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Health Law and Health Administration in Hungary

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ISBN

Dedicated to my daughter, Eliza

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List of Abbreviations

Áht.	Act CXCV of 2011 on public finances
ÁNTSZ	The National Public Health and Medical Officer Service (Állami Népegészségügyi és Tisztiorvosi Szolgálat)
CC	Constitutional Court of Hungary
DRG	Diagnostic Related Group
EA	Health Insurance Fund (Egészségbiztosítási Alap)
EMMI	Ministry of Human Resources
ETT	Medical Research Council (Egészségügyi Tudományos Tanács)
Eütv.	Act CLIV of 1997 on Healthcare (also Health Act)
GDP	Gross Domestic Product
GP	General Practitioner
GYEMSZI	National Institute for Quality and Organizational Development in Healthcare and Medicines (Gyógyszerészeti és Egészségügyi Minőség- és Szervezetfejlesztési Intézet)
HA	Health Act (Act CLIV of 1997 on Healthcare)
HFA-DB	European Health for All database
HSA	Act LXXXIII. of 1997 on Services of the Compulsory Health Insurance System (Health Services Act)
HUF	Hungarian forint (currency of Hungary)
Játv. 1	Act LVII of 2006 on central state administrative organisations, and on the legal status of the members of Government and the under-secretaries
Játv. 2	Act XLIII of 2010 on central state administrative organisations, and on the legal status of the members of Government and the under-secretaries

MHCS	Managed Health Care System
Mötv.	Act CLXXXIX of 2011 on Hungary's local self-governments (also Hungarian Municipal Code)
NGO	Non-Governmental Organisation
NGTT	National Economic and Social Council (Nemzeti Gazdasági és Társadalmi Tanács)
NHS	National Health Service
NPM	New Public Management
NSM	'das neue Steuerungsmodel'
Nvtv.	Act CXCVI of 2011 on National Assets
OECD	Organisation for Economic Co-operation and Development
OEP	National Health Insurance Fund Administration (Országos Egészségbiztosítási Pénztár)
OÉT	National Council for the Reconciliation of Interests (Országos Érdekegyeztető Tanács)
Ötv.	Act LXV of 1990 on local self-governments
PPS	Prospective Payment System
TEK	(Family physicians with) territorial service obligation(s)
TEKN	(Family physicians with operation rights and without) territorial service obligation(s)
WHO	World Health Organisation

1. Introduction

This paper is meant to fill a gap and therefore its purpose is to present the Hungarian health care system, the provided health care services, at least the most important facts and trends. In this scope it is absolutely necessary to present some specific features of the social development in Hungary and to make the schematic presentation of the current social, economic and cultural characteristics of the country. In addition to this framework, the paper places the emphasis on the examination of the legal background of this sector, since the management of this area can be easily analyzed with the jurisprudential methods, which is plausible, since several aspects of the health care system may be legally harmonized.[1]

The description of the broader legal framework is particularly relevant, especially because after 2010 the general legal framework changed significantly, especially due to the adoption of the new constitution. In addition to the legal framework, of course, the presentation of the traditional public policy trends is also necessary, because some of these processes also affect not only the content of the relevant legal instruments, but their effective enforcement, and the judicial and the professional practice as well.

This work does not attempt to be an exhaustive study, but wants at least to mention the most significant correspondences in this domain attempting to promote the knowledge related to this area and the research specific to this domain.

1 Tamás András, ‚Közigazgatási jogtudomány' [Adminsitrative legal science] in Fazekas Marianna (ed), A közigazgatás tudományos vizsgálata egykor és ma: 80 éve jött létre a budapesti jogi karon a Magyar Közigazgatástudományi Intézet [The scientific analysis of public administration in the past and today: The Institute of Hungarian Public Administration was established 80 years ago at the law faculty of Budapest] (Gondolat Kiadó 2011) 67-68.

2. Features of the Hungarian Legal System

2.1. *Introduction*

During the presentation of the Hungarian health law the consideration of at least two examination aspects is necessary: first the approach sketching the main features of the law system, second – almost as importantly – the examination which describes and assesses ‚reality' in a wider social scientific framework and through (public) policy features and processes. At the same time, it makes it possible to compare the Hungarian medical/health (law) phenomena with the similar phenomena of other countries, which may provide more objective results.[2]

The Hungarian legal system may be characterized as part of the ‚Western law legal type', within which it may be put into the continental law family.[3] However, the statements of works[4] raising the issue of belonging to the so-called post-Socialist law family are also justified, in so far as operational mechanisms typical for the members of this family of law are observable.[5]

The Hungarian legal system, the broader legal system and legal thinking has always been characterized by strong German and Austrian

2 Martina Künnecke, *Tradition and Change in Administrative Law: An Anglo – German Comparison* (Springer 2010) 266.

3 Among the characteristics of legal systems belonging to the continental law family it may be highlighted that written law has primacy over case law. The laws regulate the relations of life in an abstract way, they form a closed system. The functions of the legislator and of the law enforcer are sharply divided. The judge does not make law, but rather precedents thus making the application of law clearer. This rule prevails even if some authors correctly point out the precedential features of the uniformity decisions of the Curia, i.e. that they have the characteristics of individual sources of law (see e.g. Szalma József, ‚A precedensjogról' [About precedent law] (2011) 4(11) Új Magyar Közigazgatás 41.) As part of the continental legal system, the Hungarian legal system does not recognise binding precedents. However, lower courts are generally bound by the harmonised decisions of the Supreme Court/Curia (‚Kúria') and of the interpretations issued by the Constitutional Court (‚Alkotmánybíróság').

4 Fekete Balázs, ‚A jogi átalakulás határai – egy jogcsalád születése 1989 után Közép-Kelet-Európában' [The limits of legal transformation – the birth of a law family after 1989 in Central-Eastern-Europe] (2004) 1(1) Kontroll 4-21.

5 Ibid. 19.

orientation, due in part to the geographical features and certain cultural-historical features of Hungary. However, in addition to this, it is obvious that in the approaches of some of those dealing with the science of law or economics – from the beginning – other directions may also be observed, and therefore we may talk about French, in a given period Russian, and with periodical intensity Anglo-Saxon (American) influence. In Hungarian public law thinking a certain duality was observable for a long time – until 1945 – according to which there was simultaneously a strong legal conservatism, ‚living in the trance of the Corpus Iuris', and an up to date transmission of the most modern European legal theoretical and positive law achievements.[6]

2.2. *Features of Hungarian public and legal politics (1989 – 2010)*

A starting point of this subchapter is that new Central-Eastern-European democracies established after 1989 did not build the political system on layered, sophisticated consultation procedures and institutional systems based on wide scale social participation, but – almost exclusively – on the Parliament-centered politic formation structures operating on the principle of representation. Rezsőházy believes that one of the great problems of societies getting out from under a dictatorship is that due to the lack of civil society filling in the space between individuals and the state during their socialization, the members of these societies could never naturally learn to incorporate the identification of problems, formulation of their interests, exchange their thoughts, the harmonization of different opinions, due to which the various problem-handling methods were not developed, either.[7] From the public policy side it may be stated that in Hungary the legal and institutional requirements of representative democracy were fulfilled after 1990, but since then no material change has happened towards participative democracy; this means that Hungarian democracy ‚has frozen into' the level of representative democracy.[8]

6 Szabadfalvi József, Jogbölcseleti hagyományok [Traditions of legal philosophy.], (Multiplex Média – Debrecen University Press 1999).

7 Beszélgetés Rezsőházy Rudolffal (n. a.) [Discussion with Rezsőházy Rudolf] (2001) 6(1) Új Horizont 1, 3.

8 Dr. Jenei György, ‚Adalékok az állami szerepvállalás közpolitika-elméleti

Based on the main features of public policy/administrative environment it must be stated about Hungary in advance that a) due to the traditional ‚from top-down' system, a general – and tendency-like – weakness is the lack of democratic control, accountability and transparency; b) due to the politicized and instable practice of the reconciliation of interests, the quality of the decisions made in the public sector are often insufficient, just as their execution; c) public policy has balance problems; the weight and coordination of the relevant players is disproportionate and incalculable due to the extreme politicization, and political predominance characterizes the relationship of the political-administrative system and society, regardless,[9] d) the final phase of public policy is missing; public policy processes begin but they often do not get to the end. There is usually no evaluation phase and closure.[10]

The processes of the two decades after the Hungarian transition (1990-2010) may be exemplified with two further paradoxes:

- The integration of the Hungarian economy to the global market happened without the whole Hungarian economy catching up.
- The continuous weakening of the state and the lack of the material reform of the state budget together led to the result that a large, but ineffective state was established. ‚The Hungarian state model is too large to be a night watch state, but too powerless to be a welfare state. This model could best be called a ‚speed bump state', because it spreads out to several fields of economy and society, but it is not there where its power and organizational skills would be most needed; regarding its intentions it protects, but in reality it holds back processes, wants to prevent bad things but eventually it may be disregarded, passed by'.[11]

hátteréről' [Supplements to the public policy – theoretical background of state participation] in Hosszú Hortenzia – Gellén Márton (ed), *Államszerep válság idején* [State role in crisis] (COMPLEX Kiadó 2010) 95.

9 Ibid.

10 Pesti Sándor, *Közpolitika szöveggyűjtemény* (Rejtjel 2001) 206.

11 Pulay Gyula, ‚Az éjjeliőr államtól a fekvőrendőr államig. Merre tovább?' [From night watch state to speedbump state. Where to go from here?] (2010) 3(6-7) Új Magyar Közigazgatás 29.

However, the quick transition from state socialism to capitalism left several social questions unsolved which were present and documented already in the 1980s and generated new difficulties at the level of society. This way the less controlled and otherwise forced privatization which affected all the sectors, the radical change of consumer habits, the very fast growth of social differences and social tensions (e.g. the obvious fallback of the Roma people), and the presence of large and uneconomical social service systems which were left unchanged.

The ‚market turn' reduced to privatization and outsourcing did not result in real market competition at the end of the 20th century and at the beginning of the 21st. The monopoly of public institutions was often replaced by private monopoly. The privatization of public services resulted in the establishment of the client system and outsourcing often became the source of increased corruption. (…) This way the effectiveness of public services was not significantly increased by the use of market mechanisms. The publicly known idea, according to which in public services private enterprises are more effective than public institutions, has not been proven in any countries of the modern world.'[12] The embeddedness of such ideas was strengthened by the neoclassic economic approach, according to which the state shall intervene only in the field of those activities and services – like defense, education, public and property safety, protection of the environment – where market is not efficient or does not work at all. ‚(…) Until very recently it was assumed in Hungary that regarding their significance, tasks performed by the state are behind the activities fulfilled by private enterprises in line with market instructions.'[13]

In the 1990s – after the transition – there was a regrettable shift: during the transition to a market economy, the state withdrew from a number of fields, but during this ‚abolishment of the state' several tasks could not be exposed to the profit-oriented processes of the market. These tasks were usually incorporated to the so-called non-profit sector, which was unfortunately mixed up with the civil organizations both legally and practically: ‚It often happened that in complete sectors only the signboards were repainted,

12 Ibid. 95-96.

13 Csáki György, ‚A fejlesztő állam – új felfogásban' [The developer state – in new approach] in Csáki György (ed), *A látható kéz. A fejlesztő állam a globalizációban*. [The visible hand. The developer state in globalisation] (Napvilág Kiadó 2009) 13-14.

shifted from state to public utility status, while the old structure, the old system of operation, state financing and the old ‚expert' staff remained.'[14] This environment, however, had a weakening effect on organized civil society, upholding its – unnecessarily strong – dependent status.

The result of the ‚abolishment of the state' after the transition was quite odd, because for the establishment of the rule of law, the tool system of public administration was weakened on purpose, while from the other side the need for public services provided or organized by public administration did not decrease. However, the ‚rediscovery' of the state is not a direction to be absolutised: if the state performed all of its tasks through a central bureaucracy, it could hardly escape critical remarks about a total – and what is more important, less effective – state. Basically this is the reason why the tasks acknowledged or undertaken by the state are only partially performed by the state, in line with the principle of subsidiarity, it often relies on the organizations of the economic and civil sector, as well as – with growing significance – on the assistance of church organizations.

Related to the role of the state in the recent years the opinions that argue for the (New) Public Management State-concept weakened and those that argue for the vision of the neo-Weberian state strengthened; if the outsourcing of public tasks to external actors may jeopardize the integrity of the public administration and the stability and transparency of the responsibilities; from a financial point of view this solution is often wasteful. According to newer approaches it is essential to maintain the rule of law and to respect certain efficiency criteria (like, for example: headcount rationalization and reduction in the number of government seats), in the same time being inevitable to introduce the strategic thinking and the elements of strategic planning in public policy. Advocates of stronger state - who in the debate between the good government and good governance more firmly opted for the importance of the former

14 Pankucsi Márta, ‚Civilekkel a civilekért – Az ellenzéki szerveződésektől a minisztériumon át a Furmann alapítványokig' [With civilians for civilians – From opposition organisations through the ministry to the Furmann foundations.] in Simon János (ed), *Civil társadalom és érdekképviselet Közép-Európában* [Civil society and the representation of interests in Central-Europe] (L'Harmattan – CEPoliti Kiadó 2012) 144.

- argue that the basic requirements of accountability and responsibility-taking can be met only where the thoroughly rethought cooperation strategies between the public and private sector appear as an alternative for the uncertainties of outsourcing. This also means the reconsideration of the concept of the developer state, taking in consideration the coincidence between the power elite and the state's long-term goals (!), the relative autonomy of the state or the cooperation of a competent bureaucracy and the civil society.

2.2.1. Features of the system of social norms in Hungary in the past decades

‚We are obviously living in the age of changes in which law is becoming less the fixer of some agreed tradition. From the duality that on the one hand law is the guard of all-time status quo, but on the other hand it is one of the tools – at least in silence – of social dynamism and novelties, the latter seems to overcome the other.'[15] In other words: the two important expectations towards law are great (formal) stability on the one hand, and sensitivity able to react, considering social interest on the other.[16]

It was especially important for the Hungarian government after 2010 to base its own lawmaking, including the new Constitution (Fundamental Law of Hungary), on a solid, ‚irrefutable' – *let's say moral* – foundation because of the extraordinary extent of legal changes. In relation to this handling the examination of certain (professional) administration fields (politics) as solely regulation questions of legal nature would be a mistake. In social fields regulated by law the material presence of other type (level) of normativity is necessary; from the general rules of social behavior to the question of special responsibility relationships settled by political etiquette. The well developed law does not eliminate the raison d'etre or

15 Varga, Csaba, ‚A jog és a jogfilozófia perspektívái a jelen feladatai tükrében'. [Perspectives of law and legal philosophy in the light of the present tasks.] (2008) 51(2) Állam- és Jogtudomány 29.

16 Luhmann, Niklas, ‚A jog mint szociális rendszer' [Law as social system] in Cs. Kiss, Lajos – Karácsony, András (eds) *A társadalom és a jog autopoietikus felépítése* [The autopoietichal structure of the society and the law] (ELTE 1994) 65.

individual norms, community norms and organizational norms, as the generality of law can only be realized with the ‚intervention' of these.

Weakening of families and the dissolution of many previous social forms contributed to the formulation of the value crisis that has become general by now. *In the various fields of existence – school, official media, and family – the traditional system of rights and responsibilities has been shaken.* Besides the excessive emphasis of individual rights and opportunities the performance of obligations and the responsibility for the community has been pushed back.[17] As it was stated in a recently published volume of studies ‚the escape from all sorts of obligations' has become general. So, ‚the aspect of basic rights' might have been strengthened too much in the past decades that considered the aspects of sustainability, applicability and operability as residual items, compared to the expansion of the catalogue of rights and strengthening certain laws in content.

Further important supplement is that the trend-like changes of today's legal life – detectable both in Hungary and abroad and strengthened by crises – emphasise the aspects of operability.

Moreover, until recently, most of the papers – connected to the various fields of social sciences – takes/took the concepts of predictability, continuous expansion, growth and prosperity for granted - even without expressed mention - as the defining elements of the external environment. Since we carelessly assumed – presuming the relative peace of the past 69 years to be an irrefutable base - that the changes will be considered conjunctural fluctuation at most, like a wave motion, which all in all produces a well predictable and continuous average. This basic standpoint widely observable (and also reflected in legal politics) in social sciences was considered to be general even though a paragraph in connection with crisis management is present – in an almost compulsory way - in the majority of the papers in the past decade. This wasn't any other way in the various fields of legal science either. However the expansion of the catalogue and tool system of rights made the lawmaker and the practicing lawyer careless: the erosion of compulsory verification seemed to have started with the persistence of peace. In the frames

17 José Ortega y Gasset, *A tömegek lázadása* [The Revolt of the Masses.] (Pont Kiadó 1995) 187.

of this relativism, neutralism and value pluralism that was feeding the individualism overcame our law, and responsibilities seemed to have become residual items besides rights.

Moreover simultaneously ‚[the] model – appearing of economic nature on the surface – believed to be the condition of our [economic] prosperity failed'.[18]

2.3. *Features of the Hungarian Legal System*

Due to the recent development of the Hungarian law system there are some aspects that have strong impact on the long-term possibilities of the health care system.

One of the most important such aspect is the impact of the new crises on the human rights and the contents of these rights. Barnabás Lenkovics, member of the Constitutional Court, writes about changes affecting, among other things, the rule of law – as follows: ‚However, it shall be stated as a fact that in the twenty-year period of transition – which has always remained within the frameworks of the rule of law – the country has shrunk into a severe, broad and deep (political, economic, financial, social, moral, etc.) crisis. This crisis was created partly by factors within the Hungarian rule of law state, and partly by external (European Union and global) circumstances. (…) Due to the significant change of the circumstances, the national, EU and global crisis management, which has been going on since 2008-2009, has taken new directions. *This process comes together with significant, unusual changes, the revision of the content of fundamental laws, the withdrawal or restriction of civil rights, imposition of burdens, focusing on individual responsibility. Quick and significant changes presented new challenges to legislation, law enforcement and governmental activities, in each field of social life. Hungarian constitution-making was going on in this environment, under such circumstances, in 2010 and as result of this, Hungary's new Fundamental Law was created. The revision of the constitutional legal system is going on nowadays within the same environment, within which we may witness again new and unusual solutions. The crisis hits the so-called second generation*

18 Miszlivetz, Ferenc, ‚Válság és demokrácia – 1989 öröksége' [Crisis and democracy – the heritage of 1989.] in Simon, János (ed), *Húsz éve szabadon Közép-Európában. Demokrácia, politika, jog* [Twenty years free in Central-Europe. Democracy, politics, law.] (Konrad Adenauer Stiftung 2011) 134.

(economic, social, cultural) human rights (constitutional fundamental rights) especially hard. The members of society consider it as restriction of their rights, withdrawal of vested rights or the reduction of their degree. All in all it may be stated that the "rule of law social state" – due to objective and subjective, internal and external forces – is decreasing. Throughout Europe, and also in Hungary, many consider this a crisis of the "democratic rule of law state" and of constitutionality. The borderline and the balance between stability expected from the constitution and a rule of law state (legal security, public law validity) and forced governmental measures, quick and effective changes and modifications is obscured under these circumstances.'[19]

Searching for further elements, in the examined time period (after 2010) we may have witnessed the appearance, (re)vival, positioning in the legal system and constant communication of notions such as, among others:

a) Real social solidarity

It is obvious that the at least proper enforcement of laws and other norms – due to historical and other reasons – also within our field may only be possible through the establishment and facilitating of the development of conscious and initiative solidarity. The conclusion of this work is that the developer state does not only mean the improvement of the (concentrated) accessibility of different services and the higher level planning and publicity of certain authority functions, but also the priority of the means and institutions of social cohesion beyond budget rationality. In this the long term professional principles of certain authority fields have extremely important role, thus only the existence of these, and their validity which cannot be torn apart by changes of governments may ensure socially calculable development. At the same time we shall tell off the belief that the changes of law necessary bring about the changes of society (as well), as – referring back to the previous thought – only the *continuous representation of clear values* provide for real changes.

19 Decision 45/2012. (XII. 29.) of the Constitutional Court on the unconstitutionality and annulment of certain provisions of the transitional provisions to the Fundamental Law of Hungary – the separate opinion of Dr. Barnabás Lenkovics, Member of the Constitutional Court.

b) New contents of the notion of cooperation

Regarding the participation of society in legislation a double tendency has been present since 2010: on the one hand by keeping – some of – the traditional forums and forms (legal institutions) new – typically virtual – connection points have been established – not necessarily with legally obliging force, – while, on the other hand the maintenance of negative tendencies observed earlier in the preparation of laws (closed legislation, formal negotiations in compliance with the words of the law but in conflict with its spirit, unreasonably short deadlines) and the abolishment of certain institutionalized forums may be observed. Within the latter scope it shall be definitely mentioned that the previously existing quasi veto right of the National Council for the Reconciliation of Interests (OÉT) – a three-sided forum of labor issues existing since 1988 (!) – has been abolished in a way that the OÉT itself gave its place to a forum bearing exclusively consultation rights and lacking the obligatory cooperation of the Government – the National Economic and Social Council (NGTT) regulated by Act XCIII of 2011. OÉT was the national interest negotiating forum of the government, the trade union confederations and employers, its operative activities mainly covered the debate on draft laws in the field of labor law proposed by the government. Its quasi veto right originated from the fact that agreement on minimal wage was also made at this forum.

Regarding this issue we shall note that within most member states of the European Union

a) the forums of bilateral (autonomous) negotiations conducted exclusively with employers and the trade unions of employees,
b) the forums holding three-sided (tripartite) negotiations with the participation of the government, and the
c) the forums of multilateral consultation (civil discussion) realized with the participation of civil organizations, the representatives of sciences, churches, etc. *From the changes of the Hungarian legal system (system of laws) made after 2010 it seems to be clear that the FIDESZ-KDNP considers the first and the third forms of the previously mentioned three necessary or desired.*

c) New contents of the meaning of public interest

Another form, direction of expressing public interest and strengthen the mechanisms for the protection of public interest is the gradually increasing limitation of the ‚not significant content' of fundamental rights with respect to public interest.[20]

On 4 October 2010 approximately 700 thousand cubic meters, strongly virulent, dangerous mud spread over Devecser, Kolontár, Somlóvásárhely, Tüskevár, Apácatorna and Kisberzseny, because a retaining wall of a red mud container of the privately owned alumina factory in the close town of Ajka broke. The gravity of the catastrophe is well shown by the fact that the government first declared, then – upon the decision of the Parliament on 18 October 2010 – prolonged till 31 December 2010 the emergency situation in Vas, Veszprém and Győr-Moson-Sopron counties. As – one of the – normative answer(s) of the government given to the mentioned events Act CV of 2004 on national defence and the Hungarian Army – within the scope of extraordinary measures applicable in environmental emergencies – was supplemented with the following Article 197/A:

‚The operations of a business association may be brought – in line with those set forth in (3) – under the supervision of the Hungarian State. (2) In the name of the Hungarian State the undersecretary for public finances or a government representative may act. (3) The person defined in paragraph (2) a) reviews the financial situation of the business association, b) approves, signs the financial obligations of the business association, c) in connection with the avoidance of the situation which reasoned the introduction of the extraordinary measures and the alleviation of consequences decided in issues belonging to the competence of the main organ of the business association (…).'

It is important to mention that the provisions of the new act had (has) to be applied also in the ongoing cases. According to the reasoning of the draft law its goal was to create more effective possibilities of gov-

20 In its Decision 22/1992. (VI. 10.) of the Constitutional Court, based on the permanent practice of the body held that ‚the limitation of fundamental rights remains within constitutional limits if the limitation is not related to the untouchable essence of the fundamental law, if it is unavoidable, thus if it is forced, moreover, if the weight of limitation is not disproportionate compared to the goal which it aims at achieving'.

ernmental intervention for more effective measures against catastrophes occurring in connection with the activities of certain business associations and for the alleviation of their harmful consequences. For this it became possible that – beyond the previous, liberal legal concept – the minister responsible for public finances or a governmental representative may supervise the operations and activities of the given business association, based on the decision of the government.

d) New concepts of responsibility

Responsibility regarding the continuous, constant recognition of the rules of social relations, and the behavior in compliance with these; responsibility for behavior, for its fitting into social relationships; the *obligation of commitment to fight antisocial behaviors.* The next feature of today's Hungarian legal system cannot be separated from the – moral – issues which have been repeatedly analyzed earlier: the new, system-based concept of responsibility. With some simplification the key issue of conservative and neoconservative paradigm is responsibility, moreover, the revolution of responsibility, contrary to other – previously dominant – concepts absolutising freedom.[21] In this new approach the citizen does not appear primarily as the addressee of rights and exemptions or as consumer, but mainly as responsible citizen (also in the expectations of laws), which took place in the new laws by the more thorough, more precise and sanctioned definition of different responsibilities.

For example, according to Article O) of the Fundamental Law of Hungary *'Every person shall be responsible for his or herself, and shall be obliged to contribute to the performance of state and community tasks to the best of his or her abilities and potential'.* This is closely related to the intention to abolish decades old false public agreements: in shall be mentioned that – from July 2012 – the employment contract of the employee may be terminated also during sick-pay, which abolishes the decades long false practice (public agreement) of escaping into sick-pay – through which being supported by the state.

21 Barát, Tamás, 'Felelősség – társadalmi felelősségvállalás' [Responsibility – social responsibility.] (2012) 13(April) Társadalom, gazdaság, jog, politika. XXI. Század - Tudományos Közlemények 47.

e) Attempts to approximate law and reality

A specific phenomenon must be referred to, which by mixing reality and law is able to establish changes also in those fields where no material and socio-economic changes happened. In parallel with this, however, the approximation of law and reality, their more harmonious relationship is one of the answers of the legislator to the new social and economic challenges: e.g. according to Act XC of 2010 on the enactment and modification of certain acts regarding economy and finances some household jobs [e.g. home care offered for ill people - article 1 paragraph (2)] are taken outside of the tax system as reaction to the fact that no tax has been paid after these; the supervision of these activities is (traditionally) very difficult, and the fact of taxation was unfair in some aspects. Therefore, the modification of the law only establishes reasonable relationship with (adjustment to) reality, with significance which goes beyond the fact of deregulation.

2.3.1. Reasons for establishing the Fundamental Law

The Fundamental Law of Hungary (Magyarország Alaptörvénye) was approved on 25 April 2011 and entered into force on 1 January 2012. It's important that ‚The examination of [the] constitution, as norm category, considering its establishment, modification (amendment), subject, effect and unique characteristics requires the consideration of a complex system of aspects.'[22] One reason for this is that ‚constitution making is an act of legal and political nature at the same time'.[23]

The reason for creating this subchapter was the tremendous number of questions and impetuous debates which surrounded the establishment of this instrument abroad[24] and within the borders. During the

22 Csink Lóránt – Fröhlich Johanna, *Egy alkotmány margójára. Alkotmányelméleti és értelmezési kérdések az Alaptörvényről* [On the margin of a constitution: Constitutional scientific and interpretation issues regarding the Fundamental Law] (Gondolat Kiadó 2012) 13.
23 Ibid. 13.
24 See, for example: European Parliament resolution of 3 July 2013 on the situation of fundamental rights: standards and practices in Hungary (pursuant to the

examination of the new Hungarian constitution and the Hungarian legal system in general several ‚sharp' preliminary questions shall be answered, such as why it was necessary to create a new fundamental law more than two decades after the fall of the iron curtain, less than one decade after joining the European Union, in possession of a constitution which fully complied with international requirements.

