall be entitled to emergency care only from the first day of the month following the conclusion of the agreement until the sixth month.

It is likewise possible to pay the contribution due for six months in one sum in retrospect upon concluding the contract, in which case all the health services provided with social security funding shall be available to the insured from the first day following the month in which the agreement was concluded.

It is possible to conclude an agreement whereby the contribution is paid by another person or organization to the benefit of the person as specified in the agreement (the beneficiary).

Persons entitled to health care based on contribution payment undertaken by agreement shall not acquire entitlement for another 45 days, i.e. entitlement on so-called passive right, after the termination of the contribution payment.
Persons who fail to meet their obligation by the specified payment deadline shall lose their entitlement from the following month and that is also the end of the agreement. The form

certifying entitlement shall be submitted to the MEP within 3 days of the termination of the entitlement.

**The scope of agreement-based health care benefits**

The scope of health care benefits based on agreement is narrower than that of health insurance benefits based on other legal relationship.

A person entitled to health care benefits by agreement shall be entitled to emergency dental care only from among the dental care services provided with social security funding.

Furthermore, he shall not be entitled to reimbursement up to the extent of the corresponding domestic expenses of service expenses incurred to avert a grave hazard to his life/physical integrity in a non-EU third country or of care claimed in an EEA Member State under a form that does not conform to the community legislation.

A person entitled to agreement-based health benefits may not be provided therapy which is not available in Hungary abroad to the debit of his/her Hungarian health insurance.

**Health services provided to refugees**

Refugees enjoy the same rights and are under the same obligations as Hungarian citizens; thus they can prove their entitlement to health services by showing a TAJ card issued by the health insurance fund, and they are under the same health insurance contribution obligations as of Hungarian citizens.

## Persons excluded from insurance

Insurance does not extend to a diplomatic representative of another country, a mission member of foreign citizenship, a representative (staff member) of an international organization enjoying diplomatic immunity; an employee of an international organization enjoying diplomatic immunity; and employees of foreign citizenship of the above staying in Hungary or their spouse and children of foreign citizenship staying in Hungary and living with them.

The insurance similarly does not extend to persons employed in Hungary by a foreign employer and qualifying as foreigners. The insurance does not cover foreign persons employed in the Republic of Hungary by an employer not registered in accordance with Hungarian legislation if such person is under the effect of Regulation on 1408/71/EEC on the application of social security schemes to employed persons, self-employed persons and members of their families moving within the Community, or perform work in Hungary in the framework of posting, secondment or labour-hiring arrangements.

# 2. The structure of the health care system

The Hungarian Constitution in effect now establishes that the Republic of Hungary recognizes and promotes the right of every citizen to a healthy environment. There are laws to define the state system of health services, and the financial coverage of such services. Those living in the territory of the Republic of Hungary are entitled to the highest possible level of physical and spiritual health. The Republic of Hungary implements that right by providing for occupational safety, health care institutions as well as medical treatment, possibilities of regular physical exercise, and the protection of the constructed and the natural environment.

The Republic of Hungary implements the right to health services through the system of social security and through the social institutions. The legislative basis of what is called "social safety" is provided primarily by acts passed by Parliament. Specific regulations are often outstandingly complex.

**Forms of care**

**Preventive care**

Its purpose is to improve the ability of the population to withstand contagious diseases; to carry out screening checks; to ensure the early recognition of health damage due to unfavourable living and working conditions; physical aptitude testing; examinations to recognize complications as early as possible; action to discontinue recognized irregularities, chronic deviations and, furthermore, to prevent contagious diseases; to implement prevention based on identified individual risk factors; to monitor the healthy development of the foetus, and to protect the health of expectant mothers.

The purpose of **primary care** is to provide patients with continuous health care, regardless of their sex, age, nature of health problems, free of charge, on a continuous basis, at or near their place of residence, at their choice. The 2./2000. Act on Private Medical Praxis has further strengthened the market based operation of the family doctors' system. The family doctor service is based on the free choice of one's doctor.

**Specialist outpatient treatment**

Specialist outpatient care is generally available, free of charge, and it means one-off or *ad hoc* specialist care provided on the basis of referral by the doctor performing the patient's regular care and treatment, or the registration of the patient him/herself, and continuous specialist care in the event of a chronic disease not requiring inpatient care. General specialist outpatient care shall be provided close to the patient's lace of residence. Dermatologic, ear-nose-throat, gynaecological, surgery, ophthalmologic oncology, urological, psychiatric care, and the services of so-called *health centres* (e.g. health centre for nerve treatment, health centre for lung patients) are accessible without a referral.

### Inpatient care

General inpatient care provided free of charge in therapeutic institutions means health care services provided near to the patient's place of living, in a hospitalized/inpatient environment. It is accessible through referral by the GP continuously supervising the patient, or by the specialist treating the patient or by any other duly empowered person in accordance with the provisions of a separate legal regulation, or upon the patient's own request. Inpatient care may be aimed at diagnosis, treatment, rehabilitation or nursing requiring continuous hospital presence, including treatment requiring long periods of nursing, or treatment administered at a given time of the day, or one-off or regular therapeutic interventions requiring observation for a certain follow-up period potentially necessitating immediate health services during the observation period. Special inpatient service must be operated to ensure the treatment of a patient population reaching a certain size, as specified by separate legal regulation and determined on the basis of the occurrence frequency of diseases requiring special diagnostic and therapeutic background or the solution of professionally complex tasks.

### Other health services

Other health services include duty, ambulance service, patient transport, disaster-related medical care, donor blood management, nursing, nursing in the terminal phase, rehabilitation, supply of instruments of medical technology, supply of pharmaceuticals, psychotherapy and clinical specialised psychology, non-traditional therapy, other therapy, and expert consultancy as part of the health service.

### Duty

The duty system ensures the possibility of access to continuous medical attention in emergency cases occurring outside of the regular daily working hours. In emergencies, patients may call on any doctor, at any time, in addition to being provided assistance by the ambulance service, the hospital duty services and the family doctors on duty.

