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Article

The Development of the Private Health Sector in Hungary in a European Context

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Abstract: The aim of this paper is to examine the situation of private healthcare providers in Hungary and their relationship with publicly funded healthcare. The private healthcare sector is growing significantly in Hungary and worldwide. As a percentage of GDP in Hungary, government spending on health has always been among the lowest in Europe, averaging 5% over the last 20 years. The Hungarian state-financed healthcare continues to operate on a single-payer national health insurance system. Therefore, private healthcare is financed exclusively by private insurance and/or out-of-pocket. In 2021, the Hungarian population spent HUF 420 billion on private outpatient and inpatient care. Based on 2021 balance sheet data in Hungary, 195 providers had an annual net turnover of more than HUF 100 million, with a combined net turnover of HUF 211 billion in 2021. The total number of full-time employees was 8336, with a total of 4 218 doctors (employed or contracted) in 114 specialties, which means that a parallel healthcare system has been set up along with public care. The joint management of public and private care capacities and the introduction of sector-neutral financing would improve access to publicly funded care. Widely available and transparent private health insurance schemes could reduce the population's out-of-pocket burden. It would also be essential to increase participation in health savings schemes, as although there are currently more than 1 million members of health insurance funds, the average value of the personal accounts is meager.

Keywords: private health, health systems, health insurance, health expenditures, Hungary;

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INTRODUCTION

Privately funded health care is gaining ground strongly, and the sector is growing in importance in Hungary and worldwide. This is due to the fact that health budgets in most countries are underfunded, so the gap between what is professionally possible and what is publicly funded for the population is widening, and this is further exacerbated by the continuing growth in demand for health services. Due to the low governmental funding the patients need to finance some of their necessary healthcare services out-of-pocket everywhere. The ratio of governmental and private spending varies between countries, and also the structure of private financing is different, whether it is covered by mostly private insurance or out-of-pocket savings.

In this article we analyze the reasons behind the growth of the privately funded health sector in Hungary, and describe the size of the market from both demand and supply aspects Our aim was to examine the situation of private healthcare providers in Hungary and their relationship with publicly funded healthcare, as it is not properly researched and aggregated data is not available. This is a hot topic as healthcare financing and the improvement of the healthcare system from both access and quality aspects are top priority, and this article can support the healthcare policy decision makers to find the proper solutions.

METHODOLOGY

In this article only secondary data was collected and used. We obtained data from various sources. For the analysis of macroeconomic trends, we collected data from the OECD Health Statistics portal (OECD Health, 2023; OECD Health 2024) and from the official site of the Hungarian Health Insurance Fund (NEAK, 2024), and also used data from reports issued by the Hungarian Statistical Office (KSH, 2013; KSH 2019). For the analysis of the private health care providers' market, we collected data from the Hungarian Company Registry (Dun & Bradstreet, 2024), where the operational and financial data from the yearly statements of the companies are listed.

RESEARCH RESULTS

Macroeconomic trends

To put the private health sector in context, we must look at government health spending. Government spending on health as a share of GDP in Hungary has always been among the lowest in Europe, averaging precisely 5% over the last 20 years (ranging from 4.3% to 5.7%). The 2021 data for Hungary is 5.3%, while the 2022 figure is even lower at 4.9%. By contrast, in Germany, France and the United Kingdom, government spending on health will exceed 10% of GDP (Table 1).

Looking back over the past 20 years, one of the cornerstones was the economic recession caused by the credit crunch of 2008-2009, which forced many governments to cut central health budget spending. This has been a significant challenge because almost three-quarters of health expenditure comes from public sources, and there was a marked increase in public health expenditure before the global economic crisis, which has since been negligible. Growth in private health spending also declined after 2009, but this was less pronounced than in the public sector (cost-sharing measures). Following the fiscal austerity of 2008-2011, the steady increase in health fund spending resumed. The next milestone for the development of the private health sector was the COVID-19 pandemic, which broke out in 2020, and the measures taken to contain the pandemic only increased the demand for private health care as access to public care had been limited for a prolonged period. This was unintentional, with no cost savings for the government and meant a significant additional burden on the budget to fight the pandemic. Most of the Hungarian government's health expenditure is on curative medical care, which has been increasing significantly year by year. In contrast, the nominal amount of the pharmaceutical reimbursement budget, the third largest item, has remained stable for years, mainly due to the rise of generic drugs (Figure 1).