The subject's literature is rich in different statements: there are some who view the new constitution as result of some symbolic efforts, which would not have been necessary at all, as the post-1989 versions of the previous constitution – while keeping the original numbering of the act – established a fully democratic state governed by the rule of law in every sense, which proved to be operable also in practice. Some express their concerns about the euro-conformity of the Fundamental Law due to its unspecified (legal) notions and the limitation of certain institution (e.g. the narrowing down of the Constitutional Court's competences). Moreover, some stress that the Hungarian Fundamental Law not only meets the basic values of the European Union, but it goes further: it specifies, confirms and explains its basic values in a creative way. Among others with the method that originating from the requirement of human dignity views the world in the correlation of family and public interest, and it establishes a definitely European, but still original and model construction which rewrites balances. In order to answer the above assumption – but at least to shed light on the background legislative goals – it is useful to read one of the most authentic sources, the opinion of the prime minister of the Hungarian government after 2010, who explained the practical role of the new Fundamental Law as follows:

‚The events of 2006[25] *made it clear for Hungarians that our constitution –*

European Parliament resolution of 16 February 2012) [based on the ‚Motion for a European Parliamnet Resolution on the situation of fundamental rights: standards and practices in Hungary (pursuant to the European Parliament resolution of 16 February 2012)', Committee on Civil Liberties, Justice and Home Affairs, Rapporteur: Rui Tavares.

25 The speech of Ferenc Gyurcsány, who established government after the elections of 2006, held in front of his peers ‚was leaked' in the late summer of 2006. In the speech the Prime Minister admitted that they had continuously ‚lied' for victory at the elections. After the release of the speech the greatest turbulences of Hungarian history from the times of the 1956 revolution took place, among

together with all of its modifications – is a constitution of failures, which cannot protect us from anything. It was not able to protect us from total indebtness, from political lies, abuses of power, from police brutality, from the complete destruction of economy, from flutters […] In 2006 the Hungarians realized that Hungary was unprotected and that the basic reason for this is the powerless transitional constitution. […] They came to understand that the renewal of Hungary required a new fundamental law, which provides proper protection to Hungary and to Hungarians, and gives modern answers to the challenges of the 21st century. […] We missed our self-esteem [before]. Our national self-esteem. We missed to proudly tell everyone who we are, how we are connected, what we want; where we came from and where we are going, what we believe is good and what we consider bad.'[26]

All these intentions cry for scientific and political foundations, moreover – precisely because of the emptying of law, it became plastic and unstable and because of the vanishing of the general preventive effect – they have an even bigger wish: they make an attempt to bring morality and law ,institutionally' closer, grabbing it as the sole possible alternative. We have to add that the crisis (crises) of our age is (are) not primarily of economic nature, but rather of moral and ethical nature.[27]

Searching for the reasons of how the Hungarian constitution came into life, we can use a parallel having non-political nature, if we accept for instance the fact that the changes occurred in the world of arts can explain some of the aspects related to the present topic. Let's take for instance the fact that the basic source of the traditional, old art is the anatomically pure human figure and the faithful representation of nature. Later, at the beginning of the 20. century, the new conception of art destroys this consensus. Later - as the result of a new turn - in the 1960's the two driving forces of the modern art, that were composition and psychology, became the central point of the debate thus questioning the validity of the constructive and expressionist way of conceiving

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others on 23 October 2006, on the 50th anniversary of the Hungarian revolution and freedom fight.

26 Orbán, Viktor, ,Az újjászületés dokumentuma' [Document of revival] *Magyar Nemzet*, 25 April 2011. p. 6.

27 Vízi E., Szilveszter, ,Az erkölcs mindennek az alapja' [Moral is the foundation of everything.] in Hankiss ,Elemér – Heltai, Péter (eds), *Münchhausen báró kerestetik.* [Searching for Baron Münchhausen.] (Médiavilág 2009) 363.

the world.[28] Till that moment mankind described and understood those organizing principles which influenced the way the world worked, and increased the importance of individual visions, yet - the artists of the era felt and make it felt that the gap between the reality of everyday life and the reality presented in the works of art instead of decreasing, increased.

One might have the sensation that in spite of the fact that the modern works of arts mirror the background principles of how reality works, in fact they remain just table pictures that are trapped outside the objective reality while hanging on the wall. The works of arts must walk down the wall and invade the reality. In other words: they must become part of the reality and must avoid the elitist character thus becoming elements of the mass culture that accept the possibilities offered by the technology and the mass media, too. The disavowal of the phobias related to the mass culture and the consumer society will lead to the transformation of art into an imminent scope. The new forms of kinetic art wants to merge the technology with nature and the publicity with the art.[29]

The processes - presented above - that went on in the transformation of art can explain some of the modifications that occurred in the Fundamental Law of Hungary. The new Fundamental Law that appeared with certain changes in the text in 1989, compared to the text of *the former Constitution* (Act XX of 1949) and that had a traditional construction is closer to the ‚modern' reality and contains the actually prevailing new operating principles (multiparty democracy, market economy, etc.). The free expression of these principles became possible. In spite of the fact that the document was reworded it kept both its content and title, thus a certain degree of doubt and a critical stance was formed, as the majority considered that the text is behind those expectations that the reality-elements be connected to the matters that are important for the individual and its social and natural environment. To that extent it can be considered natural the concern of the legislator that the new Constitution (Fundamental Law of Hungary) became a document which is a significant element of the community's consciousness that functions as the engine of the individual life and of social changes. This

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28 Ingo F. Walter, *Művészet a 20. században* [Art in the 20th century] (II. Part, Taschen 2011) 499.
29 Ibid.

is reflected by the fact that the Constitution was published in the form of an individual work of art as well, the explicit goal of which was to reach more and more citizen through the printed copies, ‚to enter the lobbies, kitchens and living rooms of the average people'.

In the new millennium there has been shared the experience of a visible tension between the positive law and the everyday reality, as well as between the social consensus and the procedures built on legal norms. This tension reflects a distance that will soon result in a striking cleavage. The need for a new Constitution can be decisively traced back to this aspect: the basic procedures should be in harmony with the formulated legal norms and with the public morality - and as far as possible - with the personal desires and efforts. Or if the latter would be an excessive and too sentimental expectation, such a document should at least elaborate a catalog listing the actual and the desired value perspectives, referring to the most important challenges of the near future and to the principles of interpretation, along which any matter of politics may be debated with success. This also means that each community needs an easily accessible set of rules that it is familiar with and considers its own, and with which is able to identify itself in the dimensions other than that of routine and necessity.

A partially independent question from the above mentioned issues is whether the Fundamental Law of Hungary will be able to fill these roles or not, whether it will meet these expectations, and if yes, under which extent is this possible in Hungary if we take in consideration the circumstances the constitution was adopted in[30] and the irresolvable political opposition and all the other hindering conditions?

On important positive aspect of the new Constitution is that the it stands in front of us as an ‚upward open' constitution. This upward openness means that during the validity of the new Fundamental Law

30 The adoption of the Fundamental Law of Hungary – which was passed exclusively with the votes of the members of the governing coalition and on the basis of a draft text prepared by the representatives of the governing coalition – was conducted in the short time frame of 35 calendar days calculated from the presentation of proposal (T/2627) to the parliament, thus restricting the possibilities for a thorough and substantial debate with the opposition parties and civil society on the draft text.

one of the state's (and its organizations') main tasks is to proceed during the enactment of any normative or individual regulation or during the interpretation of Hungary's Fundamental Law by keeping in mind the interests of future generations.[31]

2.3.2. Scope and features of the legislation process

In advance it shall be stated that Hungarian legislation has gone through a shift of balances after the change in the political system: while in state socialism the enactment of decrees dominated, after 1989 the dominance of the enactment of acts may be observed (in 1985 only 3% of all laws was act, while in 2005 the ratio of the same was 16%).

Between the summers of 2010 and 2011 legislation was extremely ‚revolutionary' in Hungary, as the 266 approved acts (from which 95 were brand-new, while 171 were modifications of previous acts) and 172 decisions of the Parliament significantly exceed the annual statistics of the first years of previous governmental cycles (before and after the change of the political system in 1990). In the previous cycle between 2006 and 2010 these numbers in total are 263 (new) and 328 (modification).

Almost one-third (!) of the acts enacted in 2011 were modified in the same year: in December 63 of the 213 acts approved in 2011 – which was a new record – were modified. In the normal course of work modifications of acts are usual parts of the tasks of the Parliament, but it definitely does not fulfil the requirement of legal certainty if a newly approved act is modified several times in the same month, especially, if such modification often affects a whole ‚network' of laws. Such quick and comprehensive flow of acts and their modifications brings uncertainty to all players, as these are not easy to interpret in the first place, and often it is impossible to prepare for them.

It is also worth mentioning that in December 2011 during one month 18 acts were modified which were enacted in December, 5 of them were

31 See e.g. Article P) of the Fundamental Law of Hungary: ‚All natural resources, especially agricultural land, forests and drinking water supplies, biodiversity – in particular native plant and animal species – and cultural assets shall form part of the nation's common heritage, and the State and every person shall be obliged to protect, sustain and preserve them for future generations.'

modified several times. The act about the modification of acts serving as basis for the budget was rewritten six times by the legislator in this period. The acts on taxation, on personal income tax and on duties were each modified eleven times in the last month of the year.

3. Constitutional regulation

The highest level of regulation regarding health takes shape in the Constitution, *through the declaration of the right to health* and the presentation of the related public tasks. The conception of the right to health as a citizen's right was first introduced in the former Constitution, that is Act XX of 1949, in 1972.

The Constitutional Amendment Act changed the regulation to the extent that it guaranteed ‚[the] right to the highest level of physical and mental health' for all the people. In connection with the latter the decision of the Constitutional Court stated that ‚[the] constitutional requirements regarding the right to health can be defined as the State's responsibility to create an economic and legal environment in which the best conditions will be guaranteed for the healthy lifestyle and way of life of all the citizens' [Decision 56/1995. (IX. 15.) of the Constitutional Court] taking in consideration the load-bearing capacity of the national economy, and the possibilities of the state and society. This means that the highest level of health services must not be interpreted related to medicine, but to the capacity of the national economy. Thus this is the standard that defines the content of the obligations of the state related to health policies.

The interpretation of the right to health as a subjective right or as a state target was a recurring issue in the practice of the Constitutional Court (hereinafter referred to as CC). This issue was explained so far by the CC in the most complex manner in the Decision 54/1996. (XI. 30) of the CC. The position of CC was clear: the highest possible level of physical and mental health should not be construed as a subjective right in itself. It is conceived in ‚Article 70/D paragraph (2) of the Constitution as the States' obligation, which includes the obligation of the legislature to formulate subjective rights in certain areas of the physical and mental health policies'. Such subjective rights guaranteed by the legislation are the rights of the patients regulated by the health care law, among them in particular the right to health care, and the mandatory participation in health insurance as part of the social security, which permits access to the health care services for those patients whose material conditions otherwise would not make it possible.

As noted above, article XX of the new Fundamental Law omits the attribute ‚the highest level', and disposes about the physical and mental health, however, compared to the earlier text it extended the areas of state powers - the occupational safety and the organization of healthcare, the supporting of sports and physical training, and the protection of the environment are included in the text, and in addition it is stipulated in the very same text the obligation to have an agriculture free of genetically modified organisms and to provide healthy food and access to drinking water.

3.1. *The main provisions of the Hungarian Fundamental Law related to health*

The main provisions related to health are the following:

Art. O

Every person shall be responsible for his or herself, and shall be obliged to contribute to the performance of state and community tasks to the best of his or her abilities and potential.

Art. P

All natural resources, especially agricultural land, forests and drinking water supplies, biodiversity – in particular native plant and animal species – and cultural assets shall form part of the nation's common heritage, and the State and every person shall be obliged to protect, sustain and preserve them for future generations.

Art. XIX.

(1) Hungary shall strive to provide social security to all of its citizens. Every Hungarian citizen shall be entitled to statutory subsidies for maternity, illness, disability, widowhood, orphanage and unemployment not caused by his or her own actions. (2) Hungary shall implement social security for the persons listed in paragraph (1) and other people in need through a system of social institutions and measures. (3) The nature and extent of social measures may be determined by law in accordance with the usefulness to the community of the beneficiary's activity. (4) Hungary shall promote the livelihood of the elderly by maintaining a

general state pension system based on social solidarity and by allowing for the operation of voluntarily established social institutions. Eligibility for a state pension may include statutory criteria in consideration of the requirement for special protection to women.

Art. XX.

(1) Every person shall have the right to physical and mental health. (2) Hungary shall promote the exercise of the right set out in Paragraph (1) by ensuring that its agriculture remains free from any genetically modified organism, by providing access to healthy food and drinking water, by managing industrial safety and healthcare, by supporting sports and regular physical exercise, and by ensuring environmental protection.

Art. XXI.

(1) Hungary shall recognize and enforce the right of every person to a healthy environment.

4. The extent of the state's liability in the context of public health

The sphere of the state's responsibilities are currently set by the Healthcare Act [(Act CLIV of 1997 on Healthcare, Article 141 paragraph (1)]. The state - within the limits laid down in this Act - is responsible for the public health, in particular, for developing the conditions necessary to enable communities and individuals to protect and if necessary, to restore their health. The contents of the responsibilities are defined in the following by the text of this law. Article 143 introduces among the tasks of the state those that are related to the organization and management of health care and sets the responsibilities of the state regarding the exercising and execution of the rights, stating that the National Assembly, the Government, the Minister of Health, the state administration bodies, the local authorities, the health insurance bodies, the health service providers and the regional administrative bodies are charged with the fulfillment of these tasks.[32]

4.1. *The patient's rights*

4.1.1. General issues and concepts. The relationship between the health care provider and the patient

The healthcare services can be defined as the totality of the officially authorized health services and activities that the patient can use to prevent and heal diseases. By comparison we can see that medical services may be defined as the totality of activities performed by an authorized medical personnel for diagnosing, healing, nursing, etc. activities. Healthcare can be defined as totality of medical and health care activities related to a patient's actual health.

Any individual, business association, public and religious body, non-governmental organization may acquire the right to provide health care

32 See also: Homicskó Árpád Olivér, 'Az egészségügyi szolgáltatások jogi szabályozása' [The regulation of the Health Care Services] Jogelméleti Szemle 2007/2. http://jesz.ajk.elte.hu//homicsko30.html

services, if it meets the personal and material conditions required for the health service and has liability insurance for the service. The conceptual criteria of healthcare service include the obligation to have operating license for the offered services. The operating license may be issued by the county/city government offices or by the district or county public health's services, exceptionally, by the Office of the Chief Medical Officer (CMO).

This is briefly called ‚doctor-patient' relationship, but according to the upper mentioned facts it is more precise to speak about the relationship of the patient and the healthcare provider. In these services very often besides the physician participates many other healthcare professionals as well. Consequently, the service provider is the responsible for the compliance of services, not the doctor directly.

In this relationship the concept of the ‚patient' - similarly to the concept of the healthcare service - is interpreted much wider than in the ordinary parlance, it embraces everyone who receives or demands medical care.[33] Related to the nature of the relationship between the healthcare provider and the patient a great number of scientific studies and articles have been elaborated.[34] According to the current perception this relationship can be considered a civil law relationship, and within this category as an agency relationship, but even among civil law relationships it has a number of specific features (e.g. implicit behavior in the creation of the relationships, detailed regulation of the obligations

33 Fazekas Marianna – Koncz József, ‚Egészségügyi jog és igazgatás' [Health law and administration] in Lapsánszky András (ed), *Közigazgatási jog különös rész. Fejezetek szakigazgatásaink köréből III.* [Administrative law. Special Part. Chapters of the Special Fields of Administration. Part III] (COMPLEX 2013) 33.

34 See dr. Lomnici Zoltán Jr.: ‚Az orvosi jog és az orvosi jogviszony alapvonalai. Történeti és összehasonlító jogi elemzés' [The bases of medical law and of medical contractual relationships. Historical and comparative legal analysis] (Dphil. thesis, PTE ÁJK DI 2013); Koch, Bernhard A. (ed), *Medical Liability in Europe. A Comparison of Selected Jurisdictions* (De Guyter 2011); Jobbágyi Gábor, Az orvos-beteg jogviszony az új Ptk.-ban [The Contractual Relationship Between Patient and Physician In The New Civil Code] (2005) 1, PJK 15-20.; Dósa Ágnes, *Az orvos kártérítési felelőssége* [The Physician's Liability for Damages] (HVG-ORAC 2004); Mohos László, ‚A kezelési szerződés, mint az orvos-beteg jogviszony szabályozásának egyik lehetséges alternatívája' [The management contract as a possible alternative to the regulation of the doctor-patient relationship] (2002) 52(9) Magyar Jog.

related to information, etc.). However, this relationship is governed by several public rules - constitutional law, administrative law, financial law - that refer in part to certain services deriving of the statutory public interest and in part to the public funding of the direct contribution of the patients (payment of the service fee). Besides the legal regulation, this category of services has an extensive system of ethical norms, as well.

The constitutional aspects of the relationship are mirrored in the patient's rights.[35] One of the most significant steps of the health regulations in force since 1998, is that the Act CLIV of 1997 on Healthcare (hereinafter referred to as: HA or *Eütv.*) and the detailed implementing regulations stipulate the rights and obligations of healthcare service beneficiaries. The incorporation of patients' rights in the laws allows patients or other beneficiaries of the healthcare services to access these services as equal partners. The content of these rights are often settled by the implementing regulations of the HA.

4.1.2. The particular patient's rights

The particular patient's rights are the following:

- Access to Healthcare
  Every person is entitled, in case of emergency, to life-saving services, and in the same time to the services that could prevent serious or irreversible damage. Every patient has the right to analgesia and to the reducing of suffering. Every patient has the right – within the limits set by law – to have reasonable, adequate, accessible, appropriate and continuous treatment required by the health state of the patient. The right to equal treatment is also a requirement set by the law. A healthcare service can be considered proper if the healthcare provider respects the specific professional and ethical rules and guidelines. If there is a waiting list the patient must be informed about the reason, the expected duration and the possible consequences of the waiting.

35 Fazekas – Koncz, (n 33) 33.

- The right to human dignity
  During the healthcare of patients their human dignity must be respected. In lack of other legal dispositions, only the necessary procedures may be performed on a patient. During the healthcare services, the patients' rights may be limited only to the extent and manner – defined by law – justified by the health of the person.
  The patient's personal freedom – during the healthcare services – can be limited by the means of physical, chemical, biological or psychological methods or procedures, only in case of urgent need to protect the patient's or of another person's life, physical integrity and health. The use of torture and cruel, inhuman, degrading or punitive and restrictive measures is strictly forbidden. The restrictive measures can only last as long as the orders exist.
  The patient may be put to wait only for a good reason and for an acceptable period of time. During healthcare services the sense of modesty of the patient must be taken in consideration when asking the patient to get undressed. The patient's clothing may be removed only for professional reasons and for an acceptable period of time.
- The right to keep contact with the family
  In hospitals the other rights of the patient may be exercised taking in consideration the given conditions and the rights of the other patients and without disturbing the routine of patient care. The detailed regulation regarding this aspect – without the restriction of the rights – is elaborated by the hospital.
  The minor patient has the right to be accompanied during hospitalization by the parent, legal representative or by the person designated by the legal representative.
  Women giving birth have the right to be continuously accompanied by an adult person designated by her during labor and delivery. Postpartum mother and child – if her or her newborn's health does not preclude – should be placed in the same room.
  The patient shall have the right to keep contact with the church personnel according to his/her religious belief and to freely exercise his/her religion.
  The patients – in the absence of other legal provisions – shall have the right to use their own clothes and personal belongings.

- The right to leave the hospital
  A patient has the right to leave the healthcare facility if other persons' physical integrity or health is not endangered. This right may be restricted only in cases determined by law. The intention to leave the hospital will be communicated to the physician who will note this fact in the patient's medical record. If the patient leaves the healthcare facility without announcement, the attending physician of the patient indicates this in the medical records, and - if the patient's health conditions justifies it - notifies the authorities of the jurisdiction and, in the case of incapacitated patient his/her legal representative, too. In case of patients with restricted legal capacity the person nominated earlier by the patient, shall be announced, and in lack of such person the legal representative is the one that shall be notified.
- The right to information
  The patient has the right to be fully informed in an individualized form. The patient has the right to be fully informed about the following:
  a) the health state including medical evaluation,
  b) the recommended examinations and interventions,
  c) the benefits and risks of the proposed examinations and medical interventions, and the consequences if these procedures are rejected,
  d) the schedule of the proposed tests and interventions,
  e) the right to decide regarding the recommended examinations and interventions,
  f) the alternative solutions and methods,
  g) the process and the expected outcomes of the procedures,
  h) further procedures and interventions,
  i) the suggested lifestyle.
  It is also important that the patient has the right after receiving these information to ask further questions. The patient has the right to be informed in an adequate manner taking into account his or her age, education, literacy, mental state, and wishes in this regard, and to be helped where necessary and possible by an interpreter or sign language interpreter.

The patient shall have the right to be informed after the performance of each test or analysis regarding the results of those actions, or about their failure and about any unexpected outcomes and the causes of these. The incapacitated and partially incapacitated patients also have the right to appropriate explanations taking in consideration their age and mental state.

A patient has the right to know the names, qualifications and positions of the persons that are directly providing the services.

- The right to self-determination

  The patient shall have the right to self-determination, which may be limited only in the cases and in the manner prescribed by law. Exercising the right of self-determination means that the patient is free to decide whether he/she wants to receive healthcare or not, and which are the procedures that he/she accepts or refuses, according to the following general restrictions.

  In the case of invasive procedures and of voluntary submittance to medical treatments, it is needed the written consent of the patient. If this is not possible the consent may be given orally or in any other manner in the presence of two witnesses. The patient with a full legal capacity – if the law doesn't provide otherwise – may in the form of a public deed or fully conclusive private deed or – in the case of inability to write – in a declaration given in the presence of two witnesses to name the legally capable person who is entitled to give or refuse the consent instead of the patient and who will be informed about his/her condition.

  The patient – in the limits of the HA – has the right to dispose and make arrangements regarding the interventions on his/her corpse in the event of death. The patient may prohibit according to the provisions of this Act, the extraction of organs and tissues from his/her body for the purpose of transplantation, paramedical consumption and research or education.

  One of the most problematic issues related to self-determination is the abortion.[36]

36 For international comparison see also: Pinter, B., Aubeny, E; Bartfai, G; Loeber, O; Ozalp, S; Webb, A., *Accessibility and availability of abortion in six European countries* (2005) 10(1) European Journal of Contraception & Reproductive Health Care 51-58.

Table I.
The evolution of the number of abortions in Hungary through the years[37]

Year	Live birth	Abortions, reported	Abortion %
1950	195567	1707	0.87
1954	223300	16281	6.8
1962	130053	163656	55.7
1975	194000	96212	33.2
1989	123304	108245	46.7
1998	97301	83606	46.2
2012	90269	36118	28.6

Of course, beyond the evolution of the absolute numbers of abortions, another important issue is the ‚distribution' of induced abortions in society. A shocking data in this regard for example is, that more than half (53.7%) of the Roma female population in Hungary over the age of 19, had at least one abortion according to the 2011 survey.[38]

In Hungary, more than a quarter of pregnancies end in abortion today, and almost all abortions (97%) are carried out invoking serious crisis situation.[39] All this is possible because according to the current abortion legislation invoking a serious crisis situation, gives unlimited access to abortion on the mere request of the pregnant woman.

Hungary is one of the countries following the method of case-specific restrictions (i.e. an abortion may be carried out only for reasons itemized in the text of the law, compared with systems in which there is only a time limit). Act LXXIX of 1992 on the protection of fetal life contains detailed provisions regarding the

37 Source: *Population, vital events (1949-)* (Hungarian Central Statistical Office 2013), Hungarian Central Statistical Office, on line [http://www.ksh.hu/docs/eng/xstadat/xstadat_annual/xls/1_1ie.xls];

38 Polónyi Éva: Vélemények és tények az abortuszról a roma nők körében. / Facts and Opinions about The Abortion Amongst Roma Women/ Országgyűlés, Budapest, /Hungarian Parliament/ 2011. http://www.parlament.hu/biz/isb/tan/abortusz_roma_nok/abortusz_roma_nok.htm> accessed 22 May 2014

39 http://www.ksh.hu/docs/hun/xftp/idoszaki/pdf/terhesmegsz06.pdf> accessed 22 May 2014

interruption of the unwanted pregnancies, and the main rules of how the request for an abortion will be done and the rules for the institutions performing the abortion, too.
‚In the Republic of Hungary everyone has the inherent right to life...' – declared the former Constitution, the Act XX. of 1949. The Constitutional Court in 1991 held that the interpretation given by the Constitution cannot clarify the legal status of the fetus [Decision 64/1991. (XII.17.) of CC]. The interpretation is not precise because one cannot figure it out whether the fetus is considered a person endowed with human rights, or legally is not considered a human being. As the Constitutional Court stated this matter should be regulated by a special law or by the Constitution..
A year after the publication of the decision, the Parliament elaborated a law regarding the rules of the induced abortion (Act LXXIX of 1992 on the protection of fetal life). The preamble states that ‚the fetal life starting with the conception deserves respect and protection'. Article 6 paragraph (1) of the Act has also specified four reasons in the case of which the pregnancy may be artificially interrupted:

a) the health of the pregnant woman is seriously endangered by the pregnancy
b) the fetus - according to the results of the medical examination - suffers of serious disabilities or diseases
c) the conception took place as a result of sexual offence
d) the major crisis existing in the life of the pregnant woman

Shortly after the law took effect, several individuals and groups protecting prenatal life turned to the Constitutional Court for a solution. According to the most important motion the entire law is unconstitutional because it does not define the status of the fetus, and does not protect the rights of the fetus. The term major crisis was objected by the petitioners, because this phrase becomes the legal loophole that ‚allows abortions without any limitation'. The second decision on abortion [Decision 48/1998. (XI. 23.) of the CC] canvassed basically the term *major crisis*, but the legislature failed to satisfactorily answer some of the most important issues raised therein, thus until today the tension between the right of the fetus ‚to life' and the right to self-determination of the mother remains

to be resolved (in some explanations the problem tilts towards the mother's right to self-determination). The concept of the *major crisis* is only vaguely defined, the existing regulation describes this situation as a case of *‚physical or mental shock, or a case of social unfeasibility'.* Despite the fact that the new Fundamental Law of Hungary is more specific (in Article II there are included the following: ‚Human dignity is inviolable. Everyone has the right to life and human dignity, life of the fetus from the moment of the conception is entitled to protection.'), those who hoped that the conditions of induced abortions will be seriously tightened after 2012 must have been disappointed again. According to the current position of the great majority, the protection of the fetus is only state target, though the fetal life is protected by the Constitution, it is not the subject of ‚absolute protection.'

The decreasing result that can be observed in the above table is the consequence of the more conscious family planning, to the control of proliferation and to the increased efficiency of contraception, the new forms of state support for families (e.g. family tax benefit) and to the spread of religious considerations. Yet the concrete effects cannot be estimated because no reliable data exist in this respect. The interpretation of the above data is facilitated by the fact that according to the majority of the Hungarian literature, there is no strong correlation between the number of induced abortions and the trends in birth rates.