### The ambulance service

The ambulance service provides emergency care to patients requiring immediate medical attention by an organization empowered to provide such and to transport the patient to a health institution if necessary to ensure continued treatment, including treatment during transportation. Such ambulance services are provided by the National Ambulance Service (OMSZ) covering the whole country and other organizations authorized to do the same under the co-ordination of the OMSZ.

### Patient transportation

The objective of patient transportation is to ensure access to medical care as ordered by the doctor in cases where medical attention is not accessible otherwise.

### Disaster-related medical care

The service ensures the conditions required to eliminate danger in a disaster, and takes charge of the general management of all activities aimed at resolving the situation.

### Donor blood management

Donor blood management is a health care and social activity designed to ensure the availability for treatment purposes of blood and blood preparations and the therapeutic use of blood preparations.

### Nursing

Nursing is a collective term covering all caring and nursing efforts to improve the patient's health status, to safeguard and restore health, to stabilize the patient's condition, to prevent diseases, to mitigate suffering in a manner allowing to respect the human dignity of the patient and to prepare for/involve in the nursing tasks his/her environment.

### Nursing in the terminal phase (hospice service)

The objective of nursing terminally ill patients (hospice care) is to provide physical and spiritual nursing care for patients suffering from a fatal disease; to improve their quality of life; relieve their pains, and keep up their dignity until their decease. Hospice services must be provided as far as possible in the patient's home, among his/her family.

### Rehabilitation

Rehabilitation is organized assistance provided by society to persons with temporary or permanent health damage or disability, physical or mental disturbance, so that they can be re-integrated in the community by mobilizing their remaining capacities and abilities.

### Supply of instruments of medical technology

Instruments of medical technology – including medical aids – may be commercially distributed and used if they satisfy the quality requirements laid down by special legislation, and if the institution for this purpose has conducted the required compliance checks, and the body appointed for this purpose by special legal regulation has registered them and marked them with a certificate of compliance.

### Supply of pharmaceuticals

Supply of pharmaceuticals is part of the health care system; it is meant to ensure the availability of safe and cost-effective medication of appropriate quality listed in the official pharmaceuticals register for curative and preventive activities, as laid down in specific legislation.

### Psychotherapy and clinical psychology

Psychotherapy is a therapeutic process rooted in a variety of methods, having firm scientific fundaments, applied in case of psychic and psychosomatic disturbances individually or in groups, in several sessions of a fixed duration, by a medically or psychologically qualified leader, having relevant specialist qualification.

### Non-traditional therapy

Non-traditional therapy and alternative medicine are based on a different approach to health and illness. These methods may only be administered as substitutes under medical supervision.

### Other therapies

Other medical methods include ancillary medical services as part of the therapy on the basis of the doctor's instructions, but such therapies may also be administered without medical referral.

### Expert consultancy provided in the framework of health services

Specialist health consultancy provided as part of therapeutic and preventive services and those related to requesting social security benefits are part of the health services. These include in particular the assessment of and reporting on medical aptitude for work or for a vocation, on the capacity of earning, the extent of disability, the extent and quality of the remaining working capabilities, and conditions of further employability.

### Organisation and management of the health system

The state is responsible for the state of health of the population, especially through the establishment of the set of necessary conditions to promote health. Responsibility for organizing and managing the health system, and for exercising the related rights and fulfilling all related obligations lies with Parliament, the Government, the Minister of Health, the Office of the National Health Officer, the local governments, the health insurance agencies, and the operators of the health institution.

### The duties of Parliament

Performing its functions concerning health, Parliament takes account of and represents the interests of the population to maintain their health, and promotes the health policy objectives associated with it. It passes legislation controlling the health system, the provision systems, and their operation, and the National Health Development programme. It evaluates the progress of the programme, and the general health status of the population.

### The National Health Development Programme

The National Health Development Programme forms the basis of health planning. All the items in the programme must be implemented in the course of making and carrying out various economic, regional and urban development policies and any other decisions by the state. The programme is reviewed at least once every four years.

### The functions of the Government

The Government provides for the preparation of the Programme and its presentation to Parliament through the Minister of Health. It also determines the main principles, objectives, and major directions of its policies supporting health care and more specifically health policy;

and harmonises the implementation of the health-related tasks of the administration, ensures that commitments undertaken in various international agreements/contracts regarding the health service should be delivered, and exercises statutory supervision over the activities/operation of health insurance organizations.

**The National Health Council**

The National Health Council assists the Government to carry out its functions related to the organisation and management of the health care system. Furthermore, the Council acts as initiator, reporting organ and advisor in matters related to the development of the health policy of the Government and the related decision-making, and it controls, analyses, and evaluates the implementation of the decisions concerned.

**The tasks of the Minister of Health**

The Minister of Health manages the health sector in line with the effective legislation and the health policy decisions of the Government. His authority extends to all activities related to the health service, and to all health service providers. His activity is assisted by the Medical Research Council, by professional colleges/workshops, and national institutions.

**The functions of the State Public Health Service (ÁNTSZ)**

The State Public Health Service and its local bodies are responsible for various public duties as well as public duties and jurisdictions defined by the health administration and co-ordination authorities.

**The municipalities**

The municipalities provide for the family physician and family paediatrician services, for primary dental care, duty service related to primary care, the health visitor service and school health care in the framework of the primary health services. The board of representatives of the municipality identify and develop primary health care districts and district centres. The municipality provides for the operation of the institutions (in its ownership or use) of specialist outpatient and inpatient care, respectively.

**The tasks of the health insurers**

Health insurers arrange for the timely contractual reservation of capacities needed by health institutions to deliver health services, and ensure the financing of delivered and checked services.

**Health institution operators**

The authority of the health institution operator includes the following: founder's rights; establishment, reorganization or termination; rights related to the budget of the institution; employer rights vis-a-vis the management of the institution; approval of the code of operation and organisation, and of the rules of procedure; on-going supervision and control of the operation of the institution.