Almost half of the out-of-pocket (OOP) healthcare costs were incurred in outpatient and inpatient curative/preventive private care, which describes the private healthcare sector from the demand side, totaling HUF 420 billion in 2021. We can see that outpatient care is much more significant regarding the number of inpatient events in the private health sector (Figure 2).

Historical background and legal framework

As a legacy of the socialist system, the Hungarian publicly funded health care system continues to operate on a pillar and pay-as-you-go basis, i.e. the rate of health insurance contributions is not related to the range and quality of services provided. The National Health Insurance Fund of Hungary (NEAK) manages the Health Insurance Fund, which provides almost full coverage, ensuring universal access to publicly funded services. Although the public health care system has undergone many

developments and reforms over the last 20 years, the health insurance system has not been restructured, nor has it been multi-level and/or multi-insurance. There are several types of healthcare systems in many countries. Highlighting the "Visegrad 4" countries, Poland, like Hungary, has a single-payer system, while the Czech Republic and Slovakia have a multi-payer model with a choice of insurer (Table 2).

In Hungary, we should mention the institution of the gratuity, which was also a legacy of the previous system, and its primary function was to ensure the fastest and best quality access to services in public health care. Thus, in a system that was supposed to be 'free' but was in fact covered by health insurance contributions, its existence imposed an additional heavy burden on the population. The EHIS ("ELEF" in Hungarian) Report in 2009 reported 76 billion HUF; in 2018, this figure was 36.7 billion HUF (KSH, 2009; KSH, 2019). Over these 10 years, the level of gratuity has decreased significantly, mainly thanks to the Hungarian Residents' Association campaign and the "1001 doctors without gratuity" group. The institution of gratuity was abolished, and its acceptance was criminalized by the "Act C of 2020 on the Health Services". Of course, its entry into force on 1 January 2021 did not abolish the giving and accepting of gratuities in one fell swoop. Still, it drastically reduced its level, and during the years that have passed since, it has almost disappeared from the system. The law came into force on 1 January 2021, and, in addition to the abolition of the gratuity, it also provided that doctors and health workers had to make a declaration until 29 April 2021 whether they stay in the public health system as public servants, with the possibility of limited, pre-announced and licensed private health care options. The law underpins the government's ambition to fully separate public and private health care, i.e. health professionals working on public infrastructure and public salaries should not be allowed to practice private medicine during working hours (except for publicly funded clinics and hospitals that operate their private clinics, whereby the revenues from private health care services enrich the budget of the institutions).

In conclusion, the Hungarian private healthcare sector has to develop on a purely market basis, but with a solid ballast to date, because it has to provide such a high level of service in contrast to the "free" publicly funded healthcare in the domestic market that justifies patients paying the total cost of private care in addition to the health insurance contribution, in a so-called dual financing system.

Service provider types and their evolution

Rékassy identified the following types of private healthcare providers (Rékassy, 2014):

1. Private medical practice - "Grandma's former maid's room"
2. Genuine skimming - a classic form of pay-as-you-go
3. One-man medical practice
4. Individual doctors working together in a group practice
5. Private service of a specialized group of doctors
6. Private practice, hospital: professional vs. financial investor
7. Network health service provider or health care organizer
8. Contracted health care provider with state (NEAK) subsidy
9. Fee-paying services in public hospitals

Service types like Rékassy's have undergone significant changes in the ten years since then. One reason for this is that the sector has become "whitewashed" in certain respects, with the first two types virtually disappearing: online billing and the introduction of centralized electronic health records (EESZT), which is also mandatory for private providers, have made it virtually impossible for a doctor to provide healthcare without a business and billing, and the abolition and strict control of pay-as-you-go has meant that doctors cannot treat their private patients in publicly funded institutions.