- The right to refuse treatment

  Based on Article 20 paragraph (1) of the Health Act a patient with legal capacity shall have the right to refuse treatment, unless such a refuse would endanger the life or physical safety of others. The patient has the right to refuse any treatment the refusing of which would result in serious or permanent damage, only in a public document or a private document with full probative force. In case of inability to write, the patient may refuse the treatment orally in the presence of two witnesses. In the latter case, the refusal must be recorded in the medical record, certified with the signatures of the witnesses. *It is essential that – in contrast with the above mentioned – the patient may refuse the life-supporting or life-saving interventions only if he/she is suffering from a serious and incurable illness, which according to the contemporary medical science*

would shortly lead to death in spite of adequate health care. The refusal is valid only if a three-member medical committee has examined the patient and gives a consistent written statement regarding the fact that the patient has decided being aware that the medical conditions would exist for further treatments. Another condition of a valid refusal is that the patient three days after the medical board's decision – in front of two witnesses – reiterates the refusal. If the patient does not give his/her consent to the examination by the medical board, the statement refusing the treatment cannot be taken into account.

The members of the Committee are the patient's attending physician, a specialist who doesn't participate in the treatment, and a psychiatrist. The patient may not refuse life-sustaining or life-saving intervention if she is pregnant and expectedly is capable of bearing the pregnancy to term. In case of refusal it should be examined what reasons are behind the patient's decision, and there should be made an attempt to change the decision through personal conversations. During these personal conversations the patient should be informed again and again of the consequences of non-intervention. The statement of the patient regarding refusal can be withdrawn any time, without any formal restriction.

A person with legal capacity – for the event of subsequent legal incapacity – may refuse in a public document future life-sustaining and life-saving interventions, if he/she suffers of an incurable disease and due to the illness will not be self-supporting anymore and his/her pain cannot be eased with an appropriate medical treatment either. A patient with legal capacity – for the event of his/her future legal incapacity – may in a public document specify the person who can exercise this right instead of him.

The Constitutional Court's decision [Decision 22/2003. (IV. 28.) of the CC] rejected the suggestion that the Health Act unconstitutionally restricts the right of self-determination of a terminally ill patient by refusing to allow them ask for euthanasia. The panel of the CC concluded that the restriction of the right to self-determination existing in the legislation is necessary to protect the right to life, and this restriction is considered proportionate to achieve the goal. The Constitutional Court stated regarding the unconstitutional-

ity of active euthanasia that in the case of active euthanasia the patients' right to self-determination would conflict with two other fundamental rights. On one side there is the problem related to the doctors' freedom of conscience as for active euthanasia his active involvement is necessary, and no physician can be ordered to take part in such a procedure. On the other side euthanasia would be contradictory with the right to life, which is an absolute right and therefore the obligation of the state is to protect this right not only in the interest of the person but also against his/her will, too.

- The right to be informed regarding the health documentation/record
The patient is entitled to know the details included in his/her medical documentation and has the right to ask for information on his/her health records and data. The medical records are in the property of the health service providers, but regarding the contained data only the patient has the right to dispose of. The patient is entitled:
a) to get informed of the management of the treatment-related data
b) to get informed about the data related to his/her health
c) to have access to the medical record, and to receive copies of it on his/her own expense
d) to receive a final report when leaving the hospital
e) to get a written summary or abridged review of the health data, at his/her own expense for reasonable purposes
If the patient dies, his/her legal representative or close relative, respectively heir – based on written request – is entitled to ask for information regarding the cause of the death or the treatments and procedures applied before the death occurred, and has the right to consult and to make a copy (on his/her own expense) the health records and all the documentation related to the deceased.
- The right to medical confidentiality
The medical personnel carrying out the healthcare procedures and treatments are forbidden to reveal the personal data of the patients and the information related to their health (medical secret). They may share these information only with those who are entitled to, and they must manage data confidentially. The patient has the right to decide who may and will be informed regarding his/her disease, and about the prognosis. The patient also may totally or partially exclude

certain persons from being informed. The information related to the patient's health may be transmitted even in the absence of the consent, provided that this:

a) the law imposes;

b) the protection of the life, physical integrity and health of other people requires so.

Certain data related to the further treatment of the patient will be communicated to the person who will look after the patient even against the patient's will in the case in which the non-observance of these data would lead to the serious deterioration of the patient's health condition. (If a sentences like Don't tell to my wife - could endanger the life of the patient). Another example is the case when certain foods are forbidden in a disease.

It is important that a person has the right to specify the name of the person who will be informed about his/her hospitalization and the evolution of his/her condition. The patient may exclude anyone from those who will be informed. The hospital is obliged to inform the specified person regarding the accommodation of the patient and about the significant modification of the patient's health condition.

4.1.3. The enforcement of the patient's rights in Hungary

Almost all the branches of the legal system are involved in the enforcement of the patient's rights and in the fulfillment of the responsibilities related to health care. Legal provisions may be classified according to whether they are applicable for the institution or for the person carrying on the health care activity. The following table contains the institutions that are ‚responsible' for the enforcement of the patient's rights:[40]

40 Fazekas – Koncz, (n 33) 36.

Table II.

Branch of law	**Applicable for the health care provider**	**Applicable for the person carrying on the health care activity**
Administrative law	*Patients' complaints addressed to the operating authority* (Articles 29–29/A of the HA) *Patients' rights representative* (Articles 30–33/A of the HA) *Healthcare mediation* (Article 34 of the Act CXVI of 2000 on Mediation in Healthcare) *Healthcare inspectorate* [Articles 18-19 of the Government Decree 96/2003. (VII. 15.) on the general conditions for providing health care services and on provider licensing, and Decree 33/2013. (V.10.) of the Ministry of Human Resources]	
Civil law	*Primarily Act V of 2013 on the Civil Code* [Chapter VI./Title X (Breach of Contract) and Chapter VI./ Title IV. (Damage Resulting From Non-contractual liability)]	
Criminal Law		*According to Act C of 2012 on the Penal Code* Primarily *Art. 165 – Occupational hazards* Art. 166 – Failure to give assistance Chapter XVI: Crimes against health interventions and research policy; Art. 187 – Quackery
(Control provided by) Chambers		*Ethical Responsibility* (Articles 20-26/A of the Act XCVII of 2006 on the professional chambers in healthcare)

5. Influencing aspects of the Hungarian health care legislation - beyond the law

Which are the - not primarily legal - aspects, which determine the nature and extent of state assistance in ensuring health care in Hungary, the aspects which determine the possibilities of private health care providers or even the actual enforcement of the current laws?

The list below is not taxative in its nature, but due to its constituents the social, economic and cultural background of the current health care system can be outlined. The wording of these constituent factors is simplistic under several aspects, that is it does not focus on the exceptions and counterexamples: the list aims to show traditional directions, stable trends and pronounced new external conditions.

1. ‚The worldwide *financial and economic crisis of 2008* repeatedly, in deeper dimensions brought scientific debates about the role of the state to the surface, and within this, debates about the relationship of the state and the market, and the state and society. The majority of these debates especially target administrative-professional issues, such as basic questions like what the task of public administration is – within a broadly interpreted public administration what the desired role of the state is – what further directions the reform of public administration should take, whether the state is ready to – temporarily or permanently – take over tasks from other players, and if it does, whether it is able to perform them effectively at a proper standard.'[41]
2. Some major changes have taken place in the last ten years as a result of the *budgetary austerity measures* introduced since 2006 and the measures taken by the right wing government that came to power in 2010.
3. *There is an increase in the individual's own responsibility regarding health,* the rate of organized private financing is low, self-care culture is deficient. It is important to mention that some of the unresolved

41 Gellén Márton, ‚A közigazgatási reformok az államszerep változásainak tükrében' [Administrative reform in light of the changes of the role of state] (DPhil. thesis,/Thesis book, SZIE ÁJ DI 2012) 14.

social problems remain within the health care system (in Hungary). It is of a central importance that without the strengthening of self-financing health care becomes more and more unsustainable.

4. Health care systems are usually characterized by *the conflicting interests of the participants* (patients, providers, financers), the contradictions in economic interests, as follows:
   a) the patient wants the best service, but does not wish to pay, or is incapable of paying;
   b) the service sector is non-profit in its character, with the responsibility of public service, determining the interest of public ownership and the accountability of the owner is typically politically motivated and is professionally weak;
   c) the publicly regulated monopoly of state funding is enforced with soft budget constraints, with the lack of management incentives and strong political motivations.
5. The 2013 OECD Health at Glance report sublines that *more than one third of the medical expenses are paid by the Hungarians out of their pockets.*[42] According to the report processing 2011 data Hungary is above the 20% average of the OECD countries. The rate of direct public contribution for example in Norway and France is much lower, less than 10%, in Chile, Korea and Mexico however it exceeds 35%. In Hungary the contributions paid by the patients included the gratitude payments not known elsewhere, the amount estimated by the OECD reaching 34 billion HUF during the year under review. According to the OECD results in Hungary a high proportion, that is 36,8% of health expenditure is represented by the cost of medicines, approximately 30% was spent on the operation of hospitals, while less than 3% was used on the development of elderly long-term care institutions (facilities) in 2011. The public and private expenditure on health care together made up 7.88% of the GDP in 2011 in Hungary, while in the OECD countries the average exceeded 9.48%.[43]

42 *Health at a Glance 2013. OECD Indicators* (OECD 2013) 54.
43 Ibid.

6. In the public health care the informed, *value-conscious consumer attitude* becomes more and more accentuated.[44]
7. *In public funding an increase is visible in the efficacy considerations;* in efficacy improvements cooperation is appreciated, including the cooperation of the patient.
   After the regime change of 1989 in Hungary the healthcare system had to face a lot of new challenge, which were mainly financing problems. The solution was seen in that the state dominance had to be reduced and had to replace it with market and quasi-market mechanisms in certain parts of the health care. It was thought that the soft budget constrains causing continuous financial deficit could be fortified with these measures.[45] As a consequence of this the *managed health care system* (MHCS) operating on the uasi-market basis was introduced in 1999, and was started up on the basis of the synthesis of the American ealth Maintenance Organization and the English General Practitioner Fundholding institutional models.[46] Therefore this was a typical Hungarian managed health care system (MHCS).[47] (For more information about financial issues, see chapter 11.)
8. In 1990 178 hospitals operated 104.600 beds resulting in 9.84 *active hospital beds* per 1000 inhabitants.[48] Due to the centrally planned bed reductions and fusion of hospitals during the mid-90s in 2000 150 hospitals operated 84.200 active beds[49] resulting in 8.41 beds per

44 Baji, Petra – Pavlova, Milena – Gulácsi, László – Groot, Wim, ‚Exploring consumers' attitudes towards informal patient payments using the combined method of cluster and multinomial regression analysis – the case of Hungary' (2013) 13(1) BMC Health Services Research 1-14; Baji Petra – Pavlova, Milena – Gulácsi László – Groot, Wim, ‚Preferences of Hungarian consumers for quality, access and price attributes of health care services – result of a discrete choice experiment' (2012) 34(2) Society and Economy 293.

45 György Jóna, 'Efficiency and Resource Allocation: the Hungarian Managed Health Care System' Competitio 2011 (10)2 43-56.

46 Ibid.

47 Sinkó Eszter, 'Az irányított beteg-ellátás hazai tapasztalatai' Esély 2005/2. 52-71.

48 János M. Réthelyi – Eszter Miskovits – Miklós K. Szócska, *Organizational Reform in the Hungarian Hospital Sector: Institutional Analysis of Hungarian Hospitals and the Possibilities of Corporatization* (HNP Discussion Paper, The World Bank 2002).

49 Ibid.

1000 inhabitants. In 2011 there were 71.497 active beds resulting in 7.15 beds per 1000 inhabitants.[50]

9. Within and outside the public service system the *Information and Communication Technology* (ICT) tools become more and more important.[51]

10. Beside the solution of the country-specific problems of our (Hungarian) health care system, *the main principles of the new paradigm of 21st century medicine are also influencing: it's personalized, participatory, preventive, predictive and proactive.*[52] The new medicine is continuously associated with the patients, instead of separated interventions. The changing of attitude is necessary for spreading these principles and also gives the basis of future medical service of society. The role of patient organizations is vital during this progress. The development is possible to the direction of *patient-centred health care model* by changing the structure of residential expenditure, even during the time of global financial crisis. However, a stronger community involvement is required. Good examples of this patient organization involvement are presented in the case of rare diseases, which can be, together with orphan drugs, the precursors to personalized medicine,[53] paving the path to this direction. A closer participation of patients and their organizations is essential to transform the present health care system to the route of personalized medicine and to alter the public outlook.[54]

50 Fazekas – Koncz (n 33) 38.

51 Dévényi Dömötör, ‚Mozgásba lendült az egészségügyi infokommunikáció, az eHealth hazai eredményei és lehetőségei: Beszámoló az IME Infokommunikációs konferenciáról. 2. rész' (2013) 12(6) Informatika és menedzsment az egészségügyben 44-46; Jandó Zoltán, ‚Távdoktorok – Előretörő e-health' (2013) 57(23) 42-43; Vízvári Dóra, ‚Beszámoló az EAHIL (European Association for Health Information and Libraries) „Health information without frontiers" címmel július 4-6. között Brüsszelben megrendezett konferenciájáról' (2012) 3(3) Orvosi Könyvtárak 6-9.
See also: Quinn, Paul – De Hert, Paul, 'The Patients' Rights Directive (2011/24/EU) – Providing (some) rights to EU residents seeking healthcare in other Member States' Computer Law & Security Review (2011) 27(5) 497-502.

52 Pogány G., ‚Personalized medicine from the viewpoint of patients and their relatives' (2013) 57(1) Magyar Onkologia 11-5. *English Abstract*

53 Bochenek, Tomasz, ‚Personalized medicine and orphan drugs – a public health perspective' (2013) 12(9) Informatika és menedzsment az egészségügyben 50-53.

54 Pogány (n 52) 11.

11. *The environment in which the regulations regarding the health care institutions prevail has radically changed since the 1970s in the western countries.* The hospitals, the ‚proper community institutions' formerly providing public service, became – with some exaggeration – merely health insurance businesses, in a market sector where competition, rivalry is constantly growing. Starting with the eighties the increasing role of commercial aspects can be observed,[55] in the USA the introduction of the ‚Prospective Payment System' (PPS), which envisaged the improvement of efficiency in all respects,[56] the reduction of time spent in the institution in the case of interventions, the narrowing and reduction of the scope and volume of diagnostic procedures; providing limited services for those people who do not have insurance or are ‚underinsured', the increase in the discipline regarding billing, the aggressive collection of service fees. This system highly favoured/favours the inclusion of patients who resort to high DRG (Diagnostic Related Group) index services, such as emergency care or endoscopic examination. The hospitals started an increasing marketing activity, creating various centres specialized in well-paid areas to ensure the demand of solvent customers. The competition became particularly harsh in the domain of acute in-patient care as the formerly non-profit institutions were forced to ‚acquire' the new technologies, equipment as well as human labour solely as a result of market-based, competitive situations.

    The above mentioned issues have become the determining areas of Hungarian health care as well following the regime change, and more and more articles in the literature deal with the emergence and problems of DRG-index based care.[57]

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55 Hevér Noémi V. – Balogh Orsolya, ‚The German approach to cost-effectiveness analysis in health care' (2013) 35(4) Society and Economy 551-572.

56 Mark McClellan, ‚Reforming Payments to Healthcare Providers: The Key to Slowing Healthcare. Cost Growth While Improving Quality?' (2011) 25(2) Journal of Economic Perspectives 252-256.

57 Lampé Z. et al., ‚Erfahrungen der Umsetzung von Diagnosis Related Groups (DRG) in der ungarischen Augenheilkunde' [Experiences with the Introduction of Diagnosis Related Groups (DRG) in the Hungarian Ophthalmology] (2007) 224(7) Klinische Monatsblätter Für Augenheilkunde 575-579. *English Abstract*

12. *The existence of frameworks determined by overall public policy programs.* E.g. in the narrower field of health care such a program is the *Semmelweis Plan*. See for example Government Decision 1208/2011. (VI. 28.) on the tasks and duties resulting from the restructuring of health care, as well as the measures needed in the implementation of priority tasks.
13. *Public services in Hungary suffer from a lasting lack of resources,*[58] and this means that the patient does not receive the appropriate level of care even after gratitude payments.[59] (See also subchapter 7.1.)
    One of the most urgent tasks is to decrease or even halt the trends of leaving work and moving abroad by health workers. One of the main reasons of the shortage of workforce is the low wages. In 2010 an early-stage doctor was paid a gross amount of 150-160 thousand forints, which is approximately 500 EUR. In 2012 the base salaries of almost 86.000 people working in the health sector were raised, that of the doctors with 65,823 forints (210 EUR), while that of the professional staff with a gross average of 20.000 forints (65 EUR). In 2014 the wages of general practitioners, pediatricians, and health visitors, dentists working in primary care and care specialists working with the general practitioners were increased with an average of 30-37.000 forints (100-120 EUR).
    Here we have to mention that in Hungary the trade union movement is generally weak, and there is no difference in the field of health care, either. See for example the Democratic Trade Union of the Social and Health Care Sector Workers in Hungary (Magyarországi Munkavállalók Szociális és Egészségügyi Ágazatban Dolgozók Demokratikus Szakszervezetét - MMSZ EDDSZ).
    We also need to stress that in the European Union not only Hungary struggles with human resources problems in health care.
14. *The creation of the proper size of risk communities* is unavoidable.

58 In the local scholarly literature it is widely accepted that in an international comparison the country underfunds public health care even compared to the level of development of the country.

59 Belicza E. et al., ‚Shortage of human resources in the Hungarian health care system: short-term or long-term problem. World Hospitals And Health Services' (2003) 39(3) The Official Journal Of The International Hospital Federation [World Hosp Health Serv] 13-18.

15. *Centralization (re-centralization) arguments becoming more and more prominent.* One may consider as possible benefits the following, for example:
    - through the concentration of ownership the efficiency of management is improved
    - positive effects on employment
    - the reduction of differences and disparity in the standards of services
    - the emergence of model experiments
    - an increasing demand for outcome-measurements.
16. *The regulations of certain areas of health care or of adjacent areas become more and more process-like,* that is regarding the service providers, the services, the customer paths, the financing or even activities of authorities the aim is a coherent, full-scale and fully *transparent legal regulation*.
    For this the best example is a newly created, ‚traversing' branch of law: food law. The whole field is now covered by a unified regulation having unified view instead of the laws, which formerly ruled the food delivery chain. Its approach is named as ‚chain approach' including the principle of ‚from farm to fork', according to that the basic problems of the soil protection, the plant hygiene, the plant protection, the feeding of animals, the animal hygiene, the veterinary science, the food safety and the food quality cannot be separated from one another.[60]
17. *Major health issues, demographic trends*
    64.178 deaths (49.6% of all) in Hungary were caused by cardiovascular disease in 2012. Number of cardiovascular disease deaths peaked in 1985 with 79.355, declining continuously since the fall of the Communism. The second most important cause of death was cancer with 33.790 (26.1% of all), stagnating since the 1990s. Number of accident deaths dropped from 8.760 in 1990 to 3.758 in 2012, number of suicides from 4.911 in 1983 to 2.350 in 2012.[61] Since the fall of the Communism suicide rate decreased rapidly.
    According to Péter Polt, Chief Prosecutor of Hungary, there were

60 Kovács, Júlia Marianna, ‚The General Rules of the Hungarian Food Safety System' in *International Eco-Conference of Safe Food. Ecological Movement of Novi Sad* (Novi Sad 2012) 337-338.

61 See also: Zonda, Tamás – Bozsonyi, Károly – Veres, Elöd, ‚Seasonal Fluctuation of Suicide in Hungary Between 1970–2000' (2005) 9(1) Archives of Suicide Research 77-85.

only 133 homicides in 2012, which is the lowest data registered in the last 50 years in Hungary. Homicide rate was 1.3 per 100,000 people, which is among the lowest in the World.

Despite recent improvements, alcoholism is still a major problem in Hungary, inherited from the Socialist era. According to KSH estimations number of alcohol addicts were 1.052.000 (10% of the total population) in 1995, declined to 432.000 (4.3% of the total population) in 2005. Hungarians drank 9.7 litres of pure alcohol per capita in 2011 (40% wine, 35% beer and 24% spirit in 2005), annual alcohol consumption is constantly between 9 and 11.5 litres of pure alcohol since the 1970s.

Smoking also causes significant losses to the Hungarian society.[62] Share of daily smokers among adult population was 28% in 2012, dropped to 19% in 2013 due to the strict regulations. Nationwide smoking bans expanded to every indoor public places (including pubs), the sale of tobacco is limited to state-controlled (but privately owned) tobacco shops called Nemzeti dohánybolt (National Tobacco Shop), number of stores where people can buy tobacco reduced from 40.000–42.000 to 5.300. In 2013 WHO awarded Prime Minister Viktor Orbán in ‚accomplishments in the area of tobacco control'.

Regarding the health condition of the Roma people in Eastern European Countries it is enough to mention that, in the case of Roma people the life expectancy is 10 - 15 years shorter than the one measured for the rest of the population.[63] The health status of Roma people[64] in Hungary is worse than that of non-Roma people.[65] *The health status of the Roma people is tragic in Hungary*; the life expectancy of the members of the Roma community is significantly

62 Foley, Kristie L. – Balázs, Péter, ‚Social Will for Tobacco Control among the Hungarian Public Health Workforce' (2010) 18(1) Central European Journal of Public Health 25.

63 Rixer, Ádám, ‚Roma Civil Society in Hungary' (2013) 7(1) DIEIP 6.

64 Their number is at about 700.000 – 900.000 in Hungary.

65 Puporka Lajos – Zádori Zsolt, *The Health Status of Romas in Hungary* (NGO Studies No. 2, World Bank Regional Office Hungary 1999) 61; ‚A roma lakosság helyzete Európában - a WHO HEALTH 2020 egészségpolitikai és egészségügyi stratégiai programjának prioritásai között' (20129 90(4) Népegészségügy 219-221.

shorter than the members of the majority population as ‚there are no old Roma people'. There is much higher proportion of depression, cardiovascular and cancer-related diseases within the Roma community.[66]

Table III.

Data and statistics[67]

Indicator	Year	Value
% of population aged 0-14 years	2011	15
% of population aged 65+ years	2011	17
Crude death rate per 1000 population	2011	13
Estimated infant mortality per 1000 live births (World Health Report)	2011	5
Estimated life expectancy, (World Health Report)	2011	75
Hospital beds per 100000	2011	719
Infant deaths per 1000 live births	2011	5
Life expectancy at birth, in years	2011	75
Life expectancy at birth, in years, female	2011	78.7
Life expectancy at birth, in years, male	2011	71.2
Infant deaths per 1000 live births	2011	9
Mid-year population	2012	9.947105
Physicians per 100.000	2011	296
SDR all causes, all ages, per 100.000	2011	875
SDR, diseases of circulatory system, all ages per 100.000	2011	402
SDR, external cause injury and poison, all ages per 100.000	2011	54
SDR, malignant neoplasms, all ages per 100.000	2011	239
Total health expenditure as % of gross domestic product (GDP), WHO estimates	2011	8
Tuberculosis incidence per 100000	2011	13

66 See also: Nagy Melinda, ‚A roma populáció egészségi állapota a társadalmi válságjelenségek összefüggéseiben [The Health Status of the Romani Population in the Context of Societal Crisis] (2012) 5(1) Economica. Szolnoki Főiskola tudományos közleményei 14–23; Nárai Márta, ‚A perifériára szorult emberek egészségképe, egészségmagatartása' [Health representations and health behaviour among marginalized persons] (2013) 6(1-2) Szociális Szemle 151-155.

67 Source: *European Health for All database* (HFA-DB) http://www.euro.who.int/en/countries/hungary> accessed 12 April 2014

The total population of Hungary was 11 million in 1980. Hungary's official population on January 1, 2013 was 9.908.798. In 2014 it is less than 9.9 million. Life expectancy at birth in Hungary is among the lowest within the OECD.[68]

3.5 per cent fewer Hungarians were born during 2013 than in 2012. Discounting those who moved abroad, Hungary's population decreased by 26.545 souls between January 1st and September 1st. From a population point of view this was as if a city the size of Szentendre or Jaszbereny was simply wiped off the map.[69]

Hungary's demographic dilemma did not begin under the current government(s). The number of live births per women has fallen steadily since the early 1970s. Better diets and modern medicine mean people are living longer (there were 4.1 per cent fewer deaths the first eight months of this year than the previous year). Falling death rates mean more people are surviving into their sixties, seventies, and eighties, putting enormous strain on public finances.

18. *The uncertainty of economic macro-paths makes it impossible to track the demand for increasing public expenditure. Nevertheless in the European Union in the 2000s the paradigm change took place, as it was realized that health care costs are not a burden but one of the key drivers of economic growth.*
19. *Hungary is one of the main destinations of medical tourism in Europe*, the country is leading in dental tourism, its share is 42% in Europe and 21% worldwide.[70] The first medical tourists were Germans and Austrians in the 1980s, who seek cheap and top-quality dentistry services. Since the fall of the Communism medical tourism is an emerging business in Hungary, 60.000-70.000 people arrive for dental treatments every year, generating a revenue of 65–70 billion HUF (~325–350 million US $) in the dental sector alone.[71] The

68 http://www.oecd.org/els/health>accessed 12 June 2014

69 Éva Nagy, ‚Hungary's Demographic Dilemma' *Budapest Beacon*, October 22, 2013. http://budapestbeacon.com/public-policy/hungarys-demographic-dilemma/> accessed 11 April 2014

70 Kummer, Krisztián, ‚Hungary aims at bigger bite of dental tourism' *Budapest Business Journal*, July 9, 2012. 1.

71 Kalmár Katalin, *Characterization of Hungarian touristical turnover 2006-2009 – focus on health tourism* (Agrártudományi közlemények = Acta Agraria Debreceniensis

cost of medical treatments is between 40% and 70% of the cost in the United Kingdom, United States and Scandinavian countries.[72] The most popular medical treatments are dentistry, cosmetic surgery, orthopaedic surgery, cardiac rehabilitation, fertility treatment, dermatology, anti-aging treatment, obesity treatment, addiction programmes and eye surgery. Plastic surgery is also a key sector, 30% of plastic surgery clients in Hungary come from abroad, visitors can save 40-80% on medical expenses. Hungary is home to several medicinal spas (Lake Hévíz,[73] Széchenyi Thermal Bath, etc.), spa tourism sometimes combined with other treatments.

20. *The development of European public administration and administrative law.* Although the separation of the European Union's and the member states' administrative structure is a fundamental organization principle of the European public administration, the coordination between the two levels is essential in carrying out the tasks effectively.[74] Moreover instead of the models built upon the strict separation of national and European enforcements the spread of the so-called network co-operations, as well as multi-level cooperative procedural models can be observed - in health-related areas, too.

    For example following a reference licensing in a member state the authorities of another member state declare that the given drug represents a public health risk, based on which the latter member state wishes to refuse its marketing. These two authorities are required to develop a common position, and if this fails, following the opinion of the European Medicines Agency the Committee takes a decision by involving the pharmaceutical standing committee in a comitology procedure. This resolution is not an authorization decision yet,

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45., Debreceni Egyetem 2012) 47-50.