# 3. Regulating health insurance services

Health insurance services provided in the framework of social security split into two major categories:

- health care benefits in kind, including among others primary, specialist outpatient care, hospital-based inpatient care, and accident-related health services,
- cash benefits including among other things sick pay, pregnancy-confinement benefit, accident-related sick-pay, and accident related benefit.

**Health-insurance-based in-kind health services**

**1) Medical services in general, and changes in 2007: visit fee, hospital day fee, verifying entitlement, and institutional waiting lists**

In Hungary, as in most countries in Europe, **three service packages have been devised:** the basic package (services to be provided to everyone, regardless of legal title), the insurance package (services conditional upon a legal relation of insurance) and whatever is beyond these: the range of services not available with social security funding (services rendered for a charge or extra package).

Health services of identical professional quality are due to every person entitled to them, to the extent justified by the health status of the person concerned, taking account of the procedures of examination, therapy, and financing.

Entitlement to medical services supported by the health insurance system shall be certified by the TAJ card (or, in the case of persons insured abroad, the entitlement certificate specified by international agreement or community regulation), and a document proving the personal identity of the claimant.

**The visit fee**

A so-called visit fee is payable each time prior to the commencement of treatment if a person entitled to health services as insured or under some other title wishes to use any of the following services:

- family physician service
- dental care
- specialist outpatient care
- medical rehabilitation provided in the framework of specialist outpatient care.

The visit fee is HUF300 per occasion as a general rule, with the proviso that visit means a therapeutic or diagnostic meeting between the doctor and the patient or a diagnostic service administered by a medical assistant.

In certain cases specified by legal regulation, a visit fee of an increased amount (HUF600 or HUF1000) is payable.

**Hospital day fee**

A patient referred to active and chronic inpatient care or rehabilitation inpatient care (e.g. sanatorium) by the GP shall pay a hospital day fee of HUF300 per (calendar) day commenced in treatment.

No further hospital day fee is payable if the patient has already paid for 20 days in the given calendar year.

**Services available without visit fee or hospital day fee**

Payment reliefs are granted on the basis of disease type, treatment type or personal exemption. The visit fee and hospital day fee is payable exclusively for services provided with social security support, that is, no visit/hospital day fee is payable to private doctors and, naturally, for services provided without support or support originating from some other source than the Health Insurance Fund.

The relief is applicable – except for those younger than 18 – to the basic, not the increased, visit fee.

**Treatment available without visit fee**

Neither the basic visit fee, not the hospital day fee is payable for treatment required in the context of so-called *permanent* medical treatment.
The relevant services, available without a referral, due on the basis of being in permanent medical treatment, may be claimed without paying the visit fee, only by showing up the document certifying the "permanent" disease.

**Payment of the visit fee and the hospital day fee**

The health service provider may determine the manner of payment of the fees concerned in its own regulations. Health institutions must provide for on-site payment in cash; however, there is a statutory possibility for electronic payment or by some other so-called cash substitutes. The fees concerned may be paid also through a so-called visit pass, a health fund card, or bank card (or other cash substitutes).

**Visit fee paid in excess of 20 occasions is re-claimable from the notary**

As the visit fee is payable on each occasion, fees paid for the 21$^{st}$ and subsequent visits under the same title, by the same patient, in the same calendar year are to be refunded.

The visit fee may be re-claimed from the notary if the same patient has paid the basic (not the increased) visit fee (HUF300) 20-20 times in the areas of family doctor's primary care (including primary dental care), and of specialist outpatient services (including specialist dental care), respectively.
Appeals against the notary's decision regarding the visit fee shall be decided upon by Health Insurance Supervisory Board.

**Checking the legal relationship giving rise to entitlement**

The long-term objective of the preliminary control of legal relationships giving rise to entitlement is to ensure that social security benefits in kind be available exclusively to persons with entitlement.

Control means that each time a patient request a health services, the details of his/her legal relationship registered in the OEP (National Health Fund) database are checked to see whether the patient is registered in the OEP files.

Lack of registration with OEP does not affect the treatment: the patient must be treated irrespective of the outcome of the check, if all other conditions prevail, without a charge, and neither can treatment be refused on with reference to the OEP data.

**Institutional waiting lists**

The health institution may provide certain services on the basis of a waiting list, if the nature of the service is such or there is permanent shortage of capacities, unless the patient's condition warrants prompt treatment. The resulting institutional waiting list constitutes the schedule determining the order patient treatment in the institution, which – except for the services available through a central waiting list – is drawn up to provide health services in a specified order.

The treatments available on the basis of the waiting list (high-cost treatments, and various transplants e.g. heart transplant, liver transplant, lung transplant, kidney transplant, combined kidney, pancreas, and bone marrow transplant) and the related orders of procedures are defined by Government decree.

The order in the waiting list may not be overridden by paying a charge or on the basis of equity. If a patient's condition deteriorates, a new series of examinations may be undertaken, whose outcome may modify the positions in the waiting list.

A central and an institutional waiting list may be distinguished.

The central waiting list refers to high-cost treatments, transplants of organs or of a stem cell to generate blood cells (transplant waiting list), and it is kept by the Centre of the National Donor Blood Management Service (OVSZK). The following may be entered in the transplant waiting list: insured persons, persons entitled exclusively to health services, and foreigners possessing the preliminary consent of their insurers to the treatment.

The institutional waiting list is displayed on the website of the health care provider, and the central waiting list on that of the Centre of the National Donor Blood Management Service (OVSZK), and both are accessible from the site of the Health Insurance Supervisory Board as well.

The (anonymous) waiting list data are public property.