Over the last ten years, the trend has been that many group practices or specialized medical practices have become private clinics. In many cases, the professional investor, the physician owner, has been replaced by a financial owner and his delegated management (Rékassy et al., 2018). Whereas in 2001, there was only one network health service provider in Hungary operating exclusively in Budapest, by 2024, the number had risen to 39. The infrastructure of private healthcare providers remains largely capital-centric, with the expected trend in the coming years being the emergence of providers with nationwide coverage, the expansion of existing networks, and the organic growth and expansion of private rural practices. This is due to a clear increase in the solvent demand, which has now reached a concentration in many rural towns and cities (Hungarian population, foreign workers and health tourists combined), which seems to be recouping the high investment costs in these settlements.

Healthcare organizers are now definitely separated from care providers in most cases. Their role is increasing with the spread of health insurance schemes, as the insured is not in direct contact with the care provider. The healthcare organizers' role is

to link them in a medically professional but cost-effective way.

Service providers

It is essential to define who we consider to be private healthcare providers. Lantos wrote 2018 that having a mixed model of health care providers is more common than a pure model of ownership and financing (Lantos, 2018). The number of possible non-mixed statutory options is four: private care with private funding, private care with public funding, a publicly owned provider with a privately funded service, and finally a state-owned provider with state funding.

For defining private health service market, it is not the identity of the owner that is important, but the financing of the services used (Rékassy et al., 2018). For the purposes of this analysis, a private health service provider is defined as a health service provider that does not generate exclusively publicly financed revenue, i.e. that finances at least part of its activities from the out-of-pocket costs of the population. On this basis, private healthcare providers can be categorized, using Lantos' clusters, as firms and institutions into four business models. The first model is the privately owned service provider with purely private funding. The second model is the privately owned provider that is financed partly publicly and partly privately, and the third model is the publicly owned provider with a privately funded service, meaning that state hospitals and outpatient clinics provide services outside the national health insurance coverage.

The limitation of our analysis is that we do not have available data to separate publicly funded and privately funded revenues in the case of Model 2 institutions, so these mixed-funded firms and institutions are included in the statements with their total.

The OECD data showed that the Hungarian population spent HUF 420 billion on private outpatient or inpatient care in 2021, of which HUF 128 billion was for private dental care; minus this, we get HUF 291 billion as the total market size (OECD Health, 2023). Based on 2021 balance sheet data in Hungary, 195 providers (groups) had a net turnover of more than HUF 100 million, with a combined net turnover of HUF 211 billion in 2021. In other words, the companies we surveyed account for 73% of the total market, and only 27% of the market is accounted for by one-person medical practices and smaller private practices and clinics with a total net turnover of €80 billion.

There was a massive jump in revenue and profit after tax during the COVID-19 pandemic, with private healthcare providers seeing a 32% increase in revenue and a 90% increase in profit from 2020 to 2021 (Dun & Bradstreet, 2024). The turnover of private providers increased with the emergence of "waiting lists" in private healthcare. The 11% increase in 2022 was below that year's 14.5% inflation rate, with revenue growth typically driven by price increases rather than turnover growth (Figure 3 and Figure 4).

Figure 5 shows that the total number of employees of private health care providers was 8336 in 2023, with a total of 4218 doctors in 114 specialties (employed or contracted), i.e. a health care system parallel to public practices and hospitals was partially established.