72 ‚Hungary: Hungarian Tourism promotes medical tourism' *International Medical Travel Journal*, 12 April, 2013. 1. http://www.imtj.com/news/?entryid82=416494> accessed 2 February 2014

73 The Heviz Lake is a geological curiosity, Europe's largest thermal lake - a warm water lake situated in a peat-bed.

74 Dr. Dezső Márta – Dr. Vincze Attila, *Magyar alkotmányosság az európai integrációban* [Hungarian Constitutionality within the European Integration] (HVG-ORAC 2012) 492.

but a resolution addressed to member states the implementation of which is compulsory for the conflicting member states, which either issue or withdraw, or – in certain cases – amend the marketing authorization in such a way that it complies with the ruling.[75] The authorization, marketing and (budgetary) compensation of pharmaceutical products has a significant literature in Hungary as well.[76] Beyond the concrete example *the secondary legislation of the Union currently cover the following topics in the field of health care:*[77]

a) the health implications of occupational health and safety;
b) public health and epidemiology – in a broad sense of the European regulation this refers not only to communicable diseases, but also to any disease with serious trans-boundary risks implications.
c) the management of special risks – see chemical safety;
d) the production and marketing of medicine and medical devices;
e) the quality and safety requirements of human organs, tissues, as well as blood and blood products;
f) in the field of the coordination of national health insurance systems the cooperation of the health insurance systems of the member states. In this respect however radical change occurred in 2011 by the adoption of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, which is independent of the insurance relationships and – with certain limitations – generally allows the patient to apply for treatment in another member state with the reimbursement obligation of the own member state. It must be added that there are still several unsolved problems concerning this Directive.[78]

75 Ibid. 503-504.

76 From the newest literature see e.g.: Éva Erdős – Krisztina, Szántó, ,Public Administration and Public Finance Questions in the Administration of Medicines, especially the European Union's Responsibility on it' (2013) 16(4) *Juridical Current* 108-113.

77 Fazekas – Koncz, (n 33) 22.

78 See e.g.: Van der Molen, I. N., Commers, M. J., 'Unresolved legal questions in cross-border health care in Europe: liability and data protection' Public Health

It must be outlined that the treatment of health care by European competition law encapsulates more clearly than almost any other public service a key dilemma: to what extent are public services subject to the norms of competition law and the internal market, or are they characterized by quite different principles of solidarity and citizenship, which make the application of market and competition principles inappropriate?[79]

g) in a broader sense the related regulations of product safety, consumer protection and food safety can also be included here: the system of norms referring to the production and marketing of medical equipment and products, as well as the extensive system of norms referring to food;

h) in a broad sense the regulations regarding health care are connected to the system of the recognition of qualifications, within which the mobility of health care workers is promoted by specific rules within the EU.

21. *Financing based on gratitude payments - as a social consensus*

So-called ‚gratitude payments', another communist legacy,[80] require in practice a cash payment to have access to better treatments. In Hungary the institution of the gratitude payment spread in the 1950s; starting with this period the calculation of the wages of health care workers – deliberately kept low – have included the benefits received from the patients.

We have to add that North American medical institutions commonly have ‚grateful patient' programs that solicit donations from wealthy individuals who receive care, but those programs and donations totally differ from the abovementioned ‚sources'.[81]

(Elsevier) (2013) 127(11) 987-993.

79 See more: Tony Prosser, 'EU competition law and public services' 315. www.euro.who.int/__data/assets/pdf_file/0005/.../E94886_ch07.pdf

See also: Tamara Hervey, 'The impacts of European Union law on the health care sector: Institutional *overview'* (2011) Eurohealth 16(4) 5-7.

80 See also: Golinowska, Stanisława – Tambor, Marzena, ‚Out-of-pocket payments on health in Poland: Size, tendency and willingness to pay' (2012) 34(2) Society and Economy 253-271.

81 Julian, J. Z. et al.: Physicians as Fundraisers: Medical Philanthropy and the Doctor-Patient Relationship. (2014) 11(2) PLoS Med. 120.

Corruption is a major problem in the societies of the post-communist Central European countries. Corruption in health care has some unique characteristics undermining the efficacy of and respect for Hungarian health care. One of the forms of corruption is ‚tipping' (gratitude payment). This highly contested phenomenon is present in most of the patient/health professional's interactions in a sophisticated manner, raising serious ethical and legal dilemmas.[82] There are some who even state that Hungarian health care is based on the consensus of gratitude payments based on the Stockholm-syndrome of the privileges of the medical staff and the vulnerable patients.

If we look at the legal regulations, codes of ethics and recommendations of the health care systems of the developed world, we will find that issues of care and treatment are assessed in a sophisticated way. Certainly, it does not mean that all the actions of health care professionals are defined by the legal system or by some kind of ethical guidelines, but we can be confident in general about the overall legal and ethical consequences and implications of a certain act.[83]

Regarding gratitude payments we have to stress that it is morally reprehensible based on medical profession's code of ethics, and its reduction is the moral obligation of every doctor. *It is important, however, that the code of ethics does not classify the receiving of gratitude payment as an ethical fault (misdemeanour), and with the definition of the term of gratitude payment* it makes it clear which behaviour is not accepted, but from the legal point of view it is not considered illegal.[84]

It is also important that the Current Labour code, the applicable tax laws and their enforcement practices specifically allow the receiving of gratitude payments as they need to be included in the personal income tax return as ‚other' taxable income. Article 7.2. of Annex 1 to Act CXVII of 1995 on Personal Income Tax explicitly names gratitude payment as income which is considered taxable income.

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82 Imre Szebik, ‚Masked Ball: Ethics, Laws and Financial Contradictions in Hungarian Health Care' (2003) 9(1) Science and Engineering Ethics 109.

83 Ibid.

84 According to the Code of Ethics of the Hungarian Medical Association, article II. 15: Gratitude payment, gratitude service is every benefits and allowances of any kind which is given by the patient or the patient's relatives after treatment, without requests, to the physician, if it does not affect the quality of care even indirectly.

According to Article 52 paragraph (2) of Act I of 2013 on the Labour Code: ‚Without the prior consent of the employer the employee cannot accept or require payments from third parties for their activities as employees'. According to article (4) ‚[P]ayments determined in article (2) include any material value service given to the employee by third parties in addition to the services of the employer'. *This means that with the permission (consent) of the employer gratitude payments not previously agreed upon and not illegal for any other reasons can be accepted.* In the current judicial practice however in cases where – with regard to care received as policy-holder or as beneficiary – the patient pays directly ‚in the pocket' of the physician, bribe does not necessarily takes place (with the employer's consent and under other conditions). The receiving of bribery – in its criminal sense – can only occur if the physician (or any other health professional) specifically asks for compensation for something that the patient should otherwise not have to pay for (or not to the physician, the nurse, etc.).[85] According to the current social consensus – accepted by law enforcers as well – the physician can receive ‚gratitude payments' only when doing something (s)he is not required to do according to the protocols (e.g. extra attention). However, in practice, almost everything can be argued as being ‚more than expected', moreover it is particularly difficult to morally or legally judge situations in which the physician informs the patient about what (s)he expects ‚by implied conduct'. Ten obstetrician-gynecologists were non-finally sentenced by the Budapest Capital Regional Court *(Fővárosi Törvényszék)* of first instance on March 7, 2014 to pay fines between 1.5 and 2.4 million forints (5000 – 8000 EUR) as they requested gratitude payment for the conducting of births, which is considered a bribe. In this new and widely mediated case the central issue was the definition of gratitude payment: the subsequent voluntarily payments can be considered as such, but if it was asked and/or received in advance,

85 According to paragraph (1) of Article 291 of Act C of 2012 on the Criminal Code, whoever requests an unlawful advantage based on activities provided for enterprise operations, or receives unlawful advantage or its promise, or agrees with the person requesting or accepting unlawful promise given to third parties regarding oneself, is punishable with three years' imprisonment for committing a crime.

it needs to be assessed not only morally but criminally as well, as in this case it cannot be considered as gratitude payment, but as bribery. Previous studies on informal patient payments have mostly focused on the magnitude and determinants of these payments while the attitudes of health care actors towards these payments are less well known. A new study - involving a representative sample of 1037 respondents - aimed to reveal the attitudes of Hungarian health care consumers towards informal payments to provide a better understanding of this phenomenon.[86] The study identified three main different attitudes towards informal payments:[87] accepting informal payments, doubting about informal payments and opposing informal payments. Those who accept informal payments (mostly young or elderly people, living in the capital) consider these payments as an expression of gratitude and perceive them as inevitable due to the low funding of the health care system. Those who doubt about informal payments (mostly respondents outside the capital, with higher education and higher household income) are not certain whether these payments are inevitable, perceive them as similar to corruption rather than gratitude, and would rather use private services to avoid these payments. The researchers found that the opposition to informal payments (mostly among men from small households and low income households) can be explained by their lower ability and willingness to pay. The conclusion of that study was that a large share of Hungarian health care consumers has a rather positive attitude towards informal payments, perceiving them as ‚inevitable due to the low funding of the health care system'.[88] So, from a policy point-of-view, the change of this consumer attitude will be essential to deal with these payments

86 Baji, Petra et al., ‚Exploring consumers' attitudes towards informal patient payments using the combined method of cluster and multinomial regression analysis – the case of Hungary' (2013) 13(62) BMC Health Services Research 1. http://www.biomedcentral.com/1472-6963/13/62; see also: Baji, Petra – Pavlova, Milena –Gulácsi, László – Groot, Wim, ‚Changes in Equity in Out-of-pocket Payments during the Period of Health Care Reforms: Evidence from Hungary' (2012) 11(1) International Journal for Equity in Health 36-46.
87 Ibid.
88 Ibid.

in addition to other policy strategies.

According to another study the attitude towards gratitude payments of the medical professionals has not changed significantly in the recent years. 19% of the physicians firmly reject the parasolvency system, 70% of them does not agree with this type of financing in principle, but due to the current health care situation they are forced to accept the money offered by the patient – as the 2013 survey of the Hungarian Resident Association shows.[89] The study also points out that only 44% of the population believes that parasolvency is degrading for physicians as well, while by 87% of the health care professionals it is consider as such.

22. *Health care procurement and corruption*

Health care has always been a special area of procurement, this is confirmed by the fact that there has long been a government resolution regarding medical procurement: currently this law is Government Decree 16/2012 (II. 16.) – published based on the authorization received by Act CVIII of 2011 on the specific rules of the procurement of drugs and medical devices.

Our picture of health care would not be complete without the suggestions regarding health care procurement; in this context the phenomenon of procurement corruption is of a primary importance. The local literature has revealed the content, reasons and extent of the phenomenon which may very well be regarded as traditional.[90] In more important cases the amount of the direct damage can be significant (unjustified cost-increases, decline in the quality, the non-fulfilment of warranty obligations, etc.). The indirect damage, the performance retention due to the lack of trust, the bad examples facilitate the quick spread of corruption practices which cause even bigger losses.[91] Regarding Hungarian health care several authors stress that the practice

89 Ibid.

90 See e.g.: Dr. Papanek Gábor (ed), *A korrupció és a közbeszerzési korrupció Magyarországon* [Corrpution and procurement corruption in Hungary] (GKI Gazdaságkutató Zrt. 2009) 8-40; and Alexa Noémi – Kósa Eszter (eds), *Korrupciós kockázatok Magyarországon* [Corruption risks in Hungary] (National integrity report. Volume I. Transparency International 2008) 56-60.

91 Ibid. 129.

of gratitude payments reinforce other corruption risks in the sector.[92] According to the literature the biggest problem of centralized procurement in the field of health care is that the GYEMSZI typically purchases for one year, and the one-year cycle is unduly burdensome for the responsible as well, and due to the bureaucratic and lengthy procedures one process is hardly finalized, the next one needs to be started. *According to many, three-five year period would be optimal in order to acquire the lowest prices and in order to have true transparency (as well).* The extent of the problems in Hungary is also represented by the fact that every fourth public procurement produce is expected to end in a legal remedy process, which counteracts efficiency in Hungary.[93] Moreover in an international comparison it can be observed that regarding the areas most affected by corruption, drug-licensing and the distribution of pharmaceutical products, etc. ranks high.[94]

92 Ibid. 131.

93 Tátrai, Tünde, ‚Public Procurement as a special type of purchasing activity and its potentials for development in Hungary' (Dphil. thesis, Corvinus University of Budapest 2006) 72.

94 Rose-Ackerman, S. (ed), *International Handbook on the Economics of Corruption* (Eelgar 2006) 434.

6. Public health services in the world

6.1. *General introduction*

In Europe the continuous growth of state budget expenses and the growing indebtedness of the public sector, coupled with the effects of the financial crisis necessarily led to the need to fundamentally transform the system of community expenses and revenues. This force also resulted from the fact that the previous balance of economic liberalism and the public service systems using the service-organisation solutions building on this liberalism, but in the meantime spreading the idea of achieving social goals has been shaken.[95] In reality the search for the new balances of solutions built on the traditional values of market and public sectors have been going on since the oil crisis in the early 1970s.[96]

In the majority of today's European states the traditional, direct state (self-governmental) organisation of public services – in several fields – has been replaced by a system of services based on the division of service provision roles[97], while the conditions of services are usually – still – regulated by the central government (state administration) or the various local governments (authorities), and the public administration organisations directed by them control (supervise) compliance with the regulations.[98]

6.2. *Main European models of funding of health care services*

It is important to emphasize that the economic capacities of most countries – including Hungary – cannot keep pace with the advances and prices

95 Péteri Gábor, ‚Költségvetési és piaci megoldások egyensúlya. Területi közszolgáltatások pénzügyi szabályozása' in Horváth M. Tamás (ed), *Kilengések. Közszolgáltatási változások*. [Swings. Public service changes] (Dialóg Campus 2012) 30.
96 Ibid.
97 Hoffman István, 'A területi közszolgáltatások európai szabályozási modelljei az egészségügyben' [European regulatory models of territorial public health care services] in Horváth M. Tamás (ed), *Kilengések. Közszolgáltatási változások* [Swings. Public service changes.] (Dialóg Campus 2012) 196.
98 Horváth M. Tamás, *Közmenedzsment* [Public management] (Dialóg Campus 2005) 120-121

of medical technology. Every country needs to face the fact that there is a growing gap between the medically possible and the economically affordable. This is also due to the fact that the large systems have become ‚overloaded' everywhere; the health care and pension systems face a true crisis due to the economic crisis, to the demographic trends (ie aging) as well as to the lack of long-term planning. The poorer countries with worse economic positions are more affected than the richer countries with a better economic situation, which can devote a larger share of their gross GDP to support a modern health care system. The fundamental problem of every health care system is the way in which accessibility as well as the equality of opportunity and the appropriate standards of care can be ensured through the amount spent on health care.[99]

For the understanding of the role of the state administration and local governments in the field of the health care it is necessary to review the major models of funding of these services:

The first model is the *liberal (Anglo-Saxon)* which offers typically means-tested benefits. The second one is the *continental (Bismarckian)* model, which is based on the social security system. The *Mediterranean (Southern European)* model is distinguished by several authors. It is based on the family care and the social security system, but lower social security level is offered. Significantly different is the *Scandinavian (Nordic)* model: it is mainly funded by taxes and universal benefits are offered by it. The pre-welfare, poor care systems are distinguished by several authors and they are classified as the *residual* model.[100]

The financing of health services is significantly determined by the welfare model of the given country and three main approaches have been evolved. The first form is the health care system *funded by taxes*. In this model the health care benefits are services of a *universal nature*. The United Kingdom belongs to this model: after the Beveridge report a universal health care system, the National Health Service (NHS) has been established by the post-war Labour government. Therefore in

99 *The World Health Report 2013. Research for Universal Health Coverage* (WHO, Luxembourg, 2013) 8.

100 István Hoffman, ‚Some Thoughts on the Main European Models of the Municipal Health Services' (2013) 11(3) LEX LOCALIS – Journal of Local Self-government 633.

Great Britain the health care system is not based on the social insurance principle. Although the public (national) health care system is a universal one, but the public expenditures on health services were lesser than in the Continental countries until the reforms of the Labour Governments of the Millennium.[101]

The Swedish and Danish health systems provide universal care funded by taxes, as well, but the services of the Nordic countries are wider and higher level.[102] A transition model is followed by Spain, where the health care is funded by taxes but the cash benefits of the health (for example sick and the maternity benefits) are funded by the social insurance.[103]

The second approach is based on the Continental (Bismarckian) welfare state conception, where the health care systems are typically financed by the social insurance.[104] In these countries state benefits are granted to the following persons: the compulsorily insured persons, their family members and the persons whose insurance is paid by the state. The majority of the European countries – for example Hungary[105] – belong to this model.[106] A common characteristic of these systems is that health care is financed state or state-recognized insurance. A *special model* has been evolved in The Netherlands after the 2006 health care reforms. The former system based on the state insurance and the supplementary private insurance was replaced by the competition of the private insurers. Although the private insurers compete for the insured people – who are considered as consumers –, the system is a compulsory social insurance system, where the insurers are under strong state supervision. The activity of these insurers is regulated widely by the social law. Therefore the

101 Ibid. 634.

102 Esping-Andersen, G., Ismét a Jó Társadalom felé? [Again towards a Good Society?] (2006) 17(6) Esély 16.

103 Schmid, J., Wohlfahrtstaaten im Vergleich (Opladen: Verlag Leske + Budrich 2002) 277.

104 See also: Homicskó Árpád Olivér, 'Az egészségügyi szolgáltatások rendszertana' [System of the Health Care Services] (Jog és állam 16., Károli Gáspár Református Egyetem Állam- és Jogtudományi Kar 2010) 67.

105 We have to add that nowadays almost 50% of the publicly financed healthcare is funded by taxes in Hungary.

106 Ibid. 278.

Dutch system is considered as a special social insurance model.[107] The health care reform issues of several countries have been impacted by the social insurance model based on the competitive insurers.[108] Thus in Germany the insured people can choose among the insurers. In Germany traditionally operated several insurers: different groups had different insurers. After the reform of the 5th Book of the Social Code *(Sozialgesetzbuch)* the insured people can chose the insurer quite freely.[109] Therefore a competition has been evolved between the health insurers *(Krankenkassen)* which are defined as corporate self-governments by the German public law. A different type of competition has been evolved in Switzerland, where the social insurance system is based on the duality of the mandatory basic insurance *(Grundversicherung)* governed by the public (social) law and the additional insurance *(Zusatzversicherung)* governed by the private law. *The Hungarian reform efforts in 2007/20082 attempted to follow several elements of the Dutch and the Swiss models: it would have been based on the competition of the partly private insurers and on the principle of additional insurance.*[110]

The third main model is the *decentralized one*. Those countries belong to this form whose health care is funded by the public and private resources but the system is managed mainly by the private insurers. In this form the state insurer is not compulsory and it provides care typically for the elderly and deprived persons. The private insurers are governed by the private law especially by the capital market regulation.[111] The health care system of the United States of America could be described as a typical decentralized one, but the national health care – which is financed by taxes like the NHS in the UK – was significantly extended by the health care reforms of the Obama government.[112]

In summary: regarding the main sources of financing health insurance coverage one needs to highlight public funding on the first hand, in

107 Kirch, W., *Encyclopedia of Public Health* (Springer Verlag 2008) 657-658.
108 Ibid. 658.
109 Waltermann, R., *Sozialrecht* (C. F. Müller 2011). 76.
110 Hoffman ‚Some Thoughts on the Main European Models of the Municipal He*alth Services*' (n 100) 635.
111 Ibid.
112 Bowman, A. – Kearney, R., *State and Local Government* (Wadsworth 2012) 493.

which health insurance is financed by the taxes collected by the state or by income-proportionate, targeted taxes such as social insurance contributions; on the other hand private health insurance need to be mentioned which is in fact the ensuring of a service for a defined scope of services, which is budgeted from private (not income-based) payment (insurance fee) within a risk community established by the insurer. The content of the insurance is usually predetermined in a contract between the insured and the insurer, which sets out the terms and conditions of payment of the coverage for health care. The two basic methods of financing do not exist in a mutually exclusive way. It can be observed that all health care systems are increasingly trying to incorporate elements of competition, even if the given health care system is essentially state tax-based or social insurance-based. While the market-based elements containing items of market interests have a positive impact on operation, the state responsibility regarding wide range of benefits makes health care safe.

6.3. *Role of the local and the central government in the field of health services*

The direct and exclusive public provision of the services was replaced by the New Public Management reforms. The new system was based on the share of the roles. Four main roles are distinguished by Tamás M. Horváth. The first role is the recipient (‚consumer'), the second is the service organizer, which ‚orders' the service form the providers. The third role is the provider, whose legal status could be different (public or private bodies). The terms of the public services are defined by the central government or – in several cases – by the self-governments. These terms are monitored typically by the agencies of the central government (exceptionally the local self-government's representative bodies). Different share of these roles has been evolved in the different European countries.[113]

From a general point of view *the municipal health care services* are determined by the definition of them, the model of the funding, the public and private provider roles and by the municipal model and structure of

113 Hoffman ‚*Some Thoughts on the Main European Models of the Municipal Health Services*' (n 100) 635.

the given country.[114] Two main models of the local government health care can be classified: the first is based on the dominant provider role of the central government, and the second is based on the wide service provision of the municipal bodies.[115] *Main models of the municipal health care and their challenges. In those countries in which the central government has a dominant role in the provision of health care the local governments have not or just limited responsibility for the health care. Those countries clearly belong to this model where the central government or its agencies are responsible for the provision of the health care.* Having regard to the importance of in-patient care those countries belongs to this model, as well, where the basic services and several less complex outpatient care are provided by the local governments or their inter-municipal organizations. Obviously the central government or its agencies are responsible for the provision of in-patient services and the complex outpatient care.[116]

6.4. *Maintainers of the health care providers*

It has not been evolved state monopoly in the field of health care providers during the 20th century in the majority of the Western and Central European countries. The provider role of the churches and NGOs remained significant.

The private maintenance of the health care institutions was widely granted by the health care reforms in the 1990s.[117] The operation of the providers was transferred or the providers were actually privatized by the reforms inspired by New Public Management.[118] Thus the non-governmental providers have a significant role in the maintenance of the smaller institutes. For example in Germany in 2005 the public bodies were the maintainers of 35.1% of the hospitals, 38.2% of the hospitals were maintained by churches or non-profit organizations and 26.6% by for-profit organizations (corporations). In 1995 only 14.8% of the

114 Ibid. 638.
115 Ibid.
116 Hoffman 'Some Thoughts on the Main European Models of the Municipal Health Services' (n 100) 638.
117 Ibid. 637.
118 Horváth M. '*Közmenedzsment*' (n 88) 119–120.

hospitals were maintained by for-profit organizations. Similar process could be occurred in Hungary in the mid of the first decade of the new century where the maintenance of the smaller hospitals was transferred to corporations.[119]

119 Hoffman 'Some Thoughts on the Main European Models of the Municipal Health Services' (n 100) 638.

7. Health care and health insurance services in Hungary

7.1. *Introduction and historical overview*

The first mining health insurance was founded by János Thurzó in 1496. The first modern insurer was established in 1907, named Országos Munkásbetegsegélyező és Balesetbiztosító Pénztár (‚National Workers' Sick-benefit and Accident Fund').[120]

The first steps to overall health insurance took place in the Horthy era with the creation of Országos Társadalombiztosítási Intézet (lit. ‚National Social Insurance Institute') in 1928 (it is the predecessor of present-day Országos Egészségbiztosítási Pénztár). Social servises got complete to 1938, at that time the Hungarian social health insurance system was the most progressive and charitable in East-Central Europe.

After the World War II the Communist government fully nationalized the social insurance, since then Hungarian healthcare system is state-owned, overall and available for all of the people.

The free-market shift initiated after the end of communist rule 25 years ago put a strain on the largely centralised, wholly tax-funded public health system, which required far-reaching reforms. These resulted in the creation of the National Health Insurance Fund Administration (*Országos Egészségbiztosítási Pénztár,* herein after referred to as: OEP), in 1993.[121] The OEP, predominantly based on a social insurance system, is the public organization currently controlling the management of health care in Hungary. 80-85% of the financing for the health care comes from taxes[122] and other public revenues.

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120 Homicskó Árpád Olivér, 'A társadalombiztosítás szabályozásának alakulása a kezdetektől 1950-ig' [The develpment of the Hungarian Social Insurance System] (Acta Universitatis Szegediensis: Acta Juridica et Politica 9., SZTE ÁJK 2005) 283-320.

121 See more: White, Martin – Bojan, Ferenc, 'A new public health' (1993) 341(8836) Lancet 43.

122 See for example: Dévényi Péter, ‚Hungary: The New Hungarian Act on the Special Public Health Tax of Certain Products' (2011) 6(4) European Food & Feed Law Review 252.

In the field of health insurance after the change of regime (‚fall of the iron curtain') the government of József Antall re-introduced insurance-based health care financing (contrary to the previously applied health care treated as citizens' right), but it did not return to the insurance company system which operated more or less successfully before the war: instead the National Health Insurance Fund Administration (OEP) was established to perform insurance tasks as a state organisation, which finances health care services from the Health Insurance Fund *(Egészségbiztosítási Alap)* which manages its finances from contributions and other incomes.[123]

Social insurance (within which pension insurance and health insurance can be differentiated) is the autonomous, distinct, economy-based social subsystem of national economy based on social risk community, operating based on the principle of solidarity, with state guarantee. We need to mention at the outset that after 2010 Hungarian legislature developed a *state-dominated system* instead of the former *mixed system:* a public law, ‚enforcement oriented' turn took place.

During the public service provision reform of 2011/12 in the field of *territorial health care public services, Hungary established a centralised, state administration centred model which is similar to the Austrian model.*[124] *The former Hungarian system was based on the provider role of the local governments.* Departing from the previous regulation, the organisational system of state administration first overtook the in-patient institutions (and the integrated out-patient organisations) financed by the county self-governments, then those financed by the settlement level self-governments. According to the health care state secretariat, patient care becomes more efficient this way, as everyone will have equal access to hospitals. In line with the new regulation local governments are responsible only for basic health care services and exceptionally for certain specific special forms of care.[125]

123 See more: Homicskó Árpád Olivér, 'Az egészségügyi szolgáltatások finanszírózásának alapvető kérdései' [The Basics of the Financing of the Hungarian Health Care System] Jogelméleti Szemle 2007/3. http://jesz.ajk.elte.hu/2007_3.html.

124 Hoffman István, ‚A területi közszolgáltatások európai szabályozási modelljei az egészségügyben' (n 97) 203.

125 Biró Klára – Zsuga Judit – Kormos János – Ádány Róza, 'The effect of

In the new system, all the aforementioned health care institutions were placed under the financial management and operative supervision of the National Institute for Quality and Organizational Development in Healthcare and Medicines (GYEMSZI), a central office managed by the Ministry of Human Resources [EMMI, earlier Ministry of National Resources (NEFMI)].

Thus the health care reform of Hungary in 2011/2013 transformed one of the most decentralized service provision model of Europe to an Austrian-type partly centralized form.[126] It must be mentioned that there are several challenges related *to the model based on the dominant role of central government:* although the fragmentation of the health care could be avoided by the unified management of health services the centralized systems are more inflexible than the decentralized ones.[127]

Participation in the insurance scheme is mandatory for everyone in the workforce, including also the self-employed. Hungary has a tax-funded universal healthcare system, organized by the state-owned National Health Insurance Fund Administration (OEP). Almost 100% of the total population has an access to several health care services, that are absolutely free for children, mothers or fathers with baby, students, pensioners, people with socially poor background, handicapped people (including physical and mental disorders), etc. According to the OECD Hungary spent 7.8% of the GDP on health care in 2012, total health expenditure was 1.688.7 US$ per capita in 2011, 1.098.3 US$ governmental-fund (65%) and 590.4 US$ private-fund (35%).

Part of the costs of several public health care services are traditionally paid directly by the patient (e.g. the costs of pharmaceuticals, baths, certain dental services, work place health care), this part is the co-payment. A radically new element of this system was the visit fee (vizitdíj) introduced on 15 February 2007, and in case of hospital stay its counterpart, the hospital daily fee. Neither of these was able to remain in the Hungar-

financing on the allocation and production efficiency of the Hungarian health care system – Placing primary care into focus' (2012) 34(3) Society and Economy 433-451.

