Hospital financing in Hungary

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Context

• Number of hospital beds:
  – app. 800 per 100,000 inhabitants (2006)
    • of which 600 acute and 200 chronic
  – app. 710 per 100,000 inhabitants (2007)
    • of which 440 acute and 270 chronic

• Hospital admission rate: 22 cases per 100 inhabitants (2006)

• One day surgery rate: 10,5% (of possible cases)

• Hospitals are owned by local governments.
• Huge regional inequalities.
• Capacity decisions are made by the Ministry of Health.
• Policy goal: more definitive care at lower levels.
Overview of Hungarian hospital financing

• Large number of integrated outpatient care providers and hospitals (with both acute and chronic care)

• Fee-for-service financing in outpatient care
• Day-based financing in chronic care
• DRG-based financing in acute care since 1993
  – Continuous update (now: version 5.0)
  – No ongoing cost analysis (lobbying)

• No depreciation costs are included in DRG values
Overview of Hungarian hospital financing (2)

• Primary goal: delivering budget targets
• Various techniques:
  – Budget limitation and floating HUF/DRG conversion
  – HUF/DRG prices are set at low level, then the remaining budget is distributed among hospitals
  – „Normalizing”: average CMI is reset at 1.00
• Lack of control / supervision

• Consequences:
  – Increasing number of cases (1.4x), increasing CMI (1.2x)
  – Gaming
Introduction of degressive financing

• Primary goals: (a) no more increase in the number of acute cases, (b) less gaming and (c) keeping budget target

• Degressive financing („performance volume limit”) - 2004:
  – both for DRGs and outpatient care fees
  – up to 98% of 2003 DRGs are financed at 100% price
  – up to +5% → at 60%
  – +5% - +10% → at 30%
  – +10% - → at 10%

• Freeze (absolute limit) at 95% of previous year (July 2006)

• Decreasing the total contingent by 15%, however, increasing HUF/DRG prices by 7,5% (April 2007).

• Hospitals are free to prioritize their services within the contingent (make portfolio decisions).
Options for adjusting the limit

• Seasonal correction.
• With new purchasing contract (capacity + contingent).
• Reallocation at regional level:
  – owners among their hospitals
  – between two hospitals (with consent of owners)
• Reallocating 50% of remaining (not used) contingent:
  – at national level (Contingent Committee)
• Restructuring:
  – acute care bed → chronic care bed: 60% cont. / day-based
  – acute care bed → outpatient care: 30% cont. / 70% fee-for-service
    (later: automatic reallocation within the institution)
  – acute care bed → one day surgery: 20% cont. / contract-based
• Some procedures without limitation / with „secured” contingent.
The effect of degressive financing  
- at macro level

2003-2006:
• Case number increased by 3%.
• Total acute care days decreased by 7%.
• Volume of DRG points: +0,5%
• CMI: -2,8%
• „Loss” of hospitals due to the degression: 3,3%
  – University hospitals and specialized institutions lost more

2006-2007:
• Volume of DRG points: -20%
• Case number: -21%
• CMI: +1,2%
The effect of degressive financing
- at micro level

2003-2006:
• There was no strategic response: the limit was perceived as a temporary measure by the institutions
  – Increasing role of controlling and cost accounting (average variable cost is <30%)
  – Several hospitals went up to 110%.
  – Cheating paid off better than trading away overcapacity.
  – Exceeding the limit was seen as a lobbying tool.

2006-2007:
• No dramatic change (only in words)
• Priorities were set correctly by hospitals:
  – e.g. the same DRG output in oncology, huge decrease in orthopedics
• Differences among hospitals have increased:
  – average waiting times are standard, however some institutions created long waiting lists
Conclusions

• May be a good policy tool of cost containment but with several conditions.

• No change in strategic behaviour of hospitals.
  – Underdeveloped or nonexistent controlling systems → hospitals are revenue (not profit margin) –oriented
  – Owners are local governments

• No systematic attempt to have contingents meet real health provision needs. Missing elements:
  – Population needs;
  – Patient mobility;
  – Monitoring waiting times; OR
  – Real incentives for capacity trading.