DISCUSSIONS

Multi-level health insurance

A solution to share the additional burden on the population could be a tiered health insurance model, which could be implemented even within the existing single-payer insurance system. In 2012, Rékassy wrote that the state should commit to maintaining only a limited-access system with limited access from certain aspects of existing resources, i.e. a "basic package" should be defined, with a critical limitation, and the state health insurer should operate the supplementary insurance (Rékassy, 2012). In this case, however, the principle of solidarity would have to be abandoned, as a minimum level of benefits would have to be set for those who pay less and higher levels of contributions (i.e. supplementary insurance payers) would have to be linked to higher benefit packages. If the new system were to be budget-neutral, lower payers would be effectively excluded from higher levels of care and modern therapies, as they are the very section of society that cannot afford higher levels of private healthcare. Because of this the introduction of multi-level health insurance system is not recommended, as this would deepen the gap between the different segments of the society.

Joint management of public and private capacity

Kincses said in 2019 that "private health care is no longer complementary, it is no longer a choice, so private health care should be seen as an integral part of the care system with equal rights and obligations, there is one health care system, and there is a need for uniform professional regulation, control, professional supervision, accountability, transparency and a shared information system." (Kincses, 2019). This has since been achieved through the legislation governing the operation of private healthcare providers and their mandatory

participation in the Electronic Health Service Space (EESZT). The capacity expansions that have been and are planned for private providers would allow them to complement the public care system and thus enable more patients to access publicly funded health care more quickly, while reducing the OOP expenditure of the population. This would, however, lead to a situation where public health expenditure would become uncontrollable and therefore, sector-neutral funding would operate only through individual agreements, limited to certain therapeutic areas (e.g. renal dialysis, spinal surgery), and in recent years the opposite trend has been in place in several areas (e.g. IVR, imaging diagnostics) to achieve tighter public cost control. In our opinion the joint management of public and private capacity, the so-called sector independent financing is the right solution for the shortage of capacity in the public healthcare system. With this the waiting lists can be better managed, on the other hand proper limits should be set to each intervention to maintain budget control.

Self-care, health insurance

Without a complete structural overhaul of public health insurance, only widely available and transparent private health insurance schemes could reduce the OOP burden on the population. Rékassy reached the same conclusion in 2012, but unfortunately no significant progress has been made (Rékassy, 2012). This would require not only product development by insurers but also financial education of the population in the field of health care so that more and more people would be willing to take out insurance or participate in health savings schemes. In our opinion all market players, e.g. insurance companies, service providers and the government should invest in the education. Furthermore, it is crucial that employers increasingly look to supplementary health insurance for employees as a means of attracting and retaining staff. In the short term, this will likely be a significant source of growth in the number of insured people.

At the end of 2023, there were 1.04 million members of voluntary pension funds in Hungary (Nagy, 2023). The total savings managed in health funds exceeded HUF 81.6 billion at the end of the fourth quarter, which, when divided by the number of members, translates into savings of only HUF 78 500 per member. This average account value is very low, the overall health savings are not significant, they certainly do not cover the cost of treatment or surgery for a serious illness in private care. This situation would be significantly improved if the government made employer contributions tax deductible again, as before 2019.

CONCLUSIONS

Government spending on health in Hungary has remained stable at around 5% of GDP for the past 20 years. Although in nominal terms, the e-fund has increased significantly year-to-year since 2011, in real value, we see minimal increases or slight decreases. Consequently, the increased costs of health care are being covered by the increasing share of OOP costs in the population, as more patients seek private health care providers. This phenomenon is being mirrored on the supply side, with private healthcare providers constantly evolving and expanding both in terms of geographical coverage and service portfolio. It is important to further monitor the privately funded healthcare market in comparison with the state funded healthcare to see if the balance is appropriate and the OOP burden of the population does not exceed a certain level.