After having described the main changes in terms of access to medical care triggered by the health care reform, let us review the current health services in accordance with **effective** legislation:

| SYSTEM OF SOCIAL SECURITY BENEFITS | | | | |
|---|---|---|---|---|
| HEALTH INSURANCE SERVICES | | | PENSION BENEFITS | |
| **Health services** | **Benefits in cash** | **Accident-related benefits** | **Social security pension benefits on own right** | **Dependent's pension benefits** |
| | - pregnancy and confinement benefit<br>- child home care fee<br>- sick-pay | - accident-related health care services<br>- accident-related sick-pay<br>- accident-related benefits | - old age pension<br>- disability pension<br>- old age-disability pension | - widow(er)'s pension<br>- orphan's pension<br>- parent's benefits<br>- accident-related dependent's benefits |

| | | | | |
|---|---|---|---|---|
| *Health care services available free of charge, upon payment of the visit fee and the hospital day fee* | *Services available with price subsidy* | *Services available with partial contribution by the insured* | *Health care services based on the principle of equity* | *Medical treatment abroad* |

| *Health services aimed at the prevention and early recognition of diseases* | *Services for the purpose of treatment* | *Other medical services* |
|---|---|---|
| | - treatment by the family doctor<br>- dental care<br>- outpatient specialist care<br>- inpatient hospital care | - obstetrics care<br>- medical rehabilitation<br>- patient transportation |

**2) Services available without previous demonstration of the insurance legal relationship (basic package)**

The following services are available to persons residing in Hungary preliminary demonstration of the legal relationship giving rise to entitlement (e.g. insurance), as part of the basic package:

- **some services related to epidemiology**
- **ambulance service** to persons requiring immediate medical attention
- **emergency services** as listed in specific legislation

**Emergency**

Emergency situations are changes in the health status of a patient threatening the life of the patient or implying a risk of grave or irreversible health damage unless treatment is given without delay.

**Duty service (emergency medical service)**

The duty service system ensures continuous access to primary service, outpatient service, and inpatient service in emergency cases occurring outside working hours. The purpose of the emergency medical service is to have the patient examined, to provide ad hoc normal and

emergency treatment or to refer the patient to an inpatient institution on an emergency basis, etc. in between working hours at health care institutions.

**3) Medical services provided by the Health Insurance Fund (with price subsidy)**

**3.1. Family physician services**

In order to ensure the patient continuous access to health services, at his choice, at or his place of residence, regardless of sex, age, or the nature of the disease, a health service, i.e. a family physician service and a family paediatrician service (hereinafter: family physician service) is available as part of the primary services.

The establishment of the conditions of the family physician service, the identification of each GP's territorial competence (street list), and the hours of service are the duty of the municipality.

**3.2 Specialist outpatient service**

Specialist outpatient services provide therapeutic and preventive treatment to patients not confined to bed. This specialist outpatient service operating with a special diagnostic and therapeutic background is provided on the basis of the calculated frequency of individual diseases/illnesses for a given size of population and given areas (generally cities).

**Entitlement to outpatient treatment**

Outpatient service is usually based on referral by the competent GP: Persons provided treatment at another outpatient institution than the one to which they are referred must pay a visit fee of HUF600.

**3.3. Specialist inpatient service:**

Specialist inpatient service is provided to patients confined to bed, not treatable on an outpatient basis. The forms of specialist services differ by inpatient institution and by regional units. The various forms of specialist inpatient service are provided by hospitals, clinics, national institutions, sanatoria, and other institutions. Their services are provided on the basis of the calculated frequency of individual diseases/illnesses for a given size of population and given areas (generally cities).

Notwithstanding the rules of referral, inpatient service is available with social security support exclusively upon the payment of the HUF300 **hospital day fee**. The provider may provide certain medical services at a **charge** established at his discretion, but he must notify the insured fact of that circumstance prior to the inception of the treatment.

The patient must – except for emergency situations – pay a partial charge when claiming special inpatient services without referral, or not in accordance with the standard rules of referral, or not at the health service provider indicated on the referral document.
The following partial charges are payable in the event of claiming inpatient treatment by a non-standard procedure:

- the partial charge for claiming inpatient hospital treatment not in accordance with the standard rules of referral corresponds to 30% of the sum claimable from the health insurer

for the specific treatment, provided that the sum to be paid by the patient does not exceed HUF100 000.

- The charge payable for treatment without referral corresponds to 30% of the sum claimable from the OEP for the given treatment, not exceeding HUF100.000.

**Free choice of doctors within the health institution:**

The patient may choose another doctor instead of the one originally assigned to him on the basis of the working schedule of the health care institution at a partial charge, unless this is excluded by the professional content or urgency of the treatment justified by the patient's state of health. In return for the partial charge, the patient may also choose a doctor who is not employed (under public service employment relationship) by the given health provider.

**Completion of the treatment, patient information and discharge**

Institutions providing inpatient treatment must, upon discharging the patient, provide information concerning the financial details of the service in a so-called financial statement.

If the patient does not agree with the content of the statement, this opinion must be put in writing and be signed by the patient, and the document must be filed in the patient's documentation.

If the patient dies, the financial statement must be issued to a close relative upon the latter's request.

Following completion of the service, the referring doctor must be notified of the findings of the final examination and if the referring doctor is not the family doctor, and the patient requires permanent care due to his/her health status, then the family doctor must be notified as well.

**4) Services available at a partial charge:**

In the context of use of services enjoying social security support, the patient shall pay a partial charge on certain services listed by legal regulation (e.g. choice of doctor, treatment for the purpose of nursing, sanatorium services, etc.).

The said shall be posted at easily noticeable points in the health institution, along with the respective charges.
Prior to the inception of a service/treatment provided in return for a partial charge, the patient shall be informed of the fee payable on the given service.

**5) Health services available on the basis of the principle of equity**

Following consideration given to the patient's earning conditions, and various medical reasons, the National Health Insurance Fund may assume, out of equitableness, the entire fee of the medical treatment payable by the patient or part of it, to the debit of the Health Insurance Fund. Otherwise, the patient would only have access to the service upon the payment of the partial charge.

**Service based on the principle of equity, available with support**

Most requests for support to/assumption of the charges payable on health services provided on the basis of the principle of equity concern various implants, laser treatments, and prosthetic dentistry.

Support based on the principle of equity is only available for interventions funded from the Health Insurance Fund, i.e. interventions by a health care provider contracted by the county health insurance fund. Consequently, no support may be requested from the HI Fund for the payment of charges of private doctors or a private hospital.

