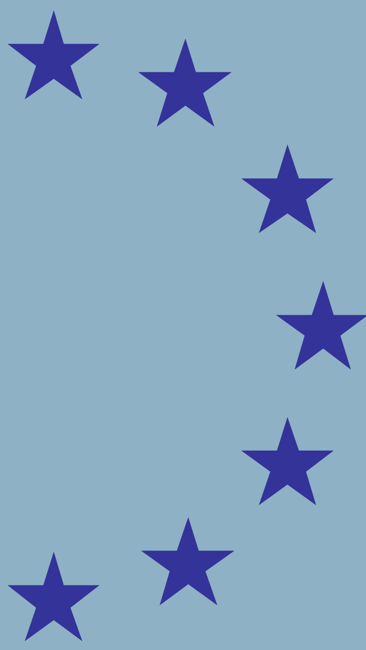
Hungary

Health Care
& Long-Term Care Systems



An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

Economic and Financial Affairs
Economic Policy Committee

Hungary

Health care systems

1.13. HUNGARY

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, Hungary had a GDP per capita of 16.3 PPS (in thousands), below the EU average of 27.9. Population was estimated at 9.9 million in 2013 and is expected to fall gradually to 9.2% by 2060, a decrease of 7.5% in contrast with the average EU increase of 3.1%.

Total and public expenditure on health as % of GDP

Total expenditure ([127]) on health as a percentage of GDP (8.1% in 2013) has decreased slightly over the last decade (from 8.6% in 2003, although it has been relatively flat since 2010), below the EU average ([128]) of 10.2%. Public expenditure is lower than in 2003, 6.1% of GDP, though it has been relatively flat since 2007. It is also below the EU average of 7.7% in 2013.

When expressed in per capita terms, total spending on health at 1486 PPS is far below the EU average of 2988 in 2013. So is public spending on health care: 944 PPS vs. an average of 2208 PPS in 2013.

Expenditure projections

As a consequence of demographic changes, health care expenditure is projected to increase by 0.8 pps of GDP, below the average growth expected for the EU (0.9 pps of GDP).([129]), according to the "AWG reference scenario". When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.5 pps of GDP from now until 2060 (EU1.6).

([127]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([128]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([129]) I.e. considering the "reference scenario" of the projections (see The 2015Ageing Report at http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

Overall, for Hungary no significant short-term risks of fiscal stress appear at the horizon, though some variables point to possible short-term challenges. Medium risks appear, on the contrary, in the medium term from a debt sustainability analysis perspective due to the still moderately high stock of debt at the end of projections (2026), and the sensitivity to possible shocks to nominal growth, interest rates and the government primary balance. Low medium-term risks are, on the contrary, highlighted by the analysis of the sustainability gap indicator S1, largely due to positive projected developments on ageing. Overall, Hungary appears to face medium fiscal sustainability risks in the medium term. No sustainability risks appear over the long run.

Health status

Life expectancy at birth (79.1 years for women and 72.2 years for men in 2013) is far below the respective EU averages (83.3 and 77.8 years of life expectancy in 2013). However, healthy life years, at birth 60.1 years for women and 59.1 years for men, are closer to the EU averages of 61.5 and 61.4 in 2013. The infant mortality rate of 5 deaths per 1000 live births (5‰) is higher than the EU average of 3.9‰ in 2013, having gradually fallen over the last decade (from 7.3‰ in 2003).

As for the lifestyle of the population, the rate of daily smokers was 26.5% in 2009, according to Eurostat, although other sources provide estimates of 31% in 2009 and 25.8% in 2014. According to the Hungarian European Health Interview Survey, the rate of current smokers was 31.4% in 2009 and 27.5% in 2014, ([130]). Since 2009 the total number of smoked cigarettes decreased by 8%, however in 2012 the number of smoked roll cigarettes was double compare to the previous result. The obesity rate of the population was at 23.6%, in 2012, the second highest proportion in the EU (after Malta) and far above the EU average of 15.5% in 2013.

Alcohol consumption was 11.2 litres per capita in 2012, above the EU average of 9.8, and it has decreased from 13.1 in 2003. According to the World Health Organisation's global status report on alcohol and health 2014 the pure