REFERENCE LIST

[1] Dun & Bradstreet (2024). Hungarian Company Registry data. Retrieved March 19, 2024, from https://www.partnercontrol.hu/

[2] European Health Interview Survey (EHIS) Hungary (2009). Health status and health care system, KÖZPONTI STATISZTIKAI HIVATAL, 2013 Népesedési és szociális védelmi statisztikai főosztály Retrieved March 19, 2024, from https://www.ksh.hu/docs/hun/xftp/idoszaki/elef/elef_2009_3.pdf

[3] European Health Interview Survey (EHIS) Hungary (2019). Health status. KÖZPONTI STATISZTIKAI HIVATAL, 2019 Retrieved March 19, 2024, from https://www.ksh.hu/docs/hun/xftp/idoszaki/pdf/egeszsegugyi_helyzetkep_2019.pdf

[4] International Social Security Association (2021). Improving health insurance systems, coverage and service quality. Retrieved March 19, 2024, from https://www.issa.int/hu/analysis/improving-health-insurance-systems-coverage-and-service-quality

[5] Kincses, G. (2019). A köz- és a magánszféra szerepe az egészségügyben [The role of the public and private sectors in health]. Magyar

Tudomány 180(10), 1510-1522. https://doi.org/10.1556/2065.180.2019.10.11

[6] Lantos, G. (2018). Párhuzamos valóság, a magán eü-i rendszer kiépülése [Parallel reality, the emergence of the private health care system]. Társadalmi Riport, https://doi.org/10.61501/TRIP.2018.16

[7] Nagy, Cs. (2023). Savings record and double-digit returns for pension funds. Retrieved March 19, 2024, from https://www.penztarszovetseg.hu/wp-content/uploads/2024/02/OPOSZ-sajtokozlemeny_Nagyot-hajraztak-az-onkentes-penztarak-2023Q4_20230207.pdf

[8] National Health Insurance Fund of Hungary - NEAK (2024). Cash flow performance of the Health Insurance Fund. Retrieved March 19, 2024, from https://www.neak.gov.hu/felso_menu/rolunk/kozerdeku_adatok/gazdalkodasi_adatok/koltsegvetes_beszamolok/EAlap_bevetel_kiadas

[9] OECD Health (2023). Health expenditure and financing. Retrieved March 3, 2024, from https://www.oecd.org/health/health-data.htm

[10] OECD Health (2024). Country Profile Hungary 2023. OECD Publishing, https://doi.org/10.1787/5adc0e05-hu

[11] Rékassy, B. (2012). A magánbiztosítás lehetséges szerepe a hazai egészségügy többlet forrásainak megteremtéséhez [The potential role of private insurance in generating additional resources for domestic health care]. IME 2012(8), 5-10. https://www.imeonline.hu/tmp/b3bfbdf0d13a12bdb22bea9b969c318e.pdf

[12] Rékassy, B. (2014). Virágozzék minden virág? A hazai magán egészségügyi szolgáltatók tipizálása és jövőképe [May all flowers bloom? Typification and vision of domestic private healthcare providers]. IME 2014(10), 12-19. https://www.imeonline.hu/tmp/bb9f6ef9dcf6e2dbc30833ed35592815.pdf

[13] Rékassy, B., Kincses, G., Révész, S., & Soltész, A. (2018). Vadkapitalizmus virágzása, azaz mit szül a szabályozatlanság az egészségügyben, I. rész [Wild capitalism in full bloom, or what unregulated health care brings, Part I]. IME, 2018(6), 8-15. https://www.imeonline.hu/tmp/9b1964d3ca1a4afe012f6ea9554d1312.pdf