No support based on the principle of equity shall be available for a service available by referral used without referral; for reducing the charge of a service accessed through a non-standard procedure; or of the free choice of one's doctor; or to cover extra costs due to a deviation from the financing, examination and therapeutic protocol upon the request of the patient, or to higher-quality accommodation or the satisfaction of special catering needs, or for services available on the basis of a waiting list (services scheduled in accordance with professional considerations).

Neither can the charges of services due to the patient free of charge – upon the payment of visit/hospital day fees – at the financed health care provider be assumed.

**6) Services not refundable by the Health Insurance Fund:**

The rules of calculating the charges of some health services not available in the framework of the compulsory health insurance system, and of some health services available at a charge are regulated by Government Decree No. 284/1997. (XII. 23.) Korm.

The costs of treatment required in conjunction with some *extreme* sports, considered particularly dangerous from the point of view of health care funding (e.g. water skiing, jet-skiing, white-water rafting, cave-climbing/caving, heat-ballooning, hand/paragliding, etc.), are covered by social security, but by the sportspeople themselves, reasonably on the basis of some special individual insurance policy.

**7) Curative treatment abroad requiring permission**

To participate in curative treatment abroad requiring permission, the recommendation of the professionally competent national institute is to be acquired by the patient or the consultant physician. Whether the treatment abroad is justifiable is decided upon by the professional board of a medical institution of national status. A condition of the favourable decision is that there should be proven record of successful application of the treatment, and the treatment should not be feasible domestically even by inviting foreign experts to Hungary. The professional board recommends a particular medical institution, inquires about their readiness to receive the patient, the possible date of commencing the intervention, its expected duration and costs. The person initiating treatment abroad presents to his/her health insurance fund the recommendation of the professional board, the welcome statement of the foreign medical institution, and a cost estimate. The National Health Insurance Fund considers the circumstances and decides on the amount of funding to be provided for the given purpose.

## Health-insurance-based cash benefits

### Reimbursement of travel costs

Travel cost reimbursement is payable to title-holders having recourse to specialist outpatient or specialist inpatient care or travelling to order or try on a medical aid, unless this is feasible through local transport, and provided that they visit the territorially competent medical institution or the one that is nearest to their place of living. The beneficiary may use the voucher issued by the doctor to travel on the lines of the railway and bus companies.

### Sick-pay

The insured having a legal relation of employment, public servant, or civil servant is, when sick, entitled to sick-pay on the date following the expiration of entitlement to sick leave at the earliest. Sick-pay is payable to the insured if he/she falls sick during the period of the insurance, or within three days of the termination thereof, and (was) obliged to pay 4% of health insurance contribution. Sick-pay is paid for up to one year, provided that the insured had a legal relation of insurance for at least one year prior to sickness. If not, the sick-pay is payable for a period equal to the time for which the insurance was continuously valid. In the event of entitlement following the termination of the insurance, the sick-pay must be paid for 90 days instead of the earlier 180. Usually, the earnings in the calendar year immediately preceding the period of incapacity to work – on the basis of which the insured had to pay his/her health insurance contribution – must be taken into account for calculating the daily sum of the sick-pay. The sum of the sick-pay corresponds to 60% of the average daily earnings per calendar day as determined and, if there were two years in continuous insurance, then 70%. The period of insurance is regarded as being continuous if it is not broken for a period longer than thirty days. 60% of the average earnings is payable for the period of inpatient care in a medical institution.

Sick-pay is payable from the first day of the incapacity to work if the worker cannot perform her work due to pregnancy or childbirth, and is not entitled to confinement benefit, or if she cannot appear at her workplace on account of an epidemiology or veterinary hygiene quarantine, and it is not possible to offer temporary alternative employment at another workplace or in a different position. In such a case the sick-pay is paid in full by the health insurance company. Private entrepreneurs and members of partnerships, family helpers, and pupils in vocational schools not entitled to sick-leave are entitled to sick-pay also from the first day of their incapacity to work.

### Accident-related sick-pay

Those incapacitated to work due to industrial accident or occupational illness are entitled to accident-related sick-pay. Persons unable to work due to the deterioration of their health related to industrial accident and requiring curative treatment or due to the lack of a medical aid shall also be regarded as incapacitated to work. Accident-related sick-pay is payable to the insured for the period of incapacity to work, not exceeding one year, regardless of the previous uninterrupted insurance period. The National Institute of Medical Consultants may extend the disbursement of the accident-related sick-pay by one year. The daily sum of the accident-related sick-pay equals the sum of the average earnings per calendar day taken into consideration as the base for calculating the sick-pay. The accident-related health service allows to grant 100% subsidy to the prices of pharmaceuticals or medical aids becoming necessary on account of the industrial accident (occupational illness), but full-scale subsidy is

conditional on that the medicine concerned be subject to OEP subsidy anyway. The industrial nature of the accident, and the manifestation of the occupational illness shall be stated by an organization entitled to award accident-related sick pay.

**Child-nursing sick-pay**

The parent is entitled to child-nursing sick-pay under the title of nursing a child:

- until the child is one year old, in the case of a child older than 1, but younger than 3 years of age, for 84 calendar days per year and per child payable to either parent,
- if the child is older than 3, but younger than 6 years of age, for 42 calendar days per year and per child, payable to either parent, and for 84 days to a single parent,
- if the child is older than 6, but younger than 12 years of age, for 14 calendar days per year and per child payable to either parent, and for 28 days to a single parent.

The days taken into account for child-nursing sick-pay refer not to calendar years, but to the period between the two birthdays of the child, and the days not used cannot be carried over to the following period.