126 Hoffman 'Some Thoughts on the Main European Models of the Municipal Health Services' (n 100) 641.

127 Ibid. 640.

ian environment for long: as result of a ‚social referendum' (9 March 2008) initiated by the opposition, both were abolished after one year of existence. The proposals would cancel government reforms which introduced doctor visit fees paid per visitation and medical fees paid per number of days spent in hospital as well as tuition fees in higher education. All three[128] were supported by vast majority (82-84 %) of voters.

7.2. *Private health care in Hungary*

In 1990 the breakdown of the unified state health care system in terms of ownership started when the Ministerial Decree of 113/1989 (XI. 15.) on health care and social enterprises made them possible in the field of health care from 1 January 1990. Nevertheless in terms of the whole of the health care service system privatization did not take place, except for GPs and a number of health care professional fields (e.g. dialysis treatments), where private enterprise has become dominant in the early nineties.

The responsibility for health care was placed on the local governments by Act LXV of 1990 on local self-governments (Ötv.) – except for national institutions, university hospitals and specialized systems for emergency services (ambulance, blood supply) – in such a way that it was the compulsory task of the local governments to ensure replacing the system of local doctors with that of general practitioners or family doctors, while specialized care – if not undertook by municipal, mainly urban local governments – had to be organized by the county governments.

One of the characteristics of the privatization of health care – even in the fields where it was indeed carried out – was that it was not associated with the acquisition of the fixed assets needed in the services. *For example many of the GP or family doctor practices are located in municipal clinics, with partly government-owned equipment and tools.*

128 '1. Do you agree that inpatient care should be exempt from daily hospital fees with effect from 1 January in the year after the referendum is held on the present issue? 2. Do you agree that family doctor care, dentistry care and special outpatient care should be exempt from consultation fees with effect from 1 January in the year after the referendum is held on the present issue? 3. Do you agree that students in state-subsidized higher education should be exempt from tuition fees?'

In 2009 attempts were made to create a private insurance-based, multi-company health care financing system, but it was rejected in a national referendum, and the law on the system was repealed, so the centralized OEP and its regional bodies having the monopoly over health care was preserved [from 2011 they are organized in (by) government offices].

The most important characteristic of private health-care in Hungary is that although private health funds, private health insurance businesses as well as for-profit and non-profit service providers do exist in health care, their role, weight and their market share is below western European countries.

Market organisations are usually business organisations (mainly joint-stock companies and limited liability companies), while civil participants are usually registered as associations, foundations (not the same as public foundations), and churches.

It is an important novelty that the previous regulation regarding public benefit organisations[129] has been replaced with the Act CLXXV of 2011 on the right to association, on the status of public benefit and the management and support of civil organisations, *which did not strengthen the role of social organisations in the performance of public tasks.* The change of financing rules and the introduction of task financing (from 2013) does not facilitate the spread of alternative forms, different from state sources.[130]

The forms of organized private financing are:

1. Services paid out-of-pocket (private purchase) - this is the dominant form;
2. Private health insurance funds;[131]
3. Business insurance;[132]
4. Occupational health services (corporate manager check-ups, etc.).

129 Act CLVI of 1997 on public benefit organizations was in effect till 1 January 2012.

130 Horváth M. Tamás, 'Kiszervezés – visszaszervezés. Változások a magyar helyi közszektorban 2010-12' [Outsourcing – resourcing. Changes in Hungarian local sector 2010-12] in Horváth M. Tamás (ed), *Kilengések. Közszolgáltatási változások* [Swings. Public service changes] (Dialóg Campus 2012) 245.

131 For details see Act XCVI of 1993 on the Voluntary Mutual Insurance Funds, as well as Government Decree 268/1997 (XII. 22.) on certain rules of management of voluntary mutual health and self-help funds.

132 For details see the provisions of Act LX of 2003 on insurance companies and insurance activities.

The immediate – that is not financed through the social security system – expenditures of the households show extreme differences in the individual domains. For example in 2011 the Hungarian population spent about 173.7 billion HUF on dental care (about 800 million U.S. dollars), while ‚only' 9.2 billion HUF (approx. 40 million U.S. dollars) on gratitude payments in the same area. As opposed to this 6 billion HUF were ‚officially' spent directly on inpatient-care (about 25 million U.S. dollars), and 38.2 billion HUF (approx. 160 million U.S. dollars) on gratitude payments in the same area.[133]

The states provides indirect subsidies through the tax system as well, through which the employee is prone to direct health care expenditure and the purchasing of services, while on the other hand it makes the provision of certain health allowances beneficial for the employer. For example after paying the membership fee to the health fund, tax relief can be applied for, while primary prevention, the promotion of lifestyle change appears in the Széchenyi Pihenőkártya (SZÉP – leisure card) which can be offered as a fringe benefit (cafeteria), with a tax reduction for the employer. *The card can be used in many areas, and as such it provides services of recreation.*

7.2.1. Private health insurance companies and private health insurance funds

Although the private health insurance companies operating in Hungary are not as successful as the ones on the western European markets, there is an increasing number of those who do not consider the level of public health care appropriate on the local level as well. These are offered alternatives by the organizations of private health insurance.

The participants expect the improvement in public benefits by the expansion of private insurance companies they consider that due to the growing private health insurance market could for example reduce the migration of doctors and could take a serious burden off the shoulders of state service providers. The private health insurance companies (such as

133 Kincses Gyula, *Az állami és a magán egészségügyi ellátórendszer átrendeződése (előadásvázlat)* [The restructuring of the public and private health care system (lecture notes)] (BKF 2013) 9.

Generali-Providencia Biztosító Zrt., Uniqa Biztosító Zrt., Union Biztosító, Allianz Hungária Biztosító, MetLife Biztosító, Signal Biztosító, etc.) have had a more serious role in outpatient care. *Inpatient care is not as demanded as outpatient care in Hungary*, it is also more expensive, the costs of which (without state involvement) cannot be undertaken by many.

The outpatient care available at private health insurance companies (more exactly the so-called secondary or supplementary services existing besides state care) is relatively cheap, but according to the participating insurance companies few people are aware of the fact that by paying for example a 5000 HUF fee a month they can avoid the waiting list. The private health insurance companies typically work with private health care providers, and that is why their customers receive care in institutions with a better infrastructure than state institutions.

The main obstacle of the spread of such insurances is that the social security system currently pays nothing for those who receive health care services under business insurance. *Thus within the current health care system few insurance providers attempt to present a product that provides services to the insured. It is much easier to contract a certain amount, which is received by the insured from the insurer in case of sickness or in need of hospital care.* It also seems unfair that anyone who is part of the public health insurance system does not receive anything from there only because they purchased a private insurance policy as well – state operators today.

An example which illustrates the situation is the case of someone – ‚belonging' to the public health insurance system – who needs a CT scan,. In this case the analysis is paid for by the National Health Insurance Fund Administration, while if it is not a vital investigation, it has to be listed months in advance. *The reason for this is not the lack of capacity, but the fact that the National Health Insurance Fund Administration only finances a specific number of tests* – he says. If anyone contracts private health insurance services, gets to have the CT done within days and does not take the place of the ‚public patient', as the investigation is performed while the machine would be idle. *The downside of private insurance is that the public health insurance system does not contribute to it.* Thus private insurance will be expensive and – especially during times of financial crisis – potential customers will not be gasping for it.

According to experts if the public health insurance fund would pay 70% of the otherwise payable compensation to the hospital, and the private insurers would do the same, everyone would benefit from it. The government would spend less, the hospital would receive more money, and private insurance *would be cheaper than they are at present,* as today the full expenses of the service need to be included in the fee. The cheaper private insurance would bring more customers to the insurance companies; joint financing would leave more resources at the public health fund, and would increase hospital revenues.

Of course this construction would require a more effective management of all aspects of the health care system. Public health care providers are usually not prepared to provide private services:

1. *the legal background is incomplete;*
2. *there is no adequately distinguished (distinguishable) capacity; and*
3. *there is a lack of proper care culture.*

It also needs to be mentioned that by 2013 with the closing of the Telki Hospital, the only – not church-run – private hospital in Hungary is Dr. Rose. Its system of inpatient care offers a high quality and complex care for the patients, in defiance with the extensive gratitude payment system existing in Hungary, as well as with the mixed financing model developed through the activity of the private health insurance companies and health funds, in which the people requiring inpatient care eventually always go back to the public service system mainly because there they do not have to pay for the actual costs of care.

The private health insurance funds (voluntary mutual health funds) organize and offer to their individual members (or the close relatives of these) services completing or even replacing social insurance care.

Here in principle it is also possible that the health fund operate health care institutions as an internal department, however this is quite unprecedented.[134]

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134 See Article 2 of Government Decree 109/1997 (VI. 25.) on the operational and management regulations of the health care institutions of voluntary mutual health funds.

http://hungarianspectrum.wordpress.com/tag/uzsoki-street-hospital/> accessed 25 June 2014

7.2.2. The Uzsoki-model

We have to admit that in Hungary hospitals can perform only a limited number of procedures (medical treatments) even if they have the capacity, in terms of both personnel and equipment, to perform more (treatments).[135] Thus, their capacity is not fully utilized.

The *Uzsoki-model* makes an attempt to face this problem: *patients who sign a separate contract with the hospital forfeiting their right to health insurance receive immediate health services (medical treatments) for a reasonable amount of money.*

What are the benefits of this arrangement for the patients? *First of all, there are no endless waiting lists.*[136] In some hospitals one has to wait two or three years for certain procedures. The waiting lists are especially long for knee and hip replacements. If the patient is ready to pay 1.2-1.7 million forints (approximately 5,000 euros) he or she can have his/her operation, and the physical therapy that follows the procedure *within a couple of weeks.*[137]

Within Uzsoki Hospital (Budapest) the members of the support staff work with these private patients as independent contractors. Their work in the private section of the hospital is carefully separated from their activities as employees of the hospital.

So, this model makes it possible for publicly financed health service providers to provide private services using their free capacities in a transparent way. It also enables private capital to be involved in finances of health services in a more radical way, e.g. letting in private health insurance funds.

It must be noticed that the Uzsoki-model is still a kind of *pilot-project,* the legal background of which has not been fully created yet.

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135 Government Decree 287/2006 (XII. 23.) on waiting lists.
http://hungarianspectrum.wordpress.com/tag/uzsoki-street-hospital/> accessed 25 June 2014

136 Dr. Bekényi József, 'Megújult a magyar önkormányzati rendszer' [The Hungarian local governmental system has been renewed] (2012) 14(1) Jegyző és Közigazgatás 6.

137 Józsa Zoltán, *Önkormányzati szervezet, funkció, modernizáció* [Local governmental organization, function, modernization.] (Dialóg Campus 2006) 188.

8. The transformation of Hungarian public administration

8.1. *Introduction*

As is is well known, in the spring of 2010 the FIDESZ-KDNP gained an outstanding, more than 2/3 majority – regarding the collected mandates – at the parliamentary elections, after which within a short period of time it has performed an in-depth transformation of the whole legal system. *It is impossible to overestimate the significance of this fact:* on the one hand, the 2/3 majority established a fortunate historical opportunity for the realisation of necessary structural reforms which have been postponed in Hungary for more than thirty (!) years, related to the great service provider systems, but at the same time it has increased the chances of legal voluntarism and of exercising power by applying only formal consultation procedures.

Within the transformation of Hungarian public administration, it became obvious after 2010 that the modification of the frameworks of certain administrative sub-systems – e.g. the local governmental system – may come to completion only together with the revision of other elements of state organisations, and together with the reform of the great service provider systems, which means that only the thorough consideration of every element of the whole system – with regard to each other – may result in permanent success.[138]

Among questions most often mentioned after the change of regime, the ideas for the clarification of the role of counties must be mentioned, with special regard to the regionalisation processes and intentions. A substantial debate has been going on for more than three decades concerning whether the ‚Hungarian county system, as a geographic, territorial, administrative unit is adequate to the tasks of modern public administration'.[139] Intentions striving for the rescaling of the geographic structure of public administration and of its power levels usually resorted to the concepts of small region, district, county, great county, region, self-governmental region. The literature has always insisted that deci-

138 Pálné Dr. Kovács Ilona, 'Középszintű reform és/vagy területi léptékváltás' [Medium level reform and/or territorial level shift] (2010) 3(1) Új Magyar Közigazgatás 13.
139 Ibid.

sions about the structure of levels – which have become more urgent with the passage of time – should be preceded by – thorough – analyses and model calculations, with the help of which it may be determined ,from the aspect of the infrastructure and institutional system of local governmental public service provision and their accessibility what the optimal territorial division is for the comprehensive supervision of the performance of tasks in the short and long run'.[140] Up to the 2010s, the majority of authors identified the necessary reforms from the aspects of the continuation and increase of decentralisation, while the practice of the past few years shows a completely new – centralising – tendency. The previous point of view regarding this issue is well summarised in the thought of the most cited author, Ilona Pálné Dr. Kovács: ,The reform of Hungarian territorial public administration is necessary not only because counties are small or large, but in order to create the conditions of a real, strong decentralisation.'[141]

An issue related to the above mentioned set of problems – which has existed for a decade – is that the territorial coordination of state administration is traditionally weak in Hungary. After 2010, the centralisation of the previously divided, difficult to coordinate authority system started (was completed); several originally independent authority organisations integrated into the metropolitan and county government offices operating as territorial body of the Government, and another important change is that the state administration tasks of local governments are gradually transferred to the newly established administrative organisation type: on 1 January 2013 approximately 80 authority tasks were transferred from the local clerks to the new district offices.

At the same time, the aforementioned significant modifications – supplemented with the realised plan of the transfer of human public service provider institutions to state maintenance from the competence of local governments – are the most important areas of the *Magyary Zoltán Public Administration Development Programme* from the aspect of the client; hence the partial concentration of territorial organisations in regional government offices, the establishment of district offices, the division of

140 Péteri (n 95) 30.

141 http://www.nki.gov.hu/files/szervezet/tevekenyseg_mukodes/Rezume_forditasai_2012_masodik%20szamig.pdf >accessed 7 July 2013

local state administration tasks between the clerk and the district offices.

However, despite the aforementioned – and to be described – significant changes, it must be stated that in the literature of administrative law, some issues which seemed to be important in the past few decades (Hungary's administrative territorial division, region-county-small region problem, etc.) are partly mock issues, in so far as in a family with two children the situation of offspring may be critical, while a four-generation family living in a single household is able to provide excellent emotional, psychological and physical development and self-realisation for its members. Like the individual success of the members of a family, the functional maturity of different administrative levels and units may be guaranteed by the appropriate division of tasks and clear procedures determining their individual relationships, as well as by a network of relationships which also include accessible, conscious and emotional elements. In such an approach, there are much more important issues than the number of administrative levels: e.g. whether the proper regulation of administrative contract has been established, public procurements have been settled properly, and further – *as we have seen, not only legal* – guarantees against corruption, etc. have been created; namely whether those fundamentally significant institutions are established which are really able to support a relatively high – multi-storey and probably eclectic-style – ‚building'.

8.1.1. New tendencies within public task performance in Hungary

8.1.1.1. Tendencies up to 2010

It may be generally stated that in the past three decades *(from 1980 to 2010)* the catalogue, system of criteria and content of public tasks have been significantly transformed. On the one hand, the scope of community tasks has extended, which appeared in the growth of budgetary, especially social and health care expenses, and, on the other hand (up to the recent past) the role of state-governmental public service providers which earlier enjoyed a monopoly decreased, and in parallel with this decision-making and management procedures have become more open.[142] *The expansion*

142 Ibid.

of state tasks (public tasks) – in line with international trends – has been continuous in Hungary in the past few decades, even though in certain periods due to increasing outsourcing, the addressees of laws and the actual performers were significantly different from each other.

8.1.1.2. Determinative directions. NPM and its rivals in the reflection of Hungarian science and practice

In Hungarian science one of the main issues – for almost a decade – has been the question of what replaces the *New Public Management's* solutions and processes weakening the state and public administration in various ways – or in other words: its clear, ‚classic' methodology.[143]

One of the reasons of uncertainty reflected by science is that while official policy – at the level of evasions – continuously refuses to use *clearly* market solutions in public administration, practice still shows that the majority of these practices – in some form – are present and enforced. Another firm sign of temporality is that the criticism formulated against NPM has not been collected into one comprehensive concept yet: even though there are some keywords (e.g. neo-Weberian model – see below), there are still serious doubts about their utility, as we will see later.[144]

Nowadays Hungarian legal literature has dealt more and more with the features of the main management schools handling the organisation issues of public services, as well as with the categorisation of the tools offered by them. As such we shall mention NPM and the governance approach strongly representing the ‚horizontal reform directions' based on the criticism of NPM, as well as the neo-Weberian approaches already mentioned – as well as the ‚well-distinguishable' market, society and state-friendly schools. [145]

143 Gellén (n 41) 5.

144 Radó Péter, ‚A szakmai elszámoltathatóság biztosítása a magyar közoktatásban' [Ensuring professional accountability in Hungarian public education] (2007) 11(12) Új Pedagógiai Szemle 6. http://epa.oszk.hu/00000/00035/00119/2007-12-ta-Rado-Szakmai.html > accessed 4 August 2013

145 Rosta Miklós, *Innováció, adaptáció és imitáció – az új közszolgálati menedzsment* [Innovation, adaptation and imitation – new public services management] (Corvinus 2010) 107.

The New Public Management approach expects the strengthening of accountability from the strengthening of ‚consumer influence' and from expanding the opportunity to choose (from the stronger enforcement of individual interests than before), and focuses on the efficiency of control mechanisms. Among its tools there are the strengthening of competition, simulation of market relationships, demand-side financing, measuring the performance of public services, application of market motivators (e.g. performance based financing, performance based wages), ‚consumer' support services, strategic planning, deregulation and application of standards, repression of the community use of service provider experts.[146]

Harsh criticism formulated against NPM techniques and approaches at the end of the 2000s – following the increasingly mixed, rather negative general appreciation Polidano (1999); Denhardt-Denhardt (2000)] – clearly emphasized their failure [Hughes (2008); Lapsley (2009)], and the obvious dysfunctions – effects hampering the achievement of targets – of solutions introduced elsewhere in imitation of the Anglo-Saxon model [Cameron (2009)].[147] However, in some fields of Hungarian public administration some NPM-related techniques were introduced in the 2000s.

The majority of criticism maintains that the internal controversies of NPM cannot be eliminated, in so far as e.g. the related community decisions theory and the manager approach formulate/formulated controversial requirements in the relationship of politicians and bureaucrats, bureaucrats and service providers, and citizens which expressly contravene with each other.[148] The previous approach supports the increased control of bureaucracy, the multi-player coordination of activities and their stricter regulation, contrary to the latter one, which – in a simple

146 Ibid. 108-109.

147 Ibid. 108-110.

148 Vass László, 'Az új közmenedzsment és a hatékonyság javítása a közigazgatásban' [New Public Management and the improvement of efficiency in public administration] (1998) 48(2) Magyar Közigazgatás 63; and Vadál Ildikó, 'Korszerű közigazgatás – avagy: kényszer szülte megoldások a közszolgáltatások szervezésében' [Modern public administration – or forced solutions in the organisation of public services] (2000) 50(1) Magyar Közigazgatás 1-6.

way – supports the higher degree of the freedom of decision making and the deregulation of the related rules. These controversies result in these models in the spread of formally perfect, but otherwise hardly transparent ‚quasi' contracts instead of real ones, and the expansion of one-target organisation reduces the controlling ability of the central government, and eventually as result of these, the operation of public administration becomes less easily monitored.[149]

Obviously it must be kept in mind that NPM is rather a movement, or moreover: a way of thinking, thus it does not appear to us as an exact collection of norms: its real advantage is that come of its solutions may offer a real alternative for increasing efficiency in certain fields, and its notions and solutions allow for given (public) administrative systems and subsystems to be evaluated and compared. *In several regards it cannot be answered whether within the provision of public services or in relation with the broadest sense of the provision of public services the NMP methods were applied in Hungary consciously or not; whether in reality they were incorporated into the selection of domestic methods by adapting external patterns, or they are results of ‚internal self-improvement' or of ‚coincidence emerging from daily political interests'.* However, knowledge about the general features of Hungarian public policy and of the legal system, the significant temporal ‚delay' of the introduction of certain solutions, and the ‚fragmentised, compromise-like' feature of the applied tools indicate that it would be a mistake to dedicate excessive – or maybe exclusive – attention to this approach in the description of Hungarian public administration. Nevertheless, the existence or lack of these tools – attached closely to NPM – or the time of their introduction may orientate the reader well in several fields, by this providing for the drawing of conclusions.

It is not possible to draw conclusions about the operation principles or self-picture of the state from the mere existence of NPM tools: these tools are applied by every democratic state, and significant differences may be observed only regarding their specific features and the degree of their application. In domestic literature, NPM primarily means a way of think-

149 Among others: Gajduschek György – Hajnal György, *A gyakorlat elmélete és az elmélet gyakorlata* (HVG-ORAC 2010); Pálné Kovács Ilona, 'Magyar területi reform és uniós fejlesztéspolitika' [Hungarian territorial reform and EU development policy.] (2007) 168(10) Magyar Tudomány 1306-1316.

ing and a set of tools which may be derived from it. Domestic literature has reflected on international dilemmas related to this topic for long.[150]

After the more than one and a half decades hegemony of the NPM approach and then (during) the observation of its failures, the theory (society approach) of ‚good governance' urging the change of approach – more precisely, renewal *still on a liberal basis* – and favouring a network system also appeared in Hungarian theory, which in the public policy decision making processes focuses more on multi-player operation based on partnership, instead of state dominance.[151]

The developments of the first decade of the new millennium brought about a brand-new paradigm, when due to capital market and other crises, state-centred solutions are clearly appreciated again. The neo-Weberian approach – keeping in mind the Weberian heritage – should be a public law type legal certainty, a rule of law and democracy approach based on normative foundation. However, many question whether the practical solutions derived from this theory reflect this or not.

In domestic literature, state-centric theories are often formulated expressly against NPM,[152] ‚[which] cannot be identified with the rejection of the everyday tools of public management (such as program planning, strategy making, tender funds, etc.), because this is a different genre with very different issues'.[153] Rejection, therefore, is an unfortunate simplification – states Tamás M. Horváth – because a social task organisation culture useful in every era and situation is sacrificed on the altar of the evaluation of state roles.[154]

By today – as referred to previously – opinions about the role of the state have strengthened which clearly favour the neo-Weberian state ideas against the *(New) Public Management state concept:* in so far as they state

150 Lőrincz Lajos, 'Közigazgatási mítoszok és valóság' [Administrative myths and reality.] (2007) 1(2) Közigazgatási Szemle 7-10.; G. Fodor Gábor – Stumpf István, 'Neoweberi állam és jó kormányzás' [Neo-Weberian state and good governance] (2009) 1(7) Nemzeti Érdek 11-14. and Hosszú Hortenzia, 'Az állam szerepe a kormányzásban' [The state's role in governing] in Gellén Márton – Hosszú Hortenzia (eds), *Államszerep válság idején* [State role during the crisis] (Complex 2010) 53.

151 Horváth M. 'Közmenedzsment' (n 98) 87.

152 Ibid.

153 Lester M. Salamon, 'The rise of the nonprofit sector' (1994) 73(4) Foreign Affairs 2.

154 Hosszú (n 152) 53.

that instead of the aspects of cost efficiency and result orientation, and as a result of these the ‚reduction' of the state, the ‚loss of its magic', and the increasing outsourcing of state functions a (more) active and stronger state should be built. Since the 1970s it has become more usual that different governments financed a broad scope of welfare services, but they commissioned the real service provider role to for-profit or non-profit organisations. This way, temporarily, the expansion of welfare services was manageable without the material broadening of bureaucracy.[155] The success of the new public management was disputed already in the 1980s: some believed it was a panacea, while others pointed out that with the introduction of the new theory, *at most only a small percentage of the costs of public institutions could be saved.*[156]

Newer approaches consider the maintenance of the requirements of the rule of law and the further enforcement of certain efficiency aspects important, but they also believe that the material incorporation of the elements of strategic thinking and strategic planning into public policy is unavoidable. The supporters of a stronger state – who also favour the importance of *good government* against the same of *good governance* – reason that the basic requirements of *transparency, accountability and responsibility-taking* may be possible only where the revised strategy of cooperation between state and private sector is introduced – e.g. contrary to the uncertainty of outsourcing and PPP constructions which relativized away strict limits.[157] *PPP construction proved to be especially unsuccessful in Hungary:* studies prepared by the Development and Methodology Institute of the State Audit Office of Hungary have clearly showed that for the foundation of the projects market surveys and impact studies about the possibilities of realisation were usually missing, moreover, economic and cost comparison calculations were not

155 For details see e.g.: Boros Anita, ‚PPP-Projekte in Ungarn' in Jan Ziekow (ed), *Wandel der Staatlichkeit und wieder zurück?* (Nomos 2011) 150-177.

156 Báger Gusztáv, *A köz- és magánszféra együttműködésével kapcsolatos nemzetközi és hazai tapasztalatok* [International and domestic experiences about the cooperation of public and private sector] (Állami Számvevőszék Fejlesztési és Módszertani Intézet 2007) 63.

157 György Hajnal – Gábor Pál, 'Some Reflections on the Hungarian Discourse on (Good) Governance' [Working Papers in Political Science 2013/3., MTA TK (Institute for Political Science, MTA Centre for Social Sciences) 2013, 3.] <http://www.mtapti.hu/uploaded_files/8519_2013_03_hajnal_pal.pdf >accessed 9 June 2013.

made (!) at all; most constructions did not meet the basic (classic) requirements – focusing on the interests of the state – formulated towards PPP investments, in so far as during such investment the realisation (construction), stand-by and operation risks should be undertaken by the investor.[158]

The contents of the expression *'Good Governance'* is almost fully identified with the New Public Management approach and its contents in the domestic literature.[159] In addition to G. Fodor and Stumpf we may also mention Egedy[160] and Frivaldszky[161]. Hajnal and Pál indicate that in a significant part of domestic literature – *contrary to international literature trends* – the homogeneous conglomerate of good governance and NPM ideas are put into contrast with a raw, *simplified way* with good government ideas and the neo-Weberian approaches identified with them.[162] One possible explanation for this is quite obvious: both the NPM approach(es) and Good Governance ideas originate from (neo) liberal ideological foundations, regardless of the fact that the latter also provides for the partial or full criticism and correction of NPM. If we also add that regarding all approaches mentioned in this work, their delayed, partial and often inconsistent, sudden introduction into the Hungarian environment is a fact, it becomes obvious – or reasonable – why domestic literature resorts to the tools of polarisation, simplification, unification, etc., even if they go against the narrowly interpreted erudition. Where these practices and specific solutions were finely tuned during three decades, the more precise differentiation, finely tuned separation of these

158 Egedy György, ‚A kormányzás parancsa' [The order of governing] (2009) 5(5) Polgári Szemle 22. <http://www.polgariszemle.hu/app/interface.php?view=v_article&ID=331>accessed july6 2013

159 János Frivaldszky, 'Jó kormányzás és helyes közpolitika-alkotás' [Good governance and proper public policy making] (2010) 11(4) Jogelméleti Szemle 22. <http://jesz.ajk.elte.hu/frivaldszky44.html>; and János Frivaldszky, 'A jó kormányzás és a helyes közpolitika formálásának aktuális összefüggéseiről' [On the actual contexts of forming good governance and proper public policy] in Szabolcs Szigeti – János Frivaldszky János (eds), A jó kormányzásról. Elmélet és kihívások. [On good governance. Theory and challenges] (L'Harmattan 2012) 51–103.