FIGURES

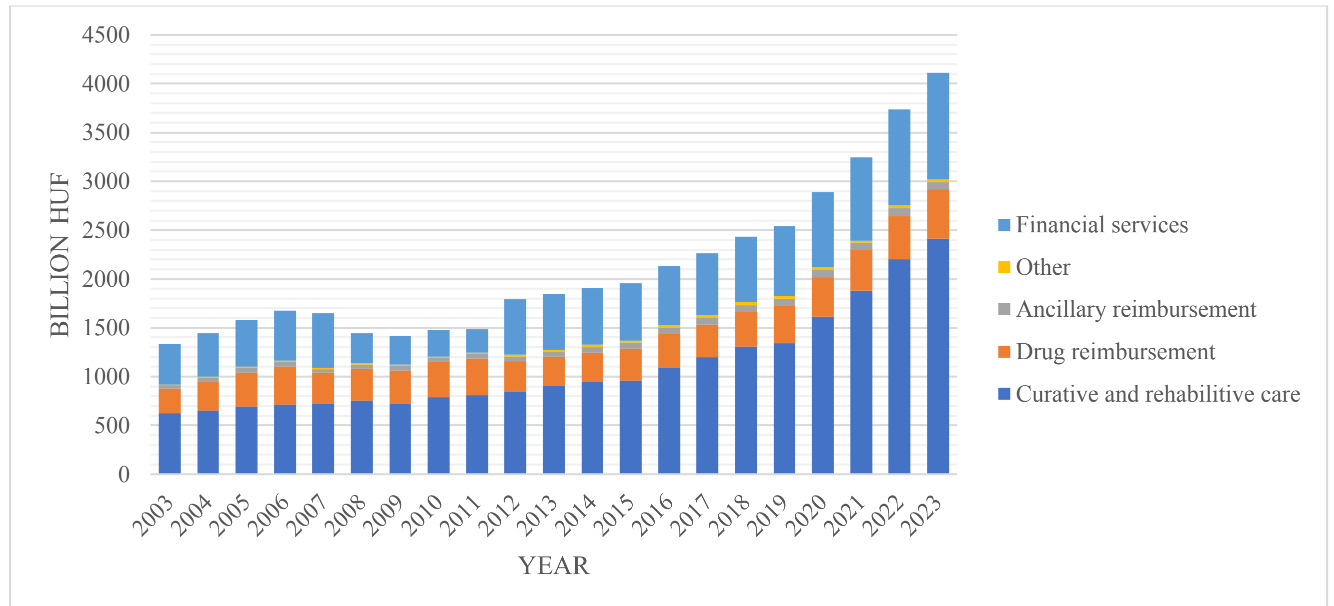

Figure 1.
Composition of Health Insurance Fund expenditure and its annual variation from 2003 to 2023
Source: compiled by the author based on NEAK Statistical Yearbook and the E-Fund Reports.