**Child-care fee**

Parents looking after a child who is younger than two years of age are entitled to child-care fee (GYED). A condition to the GYED is that the claimant should have a legal relationship of insurance on the first day of entitlement, and the mother should have had a period of insurance of at least 180 days in the two years prior to the birth. The mother is entitled to the GYED even if her insurance of at least 180 days terminated during the disbursement of her pregnancy and confinement benefits. If, instead of the father or the parents, another entitled person wishes to be the GYED recipient (e.g. the person adopting the child, or the legal guardian), then that person must have an insurance period of 180 days over the two years preceding the first day of entitlement. The child-care fee must be claimed in writing from the employer. The child-care fee corresponds to 70% of the average daily earnings per calendar day, but its monthly sum is subject to a ceiling value changing year on year. The GYED amount must be calculated on the basis of earnings applicable to sick-pay.

**Pregnancy–confinement benefits**

Eligibility for pregnancy and confinement benefits is conditional on giving birth during or within 42 days of the termination of the insurance period, and on being insured for at least 180 days during the two years prior to the birth. Pregnancy–confinement benefit is likewise due to recipients of sick-pay, accident-related sick-pay who give birth during the benefit disbursement period or within 28 days of its termination, and have a total of 180 days of insurance in the preceding two years. Pregnancy–confinement benefit is payable for the period corresponding to the maternity leave, i.e. for 168 days according to the Labour Code. The pregnancy-confinement benefit corresponds to 70% of the daily average earnings.

## Health care benefits in cash, not based on health insurance

### Sick leave

For the period of sick leave, the employee is entitled to 80% of the monthly wage specified in his work contract, less the various supplements. This sum is payable by the employer, who must, in addition to that, also pay social security contribution and the health contribution on the sum due for the period of sick leave. The consultant physician must certify incapacity for work for the total duration of the sick leave. The sick leave must not exceed 15 working days per year. The employer does not have to pay sick-leave if the insured becomes incapacitated to work on account of nursing his/her child, or an industrial accident or an occupational disease.

### Maternity leave

The Labour Code allows 24 weeks (168 calendar days) of maternity leave.
The expectant mother (young mother) may choose between taking the maternity leave within 28 days prior to the expected date of the birth or from the day of the birth. Maternity leave ends if the child is stillborn, or placed under state care, but pregnancy–confinement benefit is payable even in that case for 42 days.

### Maternity support

Maternity support is payable to women who attend pregnancy consulting at least four times during their pregnancy, or at least once in the case of premature birth. The sum of the maternity support per child corresponds to 225% of the minimum old age pension valid on the date on which the child was born. For twins, 300% of the minimum old-age pension is payable. Adoptive parents are entitled to maternity support if adoption is legally effectively permitted within 60 days following the birth, and the same is true for the legal guardian if the child is legally effectively placed under his/her care within 60 days following the birth. Maternity support may be claimed within 180 days of the birth.

### Nursing fee

The nursing fee is a financial contribution to help a close relative nursing a person in need of long-term care in his/her home. Nursing fee is payable to the close relative nursing a seriously disabled child older than 2 years of age, and incapable of looking after himself/herself, and requiring permanent and full supervision, or providing care and nursing to a person under 18. If the conditions specified by municipal decree apply, the nursing fee is payable to a close relative nursing a permanently ill person having completed his/her 18$^{th}$ year of age. The sum of the nursing fee may not be less than 60% of the minimum old-age pension ever. The period of disbursement of the nursing fee is taken into account as service period.

### Burial support

The board of representatives of the municipality may grant burial support to a person having taken charge of the burial of a deceased person without having been obliged to do so, or if such person was a relative obliged to do so, but the burial costs would jeopardize the subsistence of the persons concerned or his/her family.

### Family benefits available on citizen's rights, which are not health insurance benefits

Family benefits are payable to persons of Hungarian citizenship living in Hungary, raising a child in their household and, since our EU accession, an EEA citizen with a residence permit or a foreign citizen recognized as refugee and having an immigration permit. Main benefit types:

### Family allowance

Family allowance is payable to the biological or adoptive parent, or to a spouse living together with the parent, a foster parent or a legal guardian if they raise a child under 16 or a chronically ill or seriously disabled child (person) in their household. The family allowance is payable for a child pursuing studies in a public education institution until the child completes his/her 23rd year of age and/or until the end of the relevant school-year. For children placed in a children's home or institution, the family allowance is payable to the head of the institution.

### Child-care aid (child home care allowance)

Child care support (GYES) is payable to the parent (foster parent) who looks after a child younger than 3 years of age or, if the child is permanently ill, younger than 10 in his/her household. The parent receiving child care support may not pursue a gainful activity until the child reaches one year of age. Afterwards, the parent may undertake employment up to 4 hours a day, with no such time limit if that activity is done at home. Under certain conditions, the grandparent may also be entitled to GYES, from the date of the child's first birthday. The amount of the GYES equals the minimum old-age pension, and it is double that sum for twins.

### Child-raising benefit

Child-raising benefit (GYET) is due to parents raising three *or* more minor-aged children in their household. The benefit is payable from the date when the youngest child reaches 3 years of age until he/she is 8 years old. The sum of the child raising benefit equals the minimum old-age pension ever.

# 4. Patients' rights

## Rights and obligations of service recipients

One of the most significant developments of health legislation is the codification of rather detailed provisions concerning patients' rights. This summary and specification of patients' rights is most useful in the operation of law, and it is useful for the patients and the medical staff alike.

The law imposes the obligation, applicable to everyone, to help others in the reasonably expectable manner and, furthermore, everyone must notify the health service in the event of an emergency.

Everyone has the right to gain knowledge in the area of health preservation and development.

## Patients' rights

### 4.1. The right to health care services

The right to receive health care services means the following: entitlement in the event of an emergent need to

- life saving,
- prevention of serious and irreversible health damage,
- alleviation of pain,
- alleviation of suffering.

Patients have the right to choose their service provider, i.e. the institution and, within that, their doctor. Patients must be directed to the service provider where they are likely to be served within the shortest period of time.

The *waiting list* is a new institution of the Hungarian health care system. Patients will be placed on a waiting list in either of two cases:

- if no other provider could provide treatment/service; or
- the patient refuses to accept another provider.

In such cases, patient information shall cover the cause, period, and possible consequences of waiting.