160 Hajnal – Pál (n 159) 8.

161 Horváth M. Tamás, *Helyi közszolgáltatások szervezése* [Organisation of local public services] (Dialóg Campus 2002) 15.

162 Ibid. 23.

theories and approaches is obviously reasonable, moreover, unavoidable. However, in cases when the certain specific features of these approaches were not introduced, or only introduced in a fragmentised form, and only at the time when it was already in decline abroad, the theoretical, rough-and-ready discussion is at least understandable.

8.1.1.2.1. NPM and the Hungarian health care system

The reasons for using ‚NPM-type' solutions within Hungarian health care system were rather connected with the goal of budgetary savings, than with the intention to apply any scientific theory.

From the beginning of the 2000's, paralelly with or against NPM solutions and trends, certain *Good Governance* practices have gained ground in Western European countries, e.g. the involvement of professional entities in decision-making processes and the sharing of planning functions with affected parties. However, ‚NPM-type' solutions and practices are still vivid in Hungary: it's observable that the Government tries to strengthen the legal forms of self-care and supplemetary insurance, moreover, it tries to generate market-based competition in the healthcare sector.

(See also the 7.2.2. subchapter on the Uzsoki-model)

8.1.1.3. Notion of public services in Hungary

Even though the definition of public services has not been clarified yet in Hungarian law, as a broad starting point we may accept that ‚public services refer to the provision of tasks which under the given circumstances, up to a certain level, require community organisation and aim at satisfying common social needs'.[163]

The cataloguing of public services may be easier if we list the groups of tasks which are generally considered as ones belonging to this scope. Such tasks may be, among others, health care and health insurance services.[164]

163 Kökényesi József, 'A helyi közigazgatás szervezési tendenciái' [Organisational tendencies of local public administration.] in Horváth M. Tamás (ed), *Kilengések. Közszolgáltatási változások* [Swings. Public service changes] (Dialóg Campus 2012) 264.
164 Péteri (n 95) 35.

8.1.1.4. Provision of public services

Following the change of regime, services operating with nationwide networks – earlier state monopolies – such as railway transport, postal services, media, program transmission services and energy supply, were privatised in the form of services of public interest, after their transformation to liberalised services. Health care, social and education services were realised mainly under the responsibility and organisation of the state, and the county and settlement local governments, depending on the level of services.[165] After 1990, the Hungarian financing system of multi-sectored, decentralised public services was completed by the establishment of more or less sector-neutral financing solutions for the support of alternative service-providing institutions.[166]

There is a tendency that the participants of the private and non-profit sector, business associations, social societies, foundations and associations have also been integrated into the provision of public services, in addition to the budget bodies.[167]

However, the more or less classic forms of outsourcing have been significantly limited by the valid legal regulations, in so far as, for example, the Nvtv.[168] introduced the category called transparent organisation.[169] In addition to this, the present Hungarian tendencies show that in the organisation of public services, business associations in the exclusive ownership of state and/or local governments have become significant, which means that the role of private and mixed businesses has decreased in the provision of local public services.[170] Regarding civil organisations

165 Böszörményi Judit – Nagyné Véber Györgyi, *Az önkormányzati feladatellátás alternatív megoldásainak jelene és jövője* [Present and future of the alternative solutions of local governmental task performance] (SALDO 2008) 9.

166 A nemzeti vagyonról szóló 2011. évi CXCVI. törvény [Act CXCVI of 2011 on National Assets].

167 Előházi Zsófia, '„Házon belüli" beszerzés a helyi közüzemi és kommunális szolgáltatások szervezésében' ['Internal' acquisition in the organisation of local public utility and communal services] in Horváth M. Tamás (ed), *Kilengések. Közszolgáltatási változások*. [Swings. Public service changes] (Dialóg Campus 2012) 177.

168 Kökényesi (n 165) 266.

169 Péteri (n 95) 29.

170 Ibid. 47.

sectoral rules and the Nvtv. regulate the procedures and conditions of the conclusion of contracts much more strictly than before, thus those based on which those may participate – among others – in the provision of public services of the local governments.

With regard to this it must be stated that nowadays in the organisation of Hungarian public administration the German NPM-based model of the 1980s and 1990s, *the das neue Steuerungsmodel* (NSM) may be observed. The NSM wanted to preserve state property, but instead of the previous public law solutions (public institutions, public companies), it used private law solutions: business associations in exclusive or majority ownership of the state or self-government, in case of which acts regulated the exclusive or majority ownership of the state or self-governments. Presently we are witnessing the spread of a similar model in Hungary. It is enough to think about Article 41 paragraph (8) of the Mötv., the exclusive state or local governmental business activities of the Nvtv., expanded state non-profit business associations and local governmental holdings.

It seems that changes started in the period of economic recession starting in 2008, when several conditions affecting the operation of local governments were modified at the same time. In Hungary the political environment changed at this time and an environment supporting centralisation has existed since then. However, the indebtedness of the whole governmental sector and the strengthening of general criticism against market service organisation solutions are parts of a longer process.[171]

The possible advantages of the previous, strictly centralised local public service provision system were only partly enforced, among the reasons of which underfinancing, continuously shrinking budgetary sources of the past decades shall be mentioned.[172] In the new local governmental financing system, due to the decreasing own and shared incomes, dependence on central support will probably be more significant.[173]

‚In general we are witnessing a process in which regulations strictly react on previous outsourcing attempts, allowing the participation of non-state actors in the provision of public services and the financing of

171 Ibid.

172 Horváth M., 'Kiszervezés – visszaszervezés' (n 130) 245-246.

173 Gellén (n 41) 14.

these activities, or other kind of resource allocations. Some objections related to these may be justified up to the level of certain “diversions”, such as corruption, downgrading or “transfer” of public property or other criminal acts. Even though these do not have much to do with real outsourcing, based on this idea, the attempt to “re-do” all the controversial procedures may be observed in the strengthening of state roles at local-regional level. At the same time, however, within public administration state roles are strengthens compared to local governmental ones.’[174]

8.1.1.5. Types of public task performance

In addition to the traditional public policy question, asking which activities belong to the catalogue of public tasks, it is also important who performs these and under what authorisation and state support. Within the scope of presenting Hungarian public administration ideas, the analysis of the staff number and number of public administration institutions of the past two decades is very important, which – often – presents these as practical competition between the aspects of efficiency and effectiveness.[175] The governmental cycle after 2010 brought about some novelties in this sense, in so far as it obviously refused some of the solutions favoured by public management: the abolition of PPP-constructions within the solutions of the performance of public services started, the obligatory private pension fund system was abolished and the sector neutral state approach came to an end, even as a sceptical approach may be observed about the outsourcing of human public services.[176]

Regarding the types of public task performance, it may be stated that the primary form is the activity performed in a classic organisational structure, typically with

174 Horváth M. Tamás, ‘A közmendzsment változásai’ [Changes of public management] in Fazekas Marianna (ed), *A közigazgatás tudományos vizsgálata egykor és ma. 80 éve jött létre a budapesti jogi karon a Magyar Közigazgatástudományi Intézet* [The scientific analysis of public administration in the past and today. The Institute of Hungarian Public Administration was established 80 years ago at the law faculty of Budapest] (Gondolat Kiadó 2011) 93.
175 A novelty of the act was that it expressly appraised public power and public service provider budgetary organisations as separate categories.
176 Lőrincz Lajos, *A közigazgatás alapintézményei* (HVG-ORAC 2005) 241-242.

public sector civil servants. This usually targets public power (authority) type tasks, which traditionally mean the narrowest terrain of public administration, and the transfer of which is usually unreasonable due to the reasons of legal certainty and other guarantees. Among these we may mention the management of public registers, the issuance of permissions and certificates, and especially the direct application of force and sanctioning.

The second solution is the establishment of a so-called network of public institutions, primarily as conscious state (local governmental) step. The state creates these, because in certain fields due to the lack of expertise and other resources, separating the activities, the organisation and the staff seems to be useful. Traditionally the following may be put into this scope: a) public utilities (public companies), which basically provide for the performance of industrial and trade needs in the form of a business association, and are – more or less – in state or local governmental ownership; b) public institutions, which – typically – perform mainly the human public services already mentioned, usually with a staff of public servants, and with non-market price service; c) public bodies, which are organisations established by the law, performing public tasks, having their self-government and registered members (such as economic and professional chambers, wine communities, the Hungarian Academy of Sciences, etc.); d) public funds, which are created for the continuous provision of public tasks; and finally e) non-profit business associations (the previous public benefit business association type has been abolished in the Hungarian legal system, and the already existing ones were transformed into non-profit business associations).

In this context it should be mentioned that the public institution, public organisation and public utility expressions existed *mainly* as scientific auxiliary notions until Act CV of 2008 on the legal status and financial management of budgetary organisations formulated them as sub-types of public service provider budgetary organisations. The new institutions created by the law did not prove to be successful;[177] theoretical and substantive controversies broke the act down, and it was annulled by Parliament in 2010, returning to the previous – imprecise – regula-

177 Patyi András – Varga Zs. András, *Általános közigazgatási jog (az Alaptörvény rendszerében)* [General administrative law (in the system of the Fundamental Law)] (Dialóg Campus 2012) 257.

tion of the Act XXXVIII of 1992 on the State Budget (hereinafter: former Áht.), in this way maintaining the dogmatic problems related to administrative legal personality.

The third form is the commissioned public task performance, which transfers the originally administrative tasks to market (for-profit) or non-profit (civil) organisations operating in the private sector, based on a contractual relationship. This is often called the ‚outsourcing' of a task. Regarding contracts, we may traditionally distinguish between task-performance, transfer of public service provision, and concession contracts, as well as so-called *PPP contracts.* A typical example of the first one is the public education agreement aiming at operating the primary school, while the second is usually used for the realisation of large investments (e.g. highways) and/or for the maintenance or utilisation of the created works, etc., while an example of the third one is dormitory-building construction – proved to be unsuccessful in Hungary – in which the ownership rights go to the state, but in return for this it pays rental fee to the investor in the first 20-30 years.

8.2. *Public administration and its transformation within the field of health care*

8.2.1. Introduction

The notion of public administration may be viewed as a complex definition composed of two large traditional (partial) fields: a combination of

a) state administration and
b) self-governmental administration.

Some authors add a third element to this notion with double meaning:

c) para-administration, because public administration performs its tasks not only in classic authority organisation – mostly performing public power activities – through civil servants, but also partly through organisations established or commissioned by it. In the science of Hungarian public administration, the notion of para-administration is not clarified: it appears in the most important Hungarian works with different meaning. For example, Lajos Lőrincz considers all activities

not organised and performed in classic authority organisations,[178] while others exclude certain organisations (e.g. public bodies) established by the state (local governments) and other bodies, persons performing public administrative tasks based on service contract.[179]

8.2.2. The participants in the management of health care tasks

There are several state and administrative bodies involved in performing state health care tasks. Based on Article 143 of Act CLIV of 1997 (Eütv.) the responsibilities of performing the tasks related to the organization and management of health care, of the exercise of laws and of executing obligations – in accordance with the provisions of this Act – lies with the Parliament, the Government, the Minister, the health administration bodies (agencies), the local governments, the other maintainers of health care providers, health insurance bodies (agencies) as well as the regional health administration bodies.

The scope of benefits in the medical field, as well as that of the service providers is much wider than the group mentioned in the above Act. *For the sake of simplicity and clarity the body types and their tasks will be discussed broken down by state administrative bodies, local authorities and para-administrative bodies functioning in the given region. In all three respects both the general criteria, the new elements, and the specific body types shown in the health care sector are outlined.*

8.2.3. The transformation of state administration

In Hungary the transformation of the system of state organisations and their tasks and competences after 2010 is most obvious in the field of public administration.

First of all it must be clarified that the two main organisational principles of state administrative bodies (authorities) is the territorial principle, according to which central, regional and local state administration organisations operate, and the functionality principle, which means that

178 Ibid. 282-283.

179 Fábián Adrián (ed), *20 éves az önkormányzati rendszer* [The local governmental system is 20 years old] (Pécsi közigazgatás-tudományi közlemények 3., A „Jövő Közigazgatásáért" Alapítvány 2011) 105.

state administrative organisations have general or special competences, depending on whether their competence – as main rule – ‚generally' covers the most diverse fields of public administration, or only some specific sectoral types of cases.[180]

It should be specified already at the outset, that the public health care administration – similar to the regulatory domains – is significantly diversified.

8.2.3.1. Central state administration and its transformation

Central state administrative organisations are determinative participants of public administration. Their significance is that their competence covers the whole country, the administrative strategic and operative decision-making tasks and competences are focused in their hands, and – partly due to the mentioned features – their activity significantly exceeds the frameworks of public administration, by this significantly influencing the operations of the state and society, as well as governing activities.[181] Decision-making about the structure of state administration – and within this central state administration – as well as about the establishment, transformation, abolition and management of certain organisations belong partly to the Parliament, exercising its constitution-making[182] and legislative powers, and partly to the Government in its executive function (in governing competence).[183]

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180 In the Fundamental Law of Hungary regulations directly related to central state administrative bodies may be found primarily in articles 1, 15-23, 34, 45-46, 48-54, and in Section 4 of the Closing and miscellaneous provisions.

181 Patyi – Varga Zs. (n 179) 279-280.

182 Müller György, 'Állandóság és változás a magyar kormányzati viszonyokban (1990-2011)' [Stability and changes in Hungarian governmental structures (1990-2011)] in Fazekas Marianna (ed), *A közigazgatás tudományos vizsgálata egykor és ma. 80 éve jött létre a budapesti jogi karon a Magyar Közigazgatástudományi Intézet* [Scientific review of public administration in the past and today. The Hungarian Institute of the Science of Public Administration was established at the law faculty of Budapest 80 years ago.] (Gondolat Kiadó 2011) 140.

183 Article 18 of the Fundamental Law:

(1) The Prime Minister shall determine the Government's general policy.

(2) Ministers shall have autonomous control of the sectors of public

In relation to the Government it is necessary to make reference to the situation and significance of the prime minister. In the opinion of György Müller, analysing the Hungarian system from the aspect of the situation of the Prime Minister it may be characterised as a chancellor-type of governing, because the present German system and the Basic Law for the Federal Republic of Germany (Bonn, 1949) served as examples in 1990 and later, too.[184] However, it shall also be added that even though the Fundamental Law was the first to expressly state the dominant role of the Prime Minister within the government,[185] the *primus inter pares* role which may be observed in the previous Constitution, which trusted the Prime Minister almost exclusively with leading the body, did not reflect the actual situation, practical solutions in the 20 years preceding 2011,[186] which means – with some simplification – that the respective provisions of the Fundamental Law only expressed the situation which has existed for a long time.

It is very important to keep in mind that earlier there was no law characterising central state administrative organisations based on their type or listing them one by one. With this regard Act LVII of 2006 on central state administrative organisations, and on the legal status of the members of Government and the under-secretaries (herein after referred

administration and the subordinated organs within their competence in line with the Government's general policy, and shall perform the responsibilities determined by the Government or the Prime Minister.

184 Müller (n 184) 141.

185 Unfortunately, the word *kormányhivatal* – as a legal term – has two different meanings in today's substantial law in Hungary: one the one hand it appears as a type of central state administration organisations (translated as *government agency*) with nationwide competence, and, on the other hand, it is the territorial (county and metropolitan) state administration organisation of the government with general competence (translated as *metropolitan and county government offices*).

186 The independent regulatory body is a new category in substantial law: According to Article 23 paragraph (1) of the Fundamental Law of Hungary: 'The Parliament may establish autonomous regulatory bodies to perform and exercise particular responsibilities and competences of the executive branch by virtue of a cardinal Act'. In relation with these organisations – established as a result of the liberalisation of different (public) service provisions – it must be stressed that some of their decisions are on the border between normative and individual decisions (these two 'shift'): normative provisions hidden in individual decisions may be observed, by this establishing *quasi precedent law*, unknown in civil law.

to as: Játv. 1) has been extremely significant, as well as Act XLIII of 2010 (herein after referred to as: Játv. 2) – replacing the former one under similar name – which performed this task for the first time in Hungarian legal history.

According to Article 1 paragraph (2) of the Játv. 2 the types of central state administration organisations in Hungary are the following:

a) the Government,
b) governmental committees,
c) the Office of the Prime Minister,
d) the ministry,
e) the autonomous state administration body,
f) the government agency,[187]
g) the central office,
h) law enforcement bodies and Military National Security Service
i) the independent (autonomous) regulatory bodies.[188]

Among these ministries, governmental committees, government offices and the Military National Security Service are under the direct or indirect supervision of the Government (the latter realised through the appointed minister); while the Office of the Prime Minister is under the supervision of the prime minister, and the central offices operate under the direct supervision of the given minister. The autonomous state administration bodies – as indicated in their name – are not under the supervision of the Government, similarly to independent (autonomous) regulatory bodies. Regarding these two types of organisations, it is an important difference that the independent regulatory organisation possesses legislative competence.

Furthermore, it is important that beyond this exhaustive list, the mentioned Játv. 2 also contains the main rules of managing, directing and supervising state administrative organisations, which is important because the meaning and detailed content of these notions are described systematically in these legal instruments for the first time. It is important that from the itemised listing of the types of central state administrative bodies several (body-type)

187 Lőrincz Lajos, 'A közigazgatás alapintézményei' (n 178) 100-106.
188 See Articles 28-30 of the valid Játv.

organisations are missing which may also be part of the activities of central state administration: for example certain bodies (without the right to make decisions) are listed separately in the presently valid Játv. 2.

The most efficient categorization covering all types of organisations of central public administration is the level-based grouping.[189] In this approach, the following may be separated well: a) the level of administration, where classic, daily performance of authority tasks happens (in practice the majority of central state administrative organisations belong here); b) the first level of coordination, in which the harmony of the activities of administrative bodies acting in specific cases is ensured, as well as the primary registration of external, social needs (among others, government committees belong here, as well as cabinets and other proposing, opinion-making and advisory bodies viewed as bodies of the Government[190]); c) and the second level of coordination, at which its exclusive member, the government, ensures the ‚coordination of coordination'[191], and decides about the most important political and the most specific administrative issues.

189 Lőrincz Lajos, 'A közigazgatás alapintézményei' (n 178) 105.

190 The Hungarian National Ambulance Emergency Service (OMSZ) as well as the Hungarian National Blood Transfusion Service (OVSZ) needs to be mentioned here. The emergency service is a national public institution under the control of the Minister of Human Resources for health, an idependent entity and public service budgetary organization, the *Hungarian National Ambulance Emergency Service* (Országos Mentőszolgálat, OMSZ). For details regarding the emergency service see Decree 5/2006 (II. 7.) of the Ministry of Health. Ambulances of the Országos Mentőszolgálat (OMSZ) reach all over the country at the very latest 15 minutes. Air ambulance service got complete to 2009 with the grand opening of Szentes air ambulance station. Air ambulance bases (in Budaörs, Balatonfüred, Sármellék, Pécs, Szentes, Debrecen, Miskolc) cover all over Hungary, helicopters reach 85% of the country's territory at the very latest 15 minutes.

The Hungarian National Blood Transfusion Service (Országos Vérellátó Szolgálat) under Article 1 paragraph (1) of Government Decree 323/2006 (XII. 23.): the National Blood Transfusion Service (hereinafter: OVSZ) is an independently operating budgetary organization under the control of the Minister of Human Resources for health.

191 For details see Article 150 of the Eütv. as well as Article 4 of the Decree 4/2013 (I. 31.) of the Ministry of Human Resources on the Organizational and Operational Regulations of the Ministry of Human Resources (EMMI).

8.2.3.1.1. Central bodies of state administration

8.2.3.1.1.1. Government

The highest body of Hungarian state administration is the Government, which within its organization and management of health-related tasks – among other things – defines the principles, objectives and main directions of the government supporting health care as well as those of health policy; it manages and coordinates the implementation of the health administrative tasks; furthermore in the case of disasters it takes the necessary emergency measures and responses, and performs the general operation tasks regarding the actions to stave them off. Moreover the Government exercises legal supervision over the activities of health insurance agencies.

In summary, we can say that the Government carries out a wide range of law-preparatory activities, as well as enforcement legislation regarding the regulation of community health care, of medical activities and that of health insurance.

8.2.3.1.1.2. Ministerial level

The minister by department is the Minister of Human Resources (formerly the Minister of National Resources), the member of the Government responsible for the medical field. The minister – among others:

a) performs the professional tasks related to health education, professional training, vocational training and continuous training;
b) determines the system of professional requirements of health care;
c) promotes and coordinates the scientific research activities connected to the health sector;
d) administers the registry and information systems needed in the sector management and unitary operation of health care activities;
e) identifies and harmonizes the activities related to the production, distribution and procurement of medications and medical equipment;
f) determines the detailed rules for the evaluation of performance in the health care system;
g) manages the central agencies assigned under its control by a separate law, the national institutions in the field of health care, as well as

the public property or maintenance health care service providers (budgetary organizations);[192]

h) monitors the Health Insurance Fund.[193]

The activity of the minister is aided by the Medical Research Council (hereinafter ETT), by professional colleges as well as national institutions.[194]

It is essential that the power of the minister by department expands to all medical activities, and – regardless of legal status – to every health care provider.

The actual, operative central management of the health sector (its professional and political governance) is performed by the *State Secretariat for Healthcare (Egészségügyi Államtitkárság)* within the EMMI. This is implemented mainly in preparing government decision-making, in sectoral legislation, in sectoral planning (programs, concepts, e.g. nationwide screening program), in activities related to sectoral support. Moreover, the control of the national bodies and institutions of health care services is carried out through the State Secretariat for Healthcare. The secretary of health is – mutatis mutandis – supervised by the minister of the EMMI.[195]

It is essential that besides the EMMI the Ministry of National Economy

192 The professional colleges are the professional advisory bodies of the minister of health, the members of which are mainly the representatives of chambers, universities and professional companies, elected for 4 years.

193 For details see Article 5 of Decree 4/2013 (I. 31.) of the Ministry of Human Resources on the Organizational and Operational Regulations of the Ministry of Human Resources (EMMI).

194 The National Centre for Epidemiology, among other activities, keeps a nation-wide record of the health information of the reported infectious patients, and preserves the infectious patient records of one year for a period of 50 years.

195 The question of the professional compliance of the instruments used in the healthcare profession is an extremely important area. Based on Government Decree 180/2010 (V. 13.) on the basic principles, the conditions and the detailed rules on admitting health technologies into health insurance financing as well as on the revision and the amendment of the circle of the already admitted technologies the National Health Insurance Fund sends the so-called preliminary request for admittance 5 days after receiving the professional opinion of the Office of Health Authorization and Administrative Procedures to the GYEMSZI, as well as the competent department of the college of state health department and can address it to the Medical Research Council as well.

(NGM) also has substantive responsibilities in this area: these include some public finance tasks related to the planning and expenditure of the Health Insurance Fund.

8.2.3.1.1.3. Central offices

a) ÁNTSZ

The National Public Health and Medical Officer Service (ÁNTSZ) is composed of the Office of the Chief Medical Officer (OTH) and the national institutes under the direction of the OTH (it is essential, that the sub-regional institutes no longer exist in this form). The Office is managed by the Minister responsible for public health. The Office of the Chief Medical Officer is a central body, functionally and financially independent budgetary organization, led by the Chief Medical Officer. The Chief Medical Officer, in accordance with the legal regulations and the Statutes, administers the National Public Health and Medical Officer Service and the policy administration services of public health.

From its activity we should highlight tasks such as public health, health development, public hygiene, epidemiological management, authority tasks regarding health services.

Organizational structure of Public Health Care

- The Public Health (Care) consists of two levels: the regional level and the local level:
  - ~ at the regional level with general competence the OTH and its subordinated public health direction bodies which are part of the county or metropolitan government offices – managed by the county or metropolitan chief medical officer – public health professional management bodies,
  - ~ with special competence the radiation hygiene centres,
- At local level
  - ~ district metropolitan or district institutions functioning as the professional administrative bodies of district offices of the metropolitan government office or district departments of county government offices (hereinafter collectively referred to as district public health agency),

~ they are represented by the border, shipping and airport offices operating within the metropolitan and county administration.

The national institutes are functioning as individual budgetary organizations, which provide professional-methodological, scientific research, training, specialized training, registering, coordinating, professional and expert functions. National institutes are coordinated by the OTH, and are functioning as individual budgetary organizations with a national competence. The national institutes are as follows:

- National Institute of Primary Health Care (OALI),
- National Institute for Health Development (OEFI),
- National Centre for Epidemiology (OEK),[196]
- National Institute for Food and Nutrition Science (OÉTI),
- ‚Frederic Joliot Curie' National Research Institute for Radiology and Radio-hygiene (OSSKI),
- National Institute of Chemical Safety (OKBI),
- National Institute of Environmental Health (OKI),
- National Institute of Child Health (OGYEI).

b) EEKH

The Office of Health Authorization and Administrative Procedures (EEKH) regulated by Government Decree 296/2004 (X. 28.). The EEKH is a central office under the control of the minister for health. This includes, inter alia, the following:

- official (partly market surveillance) tasks related to medical devices;[197]
- licensing all legal activities with narcotic drugs, psychotropic and new psychoactive substances;
- the domestic recognition of medical degrees, diplomas, certificates

196 Article 154 of the Eütv.

197 For details see: Csite András – Kiss Gábor, ‚A területi és helyi közigazgatás elmúlt húsz éve – reformkísérletek és szakértői elképzelések' [The past twenty years of regional and local public administration – reform attempts and expert ideas] in Csite András – Oláh Miklós (ed), *Kormányozni lehet ugyan távolról, de igazgatni csak közelről lehet jól...* [Governing may work from a distance, but administration needs closeness…] (Hétfa Elemző Központ 2011).

and qualifications;
- the registration of cross-border service provision;
- the basic and operational registry of healthcare experts.

c) GYEMSZI

GYEMSZI (Gyógyszerészeti és Egészségügyi Minőség- és Szervezetfejlesztési Intézet, *National Institute for Quality and Organizational Development in Healthcare and Medicines*) was establishes on the 1st of May, 2011 under Government Decree 59/2011 (IV. 12.) on the National Institute for Quality and Organisational Development in Healthcare and Medicines as a state administration body responsible for regional health organization. The GYEMSZI is a central office under the control of the EMMI minister for health. Among its activities it is important that it functions as a pharmaceutical major authority; it ensures quality development in health care, the organization and coordination of medical professional trainings, as well as data collecting and processing in the health sector. Its outstanding – and widely-known – task is the sustenance of the state-owned medical institutions: it exercises organisational and professional (operative) control regarding these.

It is important that in 2013, following the metropolitan and county hospitals, the hospitals owned by the local administrations as well as their integrated institutions providing outpatient professional care (offices) came under the supervision of the National Institute for Quality and Organizational Development in Healthcare and Medicines (GYEMSZI). In theory – based on its statute – it includes 8 regional directorates; nevertheless these have not been organized up until the summer of 2014.

d) OEP

The National Health Insurance Fund Administration (herein after referred to as: OEP) is a central office under the control of the EMMI minister for health. After 2010 the administrative organization of the field of health insurance was altered in such a way that the regional offices of the OEP were integrated as healthcare specialist administrative bodies in the county or metropolitan government offices.