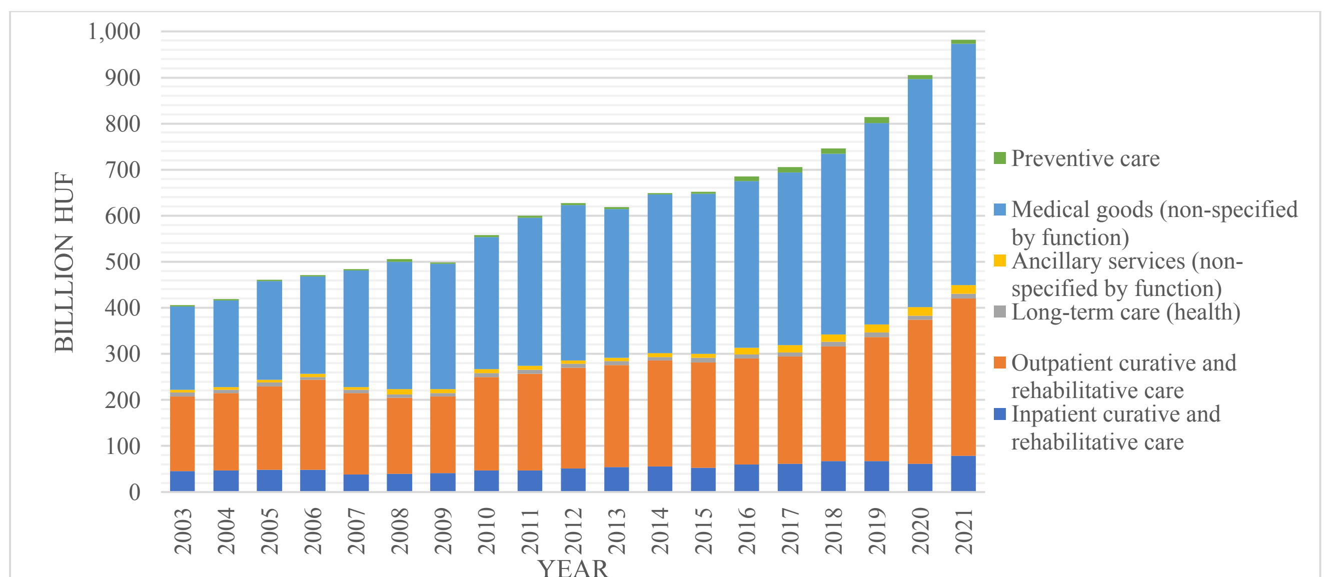

Figure 2.
Out-of-Pocket (OOP) expenditure composition in Hungary and its change from 2003 to 2021
Source: compiled by the author based on OECD Health Statistics data.

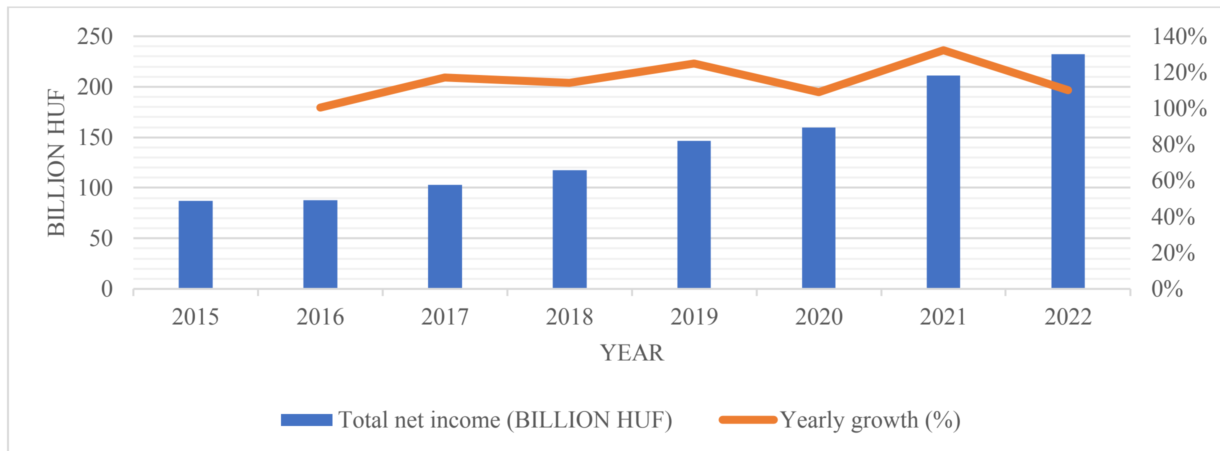

Figure 3.
Evolution of the aggregated turnover of the 192 private healthcare providers (group) from 2015 to 2022
Source: compiled by the author based on Hungarian Court of Registry data.