### 4.2. The right to human dignity

The Health Act rules that the human dignity of the patient shall be respected. In the meaning of the Act, the protection of human dignity includes the prohibition of performing any unnecessary intervention on the patient other than what is required for the treatment. (Only the law may specify exceptions to that rule.)

In the same section, the Act stipulates also that patients' rights may also be limited for a period and to the extent necessitated by the patient's state of health and specified under the law.

The personal freedom of the patient may be restricted by physical, chemical, biological, *or* psychiatric methods or procedures during medical treatment in two cases only:

- in an emergency,
- if so required by the protection of the life or physical integrity of the patient or others.

Such restrictions shall not be of a punitive nature, and may last only as long as the reason for such restrictions prevails.

### 4.3. The right of contact-keeping during health care treatment

Contact may be maintained through verbal or written communication or by receiving visitors. The patient may ban anyone from visiting him/her or getting in touch with him/her, and from information provision on his/her being in treatment or on the nature of the treatment itself.

Patients have the right to have their close relatives next to them, on a continuous basis, if possible. That title applies to three groups of patients:

- adults in a serious condition,
- minors,
- women about to give birth.

It is the right of minors, i.e. patients under 18, to have one of their parents, a legal representative, a person appointed by the legal representative or a person appointed by the patient stay close to them during their time in hospital, regardless of their state.

Under the law, clergymen may visit the patient upon his/her request and it is possible to have religious services in the hospital.

### 4.4. The right to leave the health institution

The patient may leave the institution under the following conditions (similar to those stipulated for restricting the freedom of movement for health reasons) stipulated by the law:
- the patient may not jeopardize the health or physical integrity of another person,
- exercising this right does not conflict with any other legislative provision,
- in the case of an incapacitated patient, the legal representative agrees with the patient's departure.

The patient and the close relation must be informed of discharge from the institution, possibly 24 hours prior to the discharge.

### 4.5. The right to information

The patient is entitled to information even if the treatment requires no preliminary statement of consent. Information must be personalized, comprehensive, and detailed. The right to information of minors having completed their 16$^{th}$ year of age must be observed.

The patient has the right to know the name, qualification, and position of persons directly involved in his/her treatment.

The information must be understandable in the light of the patient's age, schooling, general knowledge, state of mind, and wishes. If necessary, interpreting /sign language interpreter service must be provided.

The right to information contains the waiver of the right to be informed, provided that the patient is able to act, and non-information should not constitute a danger to others. If the patient initiates the medical intervention, then that right to information may only be waived in writing.

The patient is entitled to appoint someone else to be informed about the treatment, provided that the designated person is able to act, be authorised in writing or in some other authentic form.

The patient may prohibit information provision to others concerning his/her state and/or treatment.

The conditions of information provision must be provided for by the operator of the institution.
The right of access to health-related documentation includes the following entitlements:

- to learn the content of the documents,
- to request information and give instructions concerning that content,
- to learn specific data,
- to obtain information concerning the management of the data,
- to ask for a copy,
- to receive a discharge report,
- to ask a written – summary or outline - medical report, but only for a justified purpose, and at the person's own cost.

After the patient's decease, the "legitimate close relative" or heir will have limited access to the patient documentation, meaning access to data related to *or* possibly associated with the cause of death and data concerning the preceding medical treatment, and may also order copies at his/her own costs.

### 4.6. The right to professional secrecy

The most important provisions are the following:

- doctors may communicate health-related data only to persons entitled to receive them,
- data shall be treated confidentially,
- the patient has exclusive disposal right over such data.

The law provides exemption from confidentiality in two cases:

- if data disclosure is ordered by the law, or
- if it is necessary to protect the life, physical integrity or health of other people.

Data that prevent damage to the patient, i.e. serving the patient's interest, may be communicated to his/her nurse or carer without his/her consent. Such communication is not compulsory for the doctor.

### 4.7. The right to self-determination

The right to self-determination may only be limited through the word of law and, similarly, the cases, statutory situations subject to such limitation as well as the manner of the restriction are to be regulated under the law.

Consent to the treatment may be provided verbally, in writing, and through behaviour suggesting agreement. The patient may revoke his/her consent at any time with a reasonable cause. Revocation of the consent without a reasonable cause may be sanctioned by obliging the patient to pay a charge for services provided already.

The patient may delegate his/her right of consent or refusal to another person.

If non-intervention should jeopardize the health or physical integrity of other people, or put a foetus of at least 24 weeks in danger, or if the life of the patient is in immediate danger, it is not absolutely necessary to obtain the patient's consent.

The patient may give instructions as to the use of his/her body following death, and may prohibit removal of an organ or tissue for purposes of transplantation, treatment, research, or education.

The patient is entitled to refuse treatment. Treatment may only be administered forcibly in the event of contagious diseases, psychiatric problems and alcoholism.

A newly-introduced institution of Hungarian law is the *living will*, well-known in the Anglo-Saxon world. This contains the instructions of a fully responsible person applicable in the event of his/her incapacity to act and the simultaneous need for medical treatment. Such living wills may only be in the form of a public document. A psychiatrist's report no older than a month must be produced prior to making such statement, and it must be stated that it is a conscious decision. The statement must be renewed bi-annually, but it may be revoked unconditionally.

**Health Insurance Supervisory Board**

This is the new body designed to promote the assertion of patients' rights, responsible *inter alia* for the following:

- protection of the rights of the insured,
- audits to guarantee the compliance of health insurers and health insurance service providers with the relevant professional and quality standards, the applicable legislation and the interests of the insured persons.

The Supervisory Board also investigates reports and complaints from members of the public.

# 5. Funding

Given the fact that there is no uniform funding system in Europe, the Hungarian system can only be compared with the funding practices of individual Member States. The Hungarian methods are closest to the German, French, and Belgian techniques. In these countries, about two thirds of social protection expenditures are covered by contributions, payable in 50-60% by the employer. The same applies to the Hungarian system, where general social security is based on contribution payment, but employers pay a much higher ratio than others.