The main tasks of the OEP are:

a) the management of the Health Insurance Fund (Egészségbiztosítási Alap);

b) the register of the citizens entitled to health insurance (Social Security Number - ‚TAJ' number);

c) the financing of the compulsory health insurance;

d) the professional management of regional administrative tasks regarding cash benefits;

e) operating as the Hungarian authority in the international and EU relations of health insurance;

It needs to be emphasized that the main task of Hungarian health insurance agencies (OEP, as well as the government agencies of the metropolitan and county government offices performing health insurance fund services) is to ensure the following regarding the health care services provided by health care providers:

a) the timely lockup of the necessary capacity, as well as

b) the financing and supervision of the services provided.[198]

The official forum in the field of health insurance is organized in the following way: the appeals against the administrative decision made by health insurance professional management bodies are considered the OEP, and in some cases the appeals against administrative decisions of the OEP are considered by the Office of Health Authorization and Administrative Procedures (EEKH).

With regard to the field of health insurance it needs to be mentioned that based on Act CXVI of 2006 on authority supervision of health insurance the Health Insurance Inspectorate (Egészségbiztosítási Felügyelet) defended the rights of the insured, kept records of the data regarding the activity of the healthcare institutions, as well as the quality of healing. With its activity it helped us to make correct decisions in resolving our health care problems, and that is why it published analyses for the sake of the

198 Virág Rudolf, ‚Az államigazgatási feladat- és hatáskör-telepítés új rendszere – a járási rendszer kialakítása' [The new system of establishing state administrative tasks and competences – the establishment of districts] (2012) 2(1) Magyar Közigazgatás 11-12.

patients: e.g. ‚Betegjogi helyzet a fekvőbeteg ellátásban, illetve önkéntes egészségpénztárak összehasonlító elemzése' [Patients' rights in inpatient care, as well as the comparative analysis of voluntary health insurance funds]. The independent inspectorate ceased to exist, its tasks were partly taken over at the end of 2010 by the OEP, and by the ÁNTSZ.

e) OBDK

Based on Government Decree 214/2012 (VII. 30.) on the *National Centre for Patient Rights, Children's Rights and Documentation* (OBDK), OBDK is a central office under the control of the EMMI minister for health. Its tasks include the registration, assignment, training of the patient right advocates, and since 2014 the OBDK may act *ex officio* (that is not only based on a complaint), if it becomes aware of any facts, circumstances or omissions which could result in a violation of rights or severely injure the rights of a larger group of patients, or which is related to the access to health services, the organization of care, the order of referral, patient information.

8.2.3.2. The transformation of regional-local state administration in Hungary

Due to the fact that the county level was weakened in 1990 and the regional level was established incompletely, there was no regional public administration organisation until 2010 (at least at county level) which could have been able to coordinate the territorial operation of the different sectors (authorities) *substantially and efficiently.*[199]

199 According to Article 3 paragraphs (1) and (3) of the act the metropolitan (capital) and county government office consists of organisational units directly managed by the government agent (core office), special administrative agencies and district – and in the capital metropolitan – district offices (district offices) which form one budgetary body (organisation). The agencies of the metropolitan and county government offices, as well as the agencies of the district offices, are defined by the Government in its decree. For the listing of the agencies of government offices see Article 2 paragraph (1) of Government Decree 288/2010 (XII. 21.) on capital and county government offices. It is important that the metropolitan and the county government office operate an integrated client service, the government client ser-

A very important change was brought about with the *substantial integration of regional state administration in 2011,* which tried to provide answer to the most urging question of the past twenty years of public administration: since 1990 each government has tried to stop and reverse the high scale fragmentation of the system of territorial state administrative authorities, but before 2010 each attempt failed or resulted in only partial success.[200] The establishment of *metropolitan (capital) and county government offices* as of 1 January 2011 ended a disintegration process of two decades (see Act CXXVI of 2010 on the capital and county government offices and on the modification of acts related to the establishment of the capital and county government offices and territorial integration).[201] One main characteristic of this was the strong organisational integration of the territorial system of organisations,[202] their integration, and the disintegration and ‚re-allocation' of competence areas.[203] The integra-

vice desk. On 3 January 2011 – as the first step of the establishment of the one-site client service – the integrated client service offices of government offices, the Government client service desks were opened in 29 settlements of the country. With the establishment of districts their number has risen since 2013.

200 The Capital and County Government's Offices have integrated most of the deconcentrated territorial agencies directed by different ministers earlier.

201 Szigeti Ernő, ‚A közigazgatás területi változásai' [Territorial changes of public administration] in Horváth M. Tamás (ed), *Kilengések. Közszolgáltatási változások.* [Swings. Public service changes] (Dialóg Campus 2012) 272.

202 The merger affected approximately half of the 33 territorial – partly county, partly regional – state administrative bodies.

203 System of direction as well as internal structure of the Capital and County Government's Office reflects the distinction between professional tasks and functional tasks. Internal structure of the office is divided into the core office, the set of specialized authorities and the so called district offices. The specialized authorities are internal organizational units of the Capital and County Government's Office but they are not subordinated regarding their professional activity to the head of the Office. They are subordinated to the respected Minister regarding their professional activity. That is why the heads of specialized authorities are appointed by the Government Representative with the agreement of the respected professional superior exercising the professional direction or supervision meaning in certain cases one of the ministers. Consequently the specialized authorities (special administrative agency) of the Capital and County Government's Office – former entities as de-concentrated bodies – operate under double direction: professional direction is exercised

tion affected 14 organisations (types of organisations) and within this more than 150 bodies (authorities),[204] resulting in significant savings even in the first year.

The Capital (Metropolitan) and County Government's Offices are the territorial units of the central Government having a general scope of authority. The heads of the Capital and County Government's Offices are the Government Representatives appointed by the Prime Minister.[205]

Regarding parts of the organisational systems of the deconcentrated state administration, it may be stated that the territorial units of central deconcentrated bodies with national competence – as territorial authorities – merged into the capital and county (territorial) government offices, a significant task of which is to harmonise and facilitate the territorial performance of governmental tasks.[206] However, in the case of the territorial bodies of some organisational systems of the de-concentrated state administration, their integration to the county (metropolitan) government offices did not take place. [207]

Main elements of the scope of authority of the Capital and County Government's Office are as follows:

- Coordination and support of the execution of the Government's tasks following legal regulation and instructions of the Central Government – for this reason a board is operated in the county by the head of the office[208]
- Coordination over the organs of public administration in the county
- Coordination of the execution of the instructions of the Government in the county/in the Capital

by the Minister that directs the administrative branch while functional direction is exercised by the Government in the way of the Minister of Public Administration and Justice, finally by the head of the office, the Government Representative. As the Act CXXVI of 2010 states the functional direction is exercised and some of the functional tasks are fulfilled by an agency designated by the Government.

204 Szigeti Ernő (n 203) 272.

205 Ibid 273.

206 County Board of Public Administration

207 Government Decree 288/2010 (XII. 21) on the Capital and County Government's Offices.

208 The Government decided about the conceptual principles of the establishment of districts with its Government Decree 1299/2011. (IX. 1.).

- Decision making as an authority of 1st instance in the administrative procedure
- Revision of decisions of authority as a level of 2nd instance in the administrative procedure
- Control over the activity of all organs subordinated to the Government in the county with some exceptions (police, tax administration)
- Training and further training of civil servants in the county
- Consulting in the decision-making process of the Central Government
- Operation of front office for parties in administrative procedures in a form of integrated service for citizens
- Control of legality over local self-governments

17 specialized administrative authorities integrated into the Capital and County Government's Office are enumerated by the Government in a form of a decree.[209] *Among these authorities (specialized administrative agencies) we can find authorities on Health insurance, Public health, Rehabilitation of handicapped persons, as well.*

The specialized health insurance administrative agencies of the metropolitan and county government offices, with the professional guidance of the OEP, fulfil regional official duties regarding the cash benefits of health insurance.

The specialized public health administrative agencies of the county/metropolitan government office or the specialized public health administrative agencies of the district offices on the district level carry out their activities with the professional guidance of the OTH. And as previously mentioned, they fulfil tasks of territorial public health as well as public health, epidemiological and health-related official tasks.

8.2.3.2.1. Establishment of districts

A change which is closely related to the metropolitan and county government offices – as mentioned before – is that while earlier, from 1990 the legislator appointed the clerk (operating as body of the local governments) as addressee of majority of state administrative tasks and

209 The district system, with several hundred years' tradition in Hungary, was revived after 30 years.

competences, the districts *(járás)*[210] established on 1 January 2013 as old-new[211] public administrative units realise the management of (not all, but the majority of) state administrative tasks in a separate organisation, separating *much more clearly* than before – also organisationally – state administrative tasks falling under the responsibility of the government from local governmental tasks which are responsibilities of the local government.[212] Earlier the state administrative competences of clerks broadened continuously, but this growth was not always followed by the facilitation of necessary financial resources and other conditions.[213] It is impossible to overestimate the significance of the statement that ‚… *contrary to the original concept,* the state administrative authorities have not been fully transferred to the districts'.[214] From 2013 175 county district offices and 23 metropolitan district offices have been operating as branch offices of the government offices. District offices manage some state administrative tasks which belonged to the clerk of the local government earlier, and they also incorporate some local bodies of the authorities of metropolitan and county government offices.[215] Some tasks are transferred from the clerks to the district offices, for example tasks related to documents (address registry, passport management, vehicle registry), law enforcement tasks, child welfare, child protection

210 Virág (n 200) 15.

211 Dr. Szekeres Antal, 'A jegyző államigazgatási hatásköreinek változása' [Changes of the state administrative competences of the clerk] (2012) 14(3) Jegyző és Közigazgatás 5.

212 Barta Attila, ‚A magyar államigazgatás alsó-középszintjének átalakítása 2012-ben' [The reorganisation of the lower-middle level of Hungarian state administration in 2012] (2012) 1(2) Kodifikáció és Közigazgatás 38,

213 Regarding the details of the changes see Act XCIII of 2012 on the establishment of districts and the modification of certain related acts (Jártv., which was adopted by the Parliament on 25 June 2012) and the approval and entering into force of two government decrees established for its execution, namely Government Decree 174/2012 (VII. 26.) on the modification of certain government decrees in relation with the establishment of district (metropolitan, metropolitan district) offices, and Government Decree 218/2012 (VIII. 13.) on district (metropolitan district) offices.

214 In the summer of 2013, approximately 150 types of cases belonged to the competence of government client service desks, and this number is rising.

215 Szigeti Ernő (n 203) 281.

and those parts of social services in which the local government does not have individual consideration rights; however, some tasks remain with the clerk, such as probate action, registry management, part of first instance construction authority tasks, industrial and commercial authorization, part of social services which is related to non-civil allowances, or local taxation.

In the district offices – in addition to the core offices, which are present, just as at the government offices – *among others, the following authorities operate: a) district animal health and food inspection authority, b) district public health institute.*

From 1 January 2013 everyday administration may be performed at government client service desks operating as part of district offices, open from 8 am till 8 pm all around the country, or through the so-called clerk designated to the settlement. It must be mentioned that in this system the client may manage his issues not only at the seat of the district, but at any settlement which had operated documentation office before. At the government client service desks, where the new system in several types of cases[216] more than 100 types of requests and modes of case management are available (at approximately 300 integrated client service desks) and in general the civil servant who gets directly in contact with the clients does not participate in the management of those cases which cannot be solved immediately; therefore the substantial management of inquiries handed in at the government client service desks happen at the competent administrative authorities.

8.2.4. Tasks of the Hungarian local governments

8.2.4.1. The Transformation of the system of local governments. Introduction

Compared to the size of the country, there are too many local governments operating in Hungary, because each settlement with independent public administrative status acts as local governmental unit.[217] In Central-

216 Ibid.

217 In the meantime, the Fundamental Law also maintained the approach of local governmentalism common in continental systems, the one based on the

Eastern-Europe, from the seven EU member countries of the region, in the Czech Republic, Hungary and Slovakia local governments of settlements operate, while in Bulgaria, Poland, Romania and Slovenia, territorial local governments covering several settlements.[218] *The local governmental bodies shall be distinguished from other self-governmental bodies, such as professional or economic chambers or other organisations operating in form of other public corporation.*

At the beginning of 2010, the Fundamental Law of Hungary broke up with the fundamental right approach of the right to self-government, as it was interpreted before, and wished to establish a model in closer relationship with the state governmental subsystem of public administration, a closer cooperation between state administration and self-governmental administration.[219]

Since 1990, the notion of local government has included settlement and territorial (county) governments in Hungary.[220] It is important that nowadays the ‚weak' county governments of the post-1990 period are getting weaker;[221] in addition there is still no hierarchic structure between the settlement and the county local governments.

A significant step in the process of transforming the Hungarian local governmental system was Act CLXXXIX of 2011 on Hungary's local governments – approved on 19 December 2011 (hereinafter referred to

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general clause of local public affair, thus according to Article 31 paragraph (1) of the Fundamental Law: 'In Hungary local governments shall be established to administer public affairs and exercise public power at a local level'. Local public affairs and the tasks of local governments to be performed locally are defined in an exhaustive list in Article 13 paragraph (1) of the Mötv.

218 Article 3 paragraph (3) of the Mötv.

219 According to Article 27 paragraph (1) of the Mötv. 'County government is a territorial self-government which performs area development, rural development, area management and coordination tasks'. The majority of these tasks are defined in details in Act XXI of 1996 on area development and area management (Tftv.).

220 Dr. Bekényi József, ‚Megújult a magyar önkormányzati rendszer' [The Hungarian local governmental system has been renewed] (2012) 14(1) Jegyző és Közigazgatás 6.

221 ‚Members of local communities, as subjects of local governmentalism shall:
a) mitigate community burdens by self-care, contribute to the performance of community tasks in line with their abilities and possibilities;
b) observe and enforce the basic rules of co-habitance.'

as: Mötv. – which entered into force gradually in three phases between 2012 and 2014). The main goal of the act is to establish a modern, cost efficient, task oriented local governmental system which facilitates democratic and effective operation, and at the same time – enforcing and protecting the collective right of voters to self-government – provides stricter frameworks for local governmental autonomy.[222]

In relation with this it must be mentioned that Article 8 paragraph (1) of the Mötv.[223] – in line with the approach of the Fundamental Law, which in addition to formulating the (basic) rights also mentions the responsibilities of individuals – states that in relation to the right to self-government the local citizens exercising their right to self-government also have some responsibilities.[224]

In Hungary, as an answer to the centralisation of the system of councils, the previous act on local governments[225] practically established a separate branch of power, providing independence for each settlement with minimal central control.[226] As result of this, the operation of local governments was not effective, several settlements became indebted, and tasks were performed at a low standard: ‚(…) the act on local governments approved in 1990 carried especially negative effects regarding the regulations of the medium level.'[227]

Based on the changes of 2010, approximately 2/3 of local gov-

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222 Balázs István – Balogh Zsolt – Barabás Gergely – Danka Ferenc – F. Rozsnyai Krisztina – Fazekas János – Fazekas Marianna – Fürcht Pál – Hoffman István – Hoffmanné Németh Ildikó – Kecső Gábor – Szalai Éva (ed. Nagy Marianna – Hoffman István), *A Magyarország helyi önkormányzatairól szóló törvény magyarázata* [Explanation of the act on Hungary's local governments] (HVG-ORAC 2012) 21.
223 Act LXV of 1990 on local governments (Ötv.).
224 For details see for example: Fábián (n 164).
225 Pálné Dr. Kovács Ilona, 'A középszintű önkormányzás változó trendjei' [The changing trends of medium-level self-governmentalism] (2011) 4(10) Új Magyar Közigazgatás 25.
226 Article 34 paragraph (4) of the Fundamental Law of Hungary introduced the legality supervision of local governments as of 1 January 2012, in harmony with Article 8 of the European Charter of Local Governments. The detailed regulations are defined in Chapter VII of Act CLXXXIX of 2011 on Hungary's local governments (Mötv.).
227 Hoffman (n 100) 642.

ernmental public services were centralised and the state administrative competences of local governments significantly decreased. Therefore, in the future much stronger central administrative control will prevail.

It is important that in Hungary the establishment of government offices, created as tools of centralisation, was followed by the consolidation of county self-governmental institutions: from 2011 the state overtook the significant debts collected by county self-governments, and later it also overtook the management of county self-governmental institutions.

In parallel with the reorganisation of tasks the financing system was also transformed, from 1 January 2013 a so-called task-financing has been introduced, which means the financial support complying with the public service level set forth in law for the given task. The change may be best observed in the fact that – compared to the previous system of normative contributions and support – this amount shall be spent by the local government exclusively to the expenses of the performance of its obligatory tasks. One of the formulated goals of the regulation is to force local governments to increase their local (tax) income.

One more novelty of those introduced not long ago in local-territorial administration must definitely be mentioned: it is a great change in the relationship of state bodies and local governments that instead of the previous – less strict – system of legal control, from 2012 the practice known as legal supervision has been introduced, which significantly extends state control.[228]

8.2.4.1.1. Historical heritage and consequences of it

After 1990 the existence of the concept of ‚3,200 small republics' in the self-governmental sector reflected on the principle which abstains from establishing clear and direct inferior-superior relationships, and *as a counter-effect of the previous system(s)* it tried to define the new ‚system' as emphasizing the various freedoms. This approach caused more practical problems than necessary after 1990, both in the relationships of state administration organisations and local governments, as well as in the internal affairs of local governments (e.g. in the relationships of the representative body, the

228 Ibid. 642.

mayor and the clerk), and in the provision of public services.

Hungary belonged to the decentralized model before the public service reform 2011/2013. *The former Hungarian system was based on the provider role of the local governments.* The funding of the services has been managed by a state health insurer which has monopoly. In 2007/2008 the Hungarian government tried to evolve a competitive insurance model similar to the Dutch system,[229] but the reform failed after a referendum on visit fees. Before the reform the basic services was provided by the settlement level municipalities, and the counties *(megye)* were legally obliged to providing inpatient care and outpatient care.

The self-governments could satisfy their responsibilities regarding health care in a chosen way: by the sustenance of their own institution, in local government associations, or through contracts with private providers. The result of this was that in specialized care outpatient care – including its catchment areas – remained a typically urban (metropolitan district) task, in self-government run specialist clinics, while the hospitals were maintained by the county self-governments, as well as city self-governments in a few large municipalities.

The Act LXV of 1990 on local self-governments enabled the municipalities to take over the tasks of the counties. The new Mötv. changed this system: the settlements could provide only the basic services of health care. The counties could perform only the tasks defined by the law (now regional and rural development, spatial planning and coordination). Therefore the counties could not provide health services.[230] Thus the inpatient institutions – and the outpatient institutions integrated to the inpatient ones – became maintained by an agency of the central government (GYEMSZI) therefore Hungary could be classified as a – partly – central government centred country.[231]

So since January 1, 2012 the county and metropolitan self-government hospitals were transferred into state ownership and sustenance (GYEM-

229 Ibid.

230 The outpatient care institutions integrated in the hospitals made up 70% of the total of such institutions.

231 Adrián Fábián – István Hoffman, ‚Local Self-Governments' in András Patyi – Ádám Rixer (eds), *Hungarian Public Administration and Administrative Law* (Schenk Verlag 2014) *(article in press)*.

SZI), and since April 1, 2012 the urban hospitals were also nationalized, together with their integrated institutions providing outpatient care.[232] In 2013 Act XXV of 2013 also stipulated that the health institutions transferred into state property, moreover even the ones operating as companies must be converted into budgetary organization. Nationalization was carried out not only in the issues of property but also in the forms of functioning.

The task system of the Mötv. [hereinafter also referred to as: (Hungarian) Municipal Code] is based on the system of the former Hungarian municipal law. Thus the *municipal* and the *delegated administrative tasks* are distinguished by the new Municipal Code, as well. *Mandatory tasks, voluntarily assumed tasks* and *facultative tasks of the local government* could be classified among the municipal tasks.

The obligatory municipal tasks are defined by act having regard to the Municipal Code. A significant modification of the regulation is that *new instruments of the legal supervision* could guarantee the fulfilment of these tasks. Beyond the new instruments of legal supervision the *differentiated installation of tasks* are required. Thus the tasks of the diverse municipalities should be defined differently by the sector regulations. The main criteria of this installation of tasks are determined by the Hungarian Municipal Code. Thus 1. the nature of the duty, 2. the different capability of the local governments, especially the different economic performance, population and the size of the area of the municipality shall be taken into account [Article 11 paragraph (2) of the new Municipal Code]. The personnel, the material and the financial conditions of the performance of the obligatory tasks (public services) can be regulated not only by acts but also by the decrees of the Government of Hungary and by the decrees of the ministers after these general rules of the municipal law. The performance of the obligatory municipal tasks have *priority* because the performance of these duties could not be jeopardized by the performance of the facultative tasks of the local governments.[233]

232 Articles 152-153 of the Eütv.

233 Szőke Katalin – Füzesi Zsuzsanna, 'Egy kistelepülési egészségmodell – Települési egészségterv1 [Healthy Village Programme – Community Health Planning] (2013) 6(1-2) Szociális Szemle 141.

8.2.4.2. Health care tasks

Among the compulsory tasks:[234]

I. all local municipalities take care of the following regarding primary health care:

a) general practitioner and paediatrician care;
b) basic dental care;
c) on-call care related to primary care;
d) child-minder nurse care;
e) school health care.

GP or family physician practices in Hungary

The main providers of home medical care in Hungary can be divided into three groups in terms of the right to operate:

1. *Family physicians with territorial service obligations* (TEK). This refers to the local doctors in contract with the local governments, responsible for care in a certain area, the area of care being determined by the local governments.[235] Territorial service obligation means that the physicians cannot refuse the care (taking into practice) of patients living in the area where they perform care (patients being reported based on their residence card). Therefore they receive separate funding for this obligation, the amount of which is independent from the number of patients registered in the practice and the number of patients receiving actual care. *Currently there are around 6400 such practices.* Since the entry into force of Act II of 2000 on independent medical activity, the family physicians with territorial service obligations have been granted property value practice right, which is alienable and can be continued (e.g., by a physician spouse or child). This right constitutes practice right since January 1, 2012 and extends to the district where the family physician provinces home medical care with territorial service obligations since January 1, 2012. Currently the value of practice right shows an extraordinary ,varia-

234 Fábián – Hoffman (n 233) 7.
235 Horváth M. ,*Közmenedzsment*' (n 98) 61.

tion', in the farm areas it worth 300.000 HUF (around 1300 USD), in larger cities it can reach 12 million HUF (approximately 50.000 USD).

About half of these practices are adult general medicine practices, and the remaining two quarters are represented by the primary care service providers as well as mixed practices.

A performance contract is signed between the physician with practice right and the local government of the settlement affected by practice right, the minimum period of which is 5 years.

2. *Family physicians with operation rights and without territorial service obligations* (TEKN). The field of care of practices without territorial service obligations is not determined. These service providers and physicians are not in contractual relations with the local governments, the registration of the patients is carried out under free choice of doctors. The general practitioners without territorial service obligations, who in February 2000 had been working in this system, were automatically granted the right to operate. The practice right is a ,concession' granted through an authorization, and it qualifies the physician to provide independent medical services.
3. *Act II of 2000 on independent medical practice knows the category of general practitioners without practice right and without territorial service obligation.* The general practitioners without territorial service obligation entering the primary care system after February 2000 did not receive practice right, in their case there was need for the operation license issued by the ANTSZ in order for the physicians to start their medical practice as family practitioners. The family practitioners without territorial service obligations receive practice rights without market value and at the termination of their activity as family practitioners their immediate relatives (e.g. physician children) cannot continue patient care.

Based on the legal regulations in force the family practices without territorial service obligations lose their operation right after December 31, 2015. In 2014 there are around 250 such practices in Hungary. Any (further) reduction of the number of family practitioners could seriously jeopardize primary care, as the average age of Hungarian family practitioners is very high: 54 years, and about 30% of them

have reached the retirement age. At the beginning of 2014 around 200 family physician practices have been vacant for a relatively long time. In this respect it is also a problem that in 2013 only 68 people chose the so-called general/family medical training in domestic medical schools, and only about 40 young graduates started work.

II. in cities (with territorial service obligation), in the metropolitan districts:
in the field of professional health care, the local government ensures the operation of the publicly funded health care service provider institutions in its property or under its management, as well as the performance of publicly financed professional care duties.

III. every local government has the following environmental and community health obligations:
a) ensures the performing of sanitation and community salubrity tasks,
b) ensures insect and rodent control,
c) continuously monitors the development of the community environment and health situation and in the event of its deterioration, – within its possibilities – takes the actions within its jurisdiction or initiates the necessary actions at the competent authorities.

It also needs to be noted that the representative body of the local government shall decide on the extraction and handling of therapeutic mud and mineral springs, on the bottling, packaging and marketing of recognized mineral water, therapeutic mud and mineral spring products, and authorizes such activities.

8.2.4.3. The provision of municipal public service

Municipalities have great freedom to choose the form of the provision of the local public services. It is stated by the Article 41 paragraph (6) of the Mötv. that local governments can establish a budgetary organization, a for-profit organization, or a non-profit organization for the provision of the local public services. This paragraph allows the municipalities to contract with a natural or legal person, or with a legal subject without personality for these this provisions. A third way of for the provision

of these services is the inter-municipal cooperation. Thus the public services can be organized and managed differently. The obligation of the local governments is to ensure the accessibility to these services.[236]

A significant limitation of this freedom is the Article 41 paragraph (8) of the New Municipal Code, which allows the Parliament to define in acts several services which can be provided only by a municipal organization governed by the public law or inter-municipal associations or by companies with a majority municipal influence. Such an act is the Act CLXXXV of 2012 on waste, which allows getting waste management permission for the organizations governed by public law, or for inter-municipal associations or companies with majority central or local government influence. This regulation follows the German public service provision model, which has been largely based on the local government companies.[237]

8.2.5. Para-administrative organs

The above introduced ‚para-administration' expression refers expressly to the virtual and real similarity with public administration organs. As noted above, we use the broadest definition of para-administration: here we classify every body type (or exceptionally person), which (who) is involved in performing administrative tasks and providing public services outside the classical office frames and not primarily active in duties of official nature. The expressions public administration organ and para-administration are not defined clearly in positive law, or – in the case of para-administration – are not mentioned at all.

In its broadest perspective five basic *"para-administrative" body types can be distinguished:*

a) the budgetary organizations,

b) the semi state-semi civil or semi state-semi market body types (which are typically established by the state or the local governments, but which – to a certain extent – are distinct from the establishing institution), the essential feature of which is that they perform direct public tasks in the framework of which they come into direct contact with the customers, the ones demanding their services, or even their own members.

236 Sárközy Tamás, *Kormányzás, civil társadalom, jog* [Governing, civil society, law] (Kossuth Kiadó 2004) 5.

237 Quasi Non-Governmental Organization.

c) for-profit or non-profit body types established not by the state or by the local governments, which were not created to primarily perform administrative tasks, but which actually carry out such tasks (or carry out such tasks *as well*), or
d) so-called mixed bodies, as well as
e) other proposing and reviewing organizations

However we need to highlight that only a part of the above categories are of regulatory character, and there is significant overlap between the elements included in the above groups. *The list is mostly a dogmatic experiment, the first step of which is that phenomena which are not homogeneous from the dogmatic point of view are included in the same group aiming at the simultaneous display of all possible aspects of the concept of ,para-administration'.*

Ad a) Based on Article 7 paragraph (1) of Act CXCV of 2011 on public finances (herein after referred to as: Áht.) ,The budgetary organ is a legal person established to perform public tasks defined in law or in its founding document. The budgetary organ may be central budgetary organ, local governmental budgetary organ, minority local governmental budgetary organ, *national minority governmental budgetary organ, and public body budgetary organ.'* According to Article 7 paragraph (2) ,The task of the budgetary organ may be a) basic task, which is set as basic professional activity in the law or founding document establishing it, and (…) non-profit activity, b) business activity, which is profit oriented, non-obligatory production, service, sales activity performed from non-state resources.'