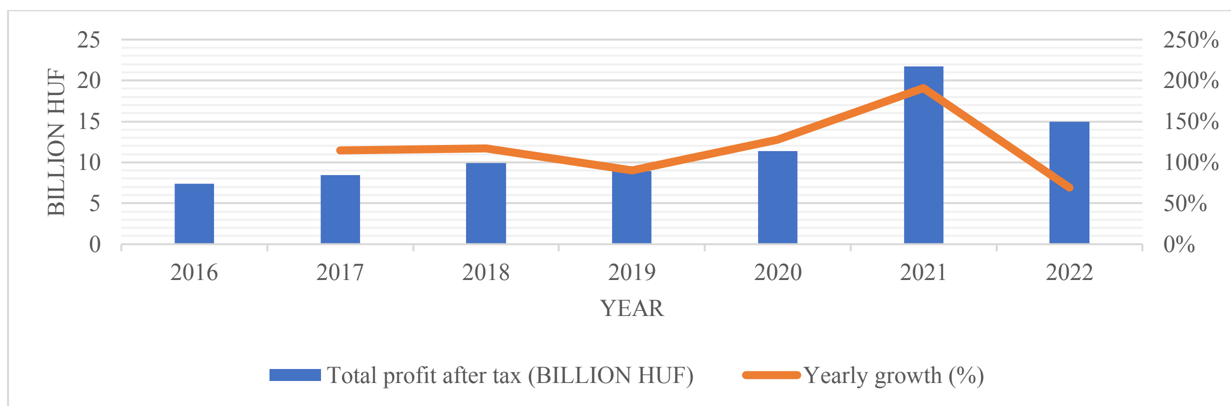

Figure 4.
Evolution of profit after tax (HUF bn) of 192 private healthcare providers (group) from 2016 to 2022
Source: compiled by the author based on Hungarian Court of Registry data.

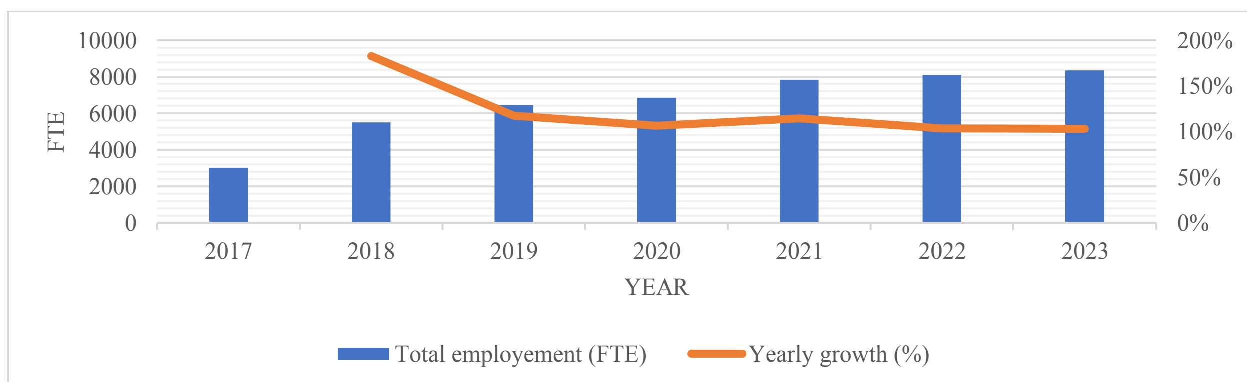

Figure 5.
Evolution of the total number of employees (FTE) of the 192 private health care providers (groups) from 2017 to 2023
Source: compiled by the author based on Hungarian Court of Registry data.

TABLES

Table 1.
Government health spending in OECD European countries as a share of GDP in 2021

Country	Government health spending as a share of GDP in 2021 (%)
Austria	9.5%
Belgium	8.6%
Czechia	8.2%
Denmark	9.2%
Estonia	5.7%
Finland	8.2%
France	10.4%
Germany	11.1%
Greece	5.7%
Hungary	**5.3%**
Iceland	8.1%
Ireland	5.2%
Italy	7.1%
Latvia	6.3%
Lithuania	5.4%
Luxembourg	4.9%
Netherlands	9.6%
Norway	8.5%
Poland	4.7%
Portugal	7.0%
Slovak Republic	6.2%
Slovenia	7.0%
Spain	7.7%
Sweden	9.7%
Switzerland	8.0%
United Kingdom	10.3%

Source: compiled by the author based on OECD Health Statistics data

Table 2.
Health financing systems in many countries around the world

The main source of basic health care coverage		List of countries
A tax-funded health system	National health system	Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden, United Kingdom, Spain
Health insurance scheme	Single-payer	Greece, Hungary, Korea, Luxembourg, Poland, Slovenia, Turkey
	Multiple insurers, with automatic affiliation	Austria, Belgium, France, Japan
	Multiple insurers, with a choice of insurer	Chile, Czech Republic, Germany, Israel, Mexico, Netherlands, Slovakia, Switzerland, United States

Source: International Social Security Association (2021)