In Hungary, some 6-7% of the GDP goes to health care.

The involvement of private resources in the primary services has reached a significant rate. Co-payment in dental care and in the refunds of pharmaceuticals has increased during the years, to a significant proportion by now. Public funding dropped from 91.2% in 1992 to a mere 69.1% by 1997, to reduce further to 65% by today.

The total revenues and expenditures of the Health Insurance Fund were HUF 1,025 billion and HUF 0,335 billion respectively, in 2003.

In Hungary, health care provision is assigned to the competence of the municipalities. They provide for primary care, and the family physician works as public employee or individual entrepreneur. Ownership of hospitals has been transferred to local governments.

The size of the health service capacities remains a key issue from a funding point of view. The number of active beds per ten thousand inhabitants is high in international comparison. Average bed occupancy was 79.4% in 2003, whereas in the majority of European countries the same indicator is around 85%. The number of patients discharged from hospital increases year on year. The number of patients discharged per 100 inhabitants rose from 21.8 in 1990 to 27.1. The number of hospital beds per 100 000 inhabitants was 792 in 2003, whereas in OECD countries the corresponding figure is typically less than 600. International comparison suggests that Hungary has three doctors per one thousand inhabitants, which is 50% higher than the OECD average of 1 doctor for 526 inhabitants, or 1.9 doctors per a thousand inhabitants. Compared to the actual size of the population, there are more doctors in Hungary than in any other OECD countries.

Hospital capacities have come down significantly from their 2006 level.

The last ten years show that the system has managed to put a brake on capacities. The number of active but unutilised beds decreased over 10 years by 25%, with annual fluctuations, and the average number of hospital days was successfully reduced by 30%. A favourable process of restructuring in underway in terms of the levels of service, having led to a 6% decrease of institutions providing inpatient care, while the number of institutions offering outpatient care rose by 35%. It is true that the number of active doctors rose by 10%, but the majority of that increment is attributable to the privatized professions (primary care, dental care), while doctor numbers have not increased significantly in outpatient and inpatient care.

## Expected trends

An analysis of upcoming demographic changes and the present age-specific expenditures of the health care system reveals that, from the point of view of the real demands to be met by the health care system, the demand-cutting effects of the contraction of the population are/will

be by and large offset by the recent shift towards what is an unfavourable age composition in terms of health care needs (the share of the elderly, i.e. of social groups in a weaker physical state, more prone to illness, has increased).

All over the world, technology development in both medical sciences and health care has implied higher costs for every health care system.

An added difficulty is that, for decades, Hungary has been characterized by a growing occurrence rate of diseases requiring the most expensive therapeutic techniques in global comparison (cardio-vascular, and tumour-induced diseases).

Unhealthy lifestyles, especially the highly unfavourable trends in alcohol consumption, smoking, and environmental hazards, result in a rising frequency of malignant tumours, and mental diseases in the entire population, and especially in men.

The rise of the life expectancy in women is expected to contribute to a further growth in the occurrence of dementia and locomotion diseases on top of the above chronic illnesses.

Domestic statistics and international experience warrant the assumption that the health damaging behavioural patterns of juveniles will spread.

No major breakthrough is likely to occur in the foreseeable future in the socio-cultural factors that determine the current state-of-health discrepancies, and even a best-case scenario heralds a slow narrowing of the gaps only.

Even if the morbidity indicators improved, the ageing of the population would intensify. The characteristic health problems of the elderly age groups, primarily mental disorders and with the rising frequency of other persistent illnesses, translate into challenges – even if morbidity conditions work out in a favourable pattern – that are impossible to handle without an overall transformation of the health care system. The gradual transformation and re-structuring of the health care system, a process going back several years, seeks forward-pointing answers and solutions also to these challenges, now that the EU experience is at hand.

# 6. Quality assurance in health care

Quality assurance work began at a fast pace in the Hungarian health care system following the change of the economic and political regime, in several dimensions and with a wide array of methods. The building and certification of the ISO system was undertaken mostly under external pressure originating from the economic sector. Some aspects of the quality system are quite widespread. The results of evidence-based medicine are being rather widely applied, and even a research centre was established. Scientific interest is significant as clearly evidenced by the formation of a number of associations, and several conferences each year attended by hundreds of participants. Professional protocols have been created in the form of local initiatives. The description of procedures is less popular. Statutory provisions are meant to promote the ultimate objective of the quality system: adequate and standard service quality and definition, assurance, control, and continuous development of service quality.

The components of the quality system are the internal and external quality system. The external quality system is the quality assurance, quality development, and quality control system of the organization exercising professional supervision.

Hospitals are under obligation to build up their **internal quality system**.

The **external quality system** is based on the licensing of health-related activities. The operation licensing procedure includes the compliance supervision of the services and the service providers, i.e. of the health specialists and the institutions. The external quality system includes the system of **compliance certification**. Certification takes the form of issuing the certification document by an organization authorized to do so, for a period specified by the legislation.

The third important area of the external quality system is, apart from statutory provisions, and the licensing procedures is the **system of technical supervision** targeted at service providers, and services themselves. The latter one is the task of the health authority.

The quality system of health care is related to the national quality regulations, thus also to **accreditation**. Accreditation is, in fact, the "certification of the certifier", i.e. the formal recognition of the fact that the organization or institution concerned is prepared to perform certain activities (inspection, certification, control) in accordance with the specified conditions.

The inspection of health providers is done by the medical officers of the county level ANTSZ bodies, who are authorized to carry out audits/inspections, and are responsible for ensuring compliance with the standards and accessibility requirements applicable to services funded by health insurers.

Another type of control is exercised through the regular inspection of prescriptions and of eligibility for sick-pay.

The professional interest protection organizations, i.e. the Hungarian Chamber of Physicians and the Chamber of Hungarian Pharmacists, maintain the registers of doctors and pharmacists in compliance with the provisions of the Data Protection Act.

Patient NGOs do not play a significant role as yet in controlling the health care system.