The practical significance of budgetary institutions is reflected in the rule of Article 1 paragraph (2) of the Áht., according to which ,The performance of public tasks shall primarily happen through the establishment and operation of budgetary organs'.

Presently a significant part of the institutions providing effective health care services (suc as hospitals, outpatient care institutions) function as budgetary organizations (as well).

Within the category of budgetary organizations we can differentiate the group of institutions which besides performing healing etc. tasks, are also significantly involved in training and other tasks as well: e.g. Some of the health institutions organized as institutes have to be classified in

this group: National Institute of Oncology, Gottsegen György National Institute of Cardiology, National Neuroscience Institute.

Ad b) This group includes mainly public foundations, public bodies as well as non-profit corporations (formerly public companies).

The public bodies are represented by professional chambers. Act XCVII. of 2006 on the professional chambers in healthcare regulates the compulsory membership-based public bodies of the health professionals. Among these we must mention:

ba) the Hungarian Medical Chamber carries out professional representation (general and individual representation of interests in such a way that it upholds ethical rules), and performs the professional ‚public control' of the members of the chamber;
bb) the Hungarian Chamber of Pharmacists; as well as
bc) the Association of Hungarian Health Professionals.

The significance of the issue is very important in Hungary, in so far as till the middle-end of the 2000s severe criticism hit the state, saying that *‚the effectiveness of the state organisation and within this, of governmental control is low due to the prolificacy of background organisations and because of the permanent intention to establish para-state pseudo-civil organisations (first of all public foundations, public bodies, non-profit business associations)'.*[238] With some play on words, however, Hungarian QUANGOs[239] may be called GUANGOs – mixing the words guano and NGO – because this type of organisation traditionally ‚settled on' various social needs, and beyond a certain point – making their financing and maintenance an end in itself – broke up with them (in other words: they covered the direct needs, real requirements from the external viewer), reducing the aspects of transparency, accountability and efficiency to secondary, or even lower, importance.

Ad c) According to Article 12 paragraph (3) of Act CXL of 2004 on the General Rules of Administrative Proceedings and Services: ‚For the purposes of this Act, "administrative authority" (hereinafter referred to

238 Patyi – Varga Zs. (n 179) 329.
239 Ibid.

as "authority") shall mean the following bodies vested with jurisdiction to carry out administrative actions:

(…)

e) other organizations, public bodies or persons vested with administrative competence by an act or government decree.'

According to section e), therefore, administrative authority may be any organisation or person which (who) cannot be considered an administrative organisation in a narrow sense. These latter entities may be also called quasi-public administrative authorities.[240]

Ad d) It must be also mentioned that in Hungarian regional-local administration, in addition to the previously analysed ‚classic' types of bodies, a ‚middle', neither state administrative, nor self-governmental type of organisation, the type of atypical mixed bodies has had increased significance lately.[241] They are always syndicalist bodies, their establishment is special compared to the bodies of the two large organisational sub-systems, while they are closely related to both. It is generally true that the main reason for their existence is that the simultaneous presentation of general and local interests, expectations would not be efficient or reasonable at other forums and scenes. They mostly lack organisational independence, but they are usually independent in performing their tasks and competences.[242] Among others Regional Health Councils *(Térségi Egészségügyi Tanácsok)* may be considered as such. Under Article 148 of the Eütv. Regional Health Councils are the bodies involved in health policy-making in the health care area determined by the act on the development of healthcare. The Council is responsible for the promotion of the work of the regional health centre, for the professional support in determining territorial service obligation, for giving advice in determining health development goals, for the assessment of the achievement of objectives, for consultancy regarding the long-term development of the health care professionals in the region and for determining the priorities in this development. The members of the council are the healthcare professional management bodies, the

240 Ibid.

241 Fazekas – Koncz (n 33) 40.

242 Katalin Hegedűs, ‚The SWOT analysis of Hungarian hospice palliative care' (2010) 9(4) Adv. Pall. Med. 111–116.

local governments or representatives of the different operators (such as churches and private operators), as well as the representatives of health care advocacy services.

Ad e) *As opposed to the typically regional ‚mixed bodies' some proposing, reviewing and coordinating bodies are present at the central level, operating next to the sector minister.*

Such a proposing, reviewing and decision-preparatory body of the minister of the EMMI is the Medical Research Council (ETT). Its characteristic is that in some cases (e.g., the operating licenses of healthcare providers) it acts as an expert, while in other cases (e.g., in authorizing specific medical research) it acts as a professional authority under Decree 34/2003 (VI. 7.) of the Minister of Health, Social and Family Affairs on the Medical Research Council.

Here we have to mention the National Patient Forum *(Nemzeti Betegfórum)* regulated by paragraphs (1) and (2) of Article 151 of the Eütv., which is formed by NGOs representing people suffering from specific diseases. The minister of the EMMI maintains contact with the NGOs operating in the field of healthcare through the National Patient Forum as well. The National Patient Forum:

a) makes proposals, gives opinions on requests, prepares analyses and assessments for the minister,
b) performs advocacy regarding the specific disease or disease group,
c) maintains contact with the specific section of the professional chamber, with the NGOs and advocacy organizations, with the competent professional chambers, with religious communities as well as with foundations.

9. Legal forms of the healthcare providing institutions and the performance of their activity

The table below shows the legal forms of the healthcare providing institutions and the performance of their activity:[243]

Table IV.

Level of healthcare	Public service provider	Private service providers
Basic level of healthcare		Authorized family physicians or limited liability companies, partnerships
Outpatient care	Primarily a budgetary organ of local or state administrative authorities	Diagnostics and special services offered by free-lance specialists or cooperatives/ partnerships, and institutions maintained by the churches
Inpatients	State administrative budgetary organ	Institutions maintained by the churches (sometimes partnerships or companies) - i.e. Dr. Rose
Rescue	Monopolistic state administrative budgetary organ(National Rescue Service)	
Transportation of the patients	(National Rescue Service)	Companies
Caregiving	State administrative budgetary organ	- Individuals - Partnerships (limited liability companies, partnerships, cooperatives, non-profit companies) - Institutions maintained by the churches - Civil/non-profit organizations
Non-conventional services		Individuals Partnerships (limited liability companies, partnerships, cooperatives)
Medicines and pharmacology		- Production and wholesale: public companies - Retail trade: authorized pharmacologists

243 Ibid.

10. Healthcare Providing System

The Healthcare Providing System deals with the healthcare services and the achievement of the goals related to public health.

The Healthcare Providing System is a coherent system the constituents of which act in a coordinated manner. The system is based on the principle of progressivity. Based on the principle of progressivity the healthcare system consists of institutions providing services to individuals with different needs respecting the principle of the division of labor. The health condition of the patient determines the required level of healthcare. This principle is meant to serve in the best possible way the interests of the patient with the highest efficiency of resource allocation.

The health care system provides care for outpatients, inpatients and sanatorium patients. It also provides home care for the patients. The levels of the healthcare system are: basic care, outpatient care, inpatient care. These services are completed with other healthcare services.

a) Basic level of healthcare

The patients are entitled to receive healthcare services – as near as possible to their inhabitancy – from specialists that provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of sex, age, or type of problem, be it biological, behavioral, or social

b) Outpatient care

The institutions specialized in outpatient care offer single or occasional care for patients sent by their family physician and for persons visiting the specialist on own intiative. These institutions offer special care for patients suffering of a chronic illness that doesn't require hospitalization. The general outpatient care will be carried on in institutions which are easy to be accessed without compromising the patient's health and using public transportation.

Outpatient care may be organized in the following forms: clinic, clinics, mobile health services, outpatient practices, nursing stations/centers,

laboratories, diagnostic centers, nursing homes, hospice services, care provided by a professional staff (e.g. physiotherapy).

c) Inpatient care

The general inpatient care is the form of care offered to patients – close to their homes – and carried out in a hospital. Such services will be provided according to the legal provisions to those patients who are hospitalized on the request of the family physician or the attending specialist. Patient may request hospitalization on own initiative as well, if justifiable. These services may be:

a) diagnostics carried out under continuous hospitalization, therapeutic, or rehabilitative care for inpatients, including long-term medical care
b) health care activities carried out in certain periods of the day for the purposes set up in the above paragraph
c) a course of treatment or a single procedure, after which it is necessary that the patient be kept under observation – and if necessary – further health care facilities can be accessed immediately.

Special care that needs specialized knowledge, special personnel and/or equipment (e.g. neurosurgery).

Organizational forms of inpatient institutions are: hospitals, national institutes, clinics, outpatient hospitals, nursing institutes.

d) further health care activities:

- Emergency duty service
- Rescue
- Transportation of the patients
- Caregiving
- Hospice and caregiving for dying patients

In 1997, hospice-palliative care was recognized by the new Health Care Act (99. §) and within the National Guidelines that were expanded in 2002 (the National Guidelines were published as a ministerial decree in 2010).

According the results of a research made by Hegedűs and her colleagues in Hungary strengths of that hospice-palliative care include a

well-developed legal mandate, government support and financing, and multi-level professional training available at various sites.[244] On the other hand, the lack of a genuine multidisciplinarity and the absence of physicians may be seen as barriers. Success may also be threatened by the lack of a comprehensive conceptualized health policy that is characteristic for Central-Eastern European political systems in general.[245]

- Rehabilitation
- Providing medicines
- Non-conventional procedures

244 These contracts – in a dogmatic approach – are so called administrative agreements, the subject and content of which are specified in detail by the laws, but the legislature gives a number of additional rights to the insurer (for example, the service provider has continuous reporting obligations, the insurer has constant right for thorough verification, there are wide opportunities for the insurer for one-sided contract resolution etc.).

245 Article 2 paragraph (1) of the HSA.

11. General issues related to financing

In the Hungarian health insurance system, the so-called National Health Insurance Fund Administration (OEP) signs financing contracts with the healthcare providers.[246] According to the provisions of Act LXXXIII. of 1997 on Services of the Compulsory Health Insurance System, called the Health Services Act (hereinafter referred to as HSA.), the contributing patients may access the services of those health care providers and institution with which the National Health Insurance Fund Administration signed a financing agreement for the given services (hereinafter referred to as funded).

Under the funding agreement the Insurer - in a very complex and post-factum financing and accounting system - will pay for the medical services instead of the patient. The principle for the accounting is different at each level of health care activities:

- in the basic level of healthcare - the number of the patients registered at a certain physician (quota)
- in the outpatient health care - the number of the treated patients
- in the inpatient health care - the performance calculated based on the actual weighted case number in a DRG (diagnosis related group).

The HSA contains an exhaustive list of health care services, disposing that the financing of these activities may be done according to:

a) the resource-related standards,
b) the tasks that must be fulfilled,
c) the recording of the number of treated patients,
d) the quota,
e) the performance criteria,
f) the quantity of the provided services,
g) the combination of the issues enumerated in par. a) – f).

In order to predict the expenses related to the health care and for the effective use of the financial resources, the legislature, the insurance company and the health care service providers use various *control mechanisms*. An essential starting point in this respect is that the patients will have

246 See: Fazekas – Koncz (n 32) 49.

access to the services and therapies – taking into account the financing, examining and therapeutic protocols issued in the base of the HSA – only in the measure justified by their health condition.[247]

Current level of development of medical science permits that most medical intervention be performed in several ways. In the major part of the cases the method is chosen based on professional considerations, but in some cases the convenience and the well-being of the patient and of the physician is also taken in consideration. The expenses of the therapy depend on the quality and content of the procedures. In the attempt to define the phrase *'health service package'* they try to limit the expenses related to health care services imposing restrictions for those who are entitled to these services.[248]

In the attempt to define the phrase 'health service package' they use several techniques. Amongst these one can see the above mentioned financing, examining and therapeutic protocols. These protocols are elaborated in Hungary since 2006 according to the legal provisions and they are applied to set in detail the content of the provided health care services.[249]

One of the most important measures taken to control the expenses related to health care services is the restriction of capacity (the limitation of the number of beds in a hospital, the efficient organization of outpatient care, etc.).

One of the limitation methods used by the insurance company is the quantitative limitation, meaning that the number of certain medical procedures set by the law for a year cannot be exceeded. After this number is reached, no more such procedures will be financed from the Insurance fund.

Yet, there is a rule called the guarantee rule, according to which the state is obliged to provide the services included in the HSA for the contributing patients, even if the costs related to these services cannot be financed from the Insurance Fund.[250]

247 The valid regulation regarding the elaborating methodology of the financing, examining and therapeutic protocols are included in Decree 5/2013 (III.5) issued by the Minister of Human Resources.

248 For details see: Fazekas – Koncz (n 32) 44.

249 Article 20 paragraph (1) of the HSA.

250 For details see: Fazekas – Koncz (n 32) 44.

The planabilty is optimized by the fact that according to the Financing Agreement, the health care service provider will:

a) use the waiting list in the case of inpatient care, if the health condition of the patient doesn't require urgent treatment

b) use the patient readmission list in the case of outpatient care (elaborated according to legal provisions) [251]

There are some health care services that are not financed by the Health Insurance Fund Administration:[252]

a) The first such category is the group of services financed from the state budget. These services will be provided without any documentation regarding the entitlement of the person. For example: emergency care, situations requiring immediate action to save the patient's life, family and woman protection activities offered to expectant mothers, access to blood supply, emergency in case of disasters.

b) The second category is the group of services paid by the employer (i.e. occupational health examination, medical expert activities)

c) The third category is the group of services for which the beneficiary will pay (e.g., accidents due to extreme sports, particularly dangerous pastime, hobbies, various aptitude tests, plastic surgery, detoxification and publishing medical report, etc.).

251 See, for example: Article 2 paragraphs (1)-(7) of the Social Security Act.

252 See, for example: Government Decree 195/1997 (XI. 5.), issued for implementation and enforcement of the Social Security Act.

12. Health care services

12.1. *Introduction. The basic principles of social insurance in Hungary*[253]

Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for these Services (hereinafter referred to as the Social Security Act) determines who the insured parties are, the extent of contributions, the method of contribution payments and obligations to keep records and supply data.

The Social Security Act disposes regarding the social security, private pensions and the coverage of these.[254] The Act is applicable for all the citizens of Hungary and for other natural persons who work independently on the basis of law in Hungary. Special provisions under the rules set out in this Act include social and community-wide risk, too.

Contribution to the social security system is compulsory according to the provisions of the law. In the compulsory social insurance scheme - in the absence of other provisions of this Act or of other laws - according to the principle of individual responsibility, if respecting the contribution requirements specified in this Act, the contributor and his relative(s) are entitled to certain social security benefits. The amount of the contribution is proportional with the insured's earnings if the law doesn't make any exception (see below). Another important aspect is that the employer is also obliged to contribute to the social security system to cover the expenses of eventual health and social problems of the employees (see below). [255]

The attributions of the state related to the functioning of the social security system and to the possibilities related to the development of the national economy:

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253 Health insurance is a proportionately calculated compulsory tax-like contribution (HI). The employer is obliged to pay the HI calculated on the basis of the salary for its employees (individuals having permanent residence in the country), and the employee (individuals having permanent residence in the country) is also obliged to pay the HI based on the earned wage.

254 Article 3 paragraph (1) of the Social Security Act.

255 Of course this is only a general rule. E.g. the so-called family allowance can reduce the amount collected for in-kind and cash contributions for health insurance and pension contributions.

a) compiling the list of the services included in the social security system,
b) determination of the sums payable to cover costs of the provided services,
c) elaborating the regulations related to the determination, declaration, recovery and recording of the sums mentioned in the point above,
d) regulating the system that ensures the control for the registration and monitoring of the contributions and services.[256]

12.2. *The beneficiaries of the social insurance system*

Since the compulsory social insurance system exists, the regulation differentiates two major groups:

- The insured citizens are those persons, who become entitled to certain health care services by paying the health contribution. The types of the insurance relationship are listed in the Social Security Act [Art. 5 paragraph (1)]. Insured citizens are predominantly those who fall into the category of employed people, public servants, self-employed or service providers, individual entrepreneurs, persons seeking for employment or having apprenticeship or study contracts.

The rate of the health insurance and labor market contribution to be paid by the insured is of 8.5 percent. Within the health insurance and labor market contribution, the rate of the in-kind contribution is 4 percent, the monetary contribution to health insurance is 3 percent, and the labor market contribution is of 1.5 percent.[257]

- Those entitled to certain services of the social security system cannot access cash benefits (as a rule they are entitled to health care services in case of accidents and to some medical services), they don’t pay any contribution, the costs of their treatment is financed form the central budget (the sums are transferred to the Health Insurance Fund)

256 Regarding the socially disadvantaged persons, see Article 54 of Act III of 1993 on Social Administration and Social Services.

257 Hajdú József – Homicskó Árpád, ’Bevezetés a társadalombiztosítási jogba’ [Introduction to the Social Security Law] (Patrocinium 2014) 58.

To health care services in case of accident are entitled for example: pupils and students of the higher education institutions (not including foreign nationals), mentally ill people treated in the sociotherapeutical medical institutes, and addicts, detained, persons being in pre-trial detention, persons being imprisoned and sentenced to prison sentence.

Entitled to health care services are – in addition to those insured – e.g. those who live on sickness benefit, maternity allowance, child care allowance, accident and sickness allowance, full-time students, students in social need, homeless, minors with domestic residence, or minors who are Hungarian citizens, but have only temporary residence.[258]

The domestic citizen who is uninsured and not eligible for health care services, is required to contribute to the costs of medical services. For example – among others – those who develop additional activities are obliged to pay health service contribution, the amount of which is since January the 1st 2014, HUF 6810/per month (227 HUF per day).[259]

The social security benefits may be accessed also on the basis of an agreement (this option is basically available for foreign persons, who are not included in the categories described above).[260] One may enter into an agreement with the Health Insurance Company for the own health care services or those provided for the cohabiting child. In this case a contribution – stipulated by the law – will be paid by the future beneficiary. The conclusion of the relevant agreement will be done at the (County/Metropolitan) Governmental Cash Management Office of the Health Insurance Department. The minimal amount of the contribution for which this agreement may be concluded is 50% of the minimum wage for adults, and 30% of the minimum wage for children under the age of 18 and students (with foreign citizenship) studying at Hungarian Universities.

The period of the validity of the health insurance is extended for a certain period of time after the expiry of the entitlement. This is called passive entitlement. The period of the passive entitlement is generally 45 days long.

258 Article 3 paragraph (1) of the Social Security Act.
259 Article 14 paragraph (1) of the Social Security Act.
260 Article 29 paragraph (4) of the HSA.

The sphere of services – that can be accessed by those who are or not entitled regardless to whether contributing or not, having insurance or not, obliged to support any further costs or not – is set by a separate law.

12.3. *Services covered by health insurance*

The services provided through the social insurance system can be accessed in the form of health insurance or pension insurance.[261]

The services covered by health insurance in Hungary are:

a) *health care services,*
b) *benefits in cash,*
c) *services in case of accidents,*
d) *services offered to people with altered working abilities.*

12.3.1. Health care services provided by the health insurance system

In order to access the health care services - in lack of other legal provisions - the entitled person must have a Social Insurance ID-number (SIID) and a valid ID card (the persons over 14 years).[262]

a) Health care services available free of charge

I. Prevention and health care services for the early detection of the disease

II. Medical treatments:

a) health care provided by the family physician;
b) services provided by dentistry;
c) outpatient care.
Some of these outpatient services may be accessed without a referral, but some are prerequisited by a referral. The insured person – as a general rule – may access without a referral the following health care services:
ca) dermatology
cb) gynecology and pediatric gynecology

261 Government Decree 217/1997. (XII. 1.) on the Execution of Act on Services of the Compulsory Health Insurance System.
262 Article 3 paragraph (1) of the HSA.

cc) urology
cd) psychiatry and addictology
ce) ear, nose and throat specialist and pediatric ear, nose and throat specialist
cf) ophthalmology and pediatric ophthalmology
cg) surgery and emergency surgery
ch) oncology[263]

Those special health care services that are not listed above can be accessed by the insured person (as a general rule) based on the referral issued by the family physician or family pediatrician (hereinafter the family physician), the dentist for the purpose of concilium, and the outpatient care providing physician. *However, there are some very costly exploration methods [MRI (magnetic resonance imaging), CT (computed tomography), DSA (digital subtraction angiography)], for which it is necessary the referral of the outpatient or inpatient hospital's specialist.* The inclusion on the waiting list for the PET-CT (positron emission tomography-computed tomography) will be done based on the recommendation of the outpatient or inpatient hospital's clinical oncologists, hematologists, neurosurgeons and neurologists in concordance with the indications of the law.[264]

d) In-patient health care services
In-patient health care services can be accessed by the insured person (as a general rule) based on the referral issued by the family physician or family pediatrician (hereinafter the family physician), the dentist for the purpose of concilium, and the outpatient care providing physician.[265]

III. Other health care services:

a) health care provided by the obstetrician
b) medical rehabilitation
c) transportation of the patients, rescue

263 Article 3 paragraph (3) of the HSA.
264 Article 21 paragraph (1) of the HSA.
265 For international comparison see: Baji Petra – Boncz Imre – Jenei György – Gulácsi László, ‚Comparing cost-sharing practices for pharmaceuticals and health care services among four central European countries' (2012) 34(2) Society and Economy 221-240.

b) Services with subsidized price

The insured is entitled to receive the price of the medicines ordered for therapeutic scopes, of the medication for particular nutritional purposes, of the medical devices and of the medical supplies, and of the in-patient hospital treatment, as well as to get funding for the repairing and rental fees of the medical devices.[266] The most typical health care service is the spa service.

c) Health services available for partial charge[267]

The ensured person is entitled to partial orthodontics and prosthesis (over 18 years) for partial charge. The ensured is also entitled to access a health care service prerequisited by a referral, without such a document if ready to pay a partial charge.

d) Health services available of equity reasons

The OEP – from the budget of the EA and to a certain limit – may subsidize of equity reasons some activities, procedures and treatments that are professionally accepted in Hungary but are not yet included on the list of financed services. The application of a certain medical procedure for other reason than the traditionally accepted one may also be subsidized by the OEP in the conditions mentioned above. Besides, if the patient is ready to partially contribute to the costs of the procedure, the Company may take over the remaining expenses.[268]

e) Treatment abroad

Council Regulation (EC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community and the Regulation (EC) No 883/2004 of the European Parliament and

266 Article 26 paragraph (1) of the HSA.
267 For more details see: Fazekas – Koncz (n 32) 41-43.
268 Articles 42/A - 42/D of the HSA.

of the Council of 29 April 2004 on the coordination of social security systems (hereinafter referred to as EC Regulation 883/2004) have become applicable for the Hungarian health care system as well, since 2007. Starting with the middle of the nineties - primarily based on the jurisprudence of the European Court of Justice - an important process of change began regarding the possibilities of accessing health care services provided by a member state other than the state of residence. The European Court of Justice has consistently held that the principle of free movement of services and rules must be validated related to the sphere of health care services, too. The outcome of this is the Directive 2011/24/EU of 9 March elaborated by the European Parliament and the Council regarding the market of cross-border health care services and patients' rights (hereinafter: Directive 2011/24/EU), which prescribes not just the cooperation based on mutual liability between the national health insurance systems of the member states, but in the same time the patients' right to freely choose a health care service provider in another Member State, too.[269]

We must add to this point that residents of the European Union, Iceland, Norway, Liechtenstein and Switzerland, who are entitled to health care of the national health services or mandatory health insurance scheme of their respective countries of residence, can receive in Hungary the health care which becomes necessary on medical grounds during temporary stay in Hungary taking into account the nature of the benefits required and the expected length of stay.

Patients of another Member States can choose whether they receive cross-border healthcare under the same conditions as Hungarian insured persons or as private patients. The first option means in practice that the patient is subject to the same conditions concerning the access to treatment as Hungarian insured persons e.g. waiting lists, s/he receives treatment from a healthcare provider contracted to the National Health Insurance Fund Administration and s/he pays the charges equaling to the domestic cost. In case of the second option the patient is treated fully as a private patient, in particular s/he is cared in a private health care provider and s/he has to pay the charges determined by the healthcare provider.

269 Article 43 paragraph (1) of the HSA.

12.3.2. Financial services of the health insurance systems

Financial services of the health insurance systems are:

a) pregnancy confinement benefit;
b) child care fee;
c) sick-allowance.

Ad a) If the woman who bore a child acquired an insurance term of at least 365 days in the two years preceding the birth, she becomes entitled to pregnancy confinement benefit. This support can be granted for the 168 days after the child is born. This maternity benefit is 70% of the average daily wage.

Ad b) Eligible for child care fee is the parent, who within the last two years prior to the requesting of the aid - and in the case of birth giving mothers, prior to the date of birth - had valid insurance for at least 365 days. After the expiry of the pregnancy confinement benefit those parents who had been employed formerly are entitled to a child care fee until the child has reached the age of two. The maximum period that the child care benefit may be accessed is equal with the number of days for which the mother had valid insurance within the two years prior to the childbirth (when giving birth to a child) or to the obtaining of the parental rights. Its amount is 70% of the average daily wage (calendar day), but not more than 70% of double the average wages per month.[270]

Ad c) Eligible for sick allowance are those persons who became unable to work and to whom the provisions of the Social Security Act are applicable.[271]

The amount of sick allowance is calculated based on the average income per calendar day and is[272]

a) 60% in the case of a two years with valid insurance
b) 50% in case of a shorter period of time with valid insurance

270 Article 39 paragraph (1) of the HSA.
271 Article 18 paragraph (4) of the Social Security Act and Article 19 paragraph (5) of the same Act.
272 Article 39 paragraph (1) of the HSA.

The sick allowance is paid to the hospitalized patients, but the amount paid for a day cannot exceed the thirtieth part of the 200% of the minimum wage valid on the first day of the entitlement.

It is important the fact that the employer also contributes to the payment of this sum: if the employee is in incapacity of work and needs inpatient care the employee will pay one-third of the sick allowance in the form of a contribution.[273]

If a person is entitled simultaneously to various type of allowances (sick allowance, child care fee, pregnancy confinement, accident aid), he/she – as a general rule – must choose one of these benefits.[274]

12.3.3. Accident benefits of the health insurance system

Services in case of accidents:

a) accident health service;
b) sick allowance in case of accident,
c) benefits in case of accidents.

Ad a) To health care services in case of accident are entitled for example: pupils and students of the higher education institutions and the pupils/ students of other institutions not included in the system of public education excepting foreign citizens.[275]

Ad b) As a general rule the provided financial assistance equals the insured person's income used as a basis for calculating the health insurance contribution, i.e. 100% of income used as a basis for calculating accident sick pay, or 90 percent of such income in relation to road accidents.

Ad c) To accident allowance are entitled persons who have suffered an accident at work causing over 13 percent damage to their health and are not eligible for the allowance for people with altered working abilities. According to the general rule, if the degree of damage doesn't exceed

273 Article 15 paragraph (2) of the Social Security Act.
274 Article 57 paragraph (1) of the HSA.
275 Article 50 of the HSA.

20%, the accident allowance can be accessed for two years, if it exceed 20% there is no such time limitation.[276]

12.3.4. The benefits provided by the health insurance system to the persons with altered working abilities[277]

The health insurance agency – in the context of the Health Insurance Fund's annual budget – may set maternity benefits, child care fees and sick allowance for an insured person based on equity reasons even if he/she doesn't have the necessary period of valid insurance.

Benefits offered to people with altered working abilities are:

a) disability allowance;

b) rehabilitation allowance.

276 Article 57 paragraph (1) of the HSA.

277 Article 50 of the HSA.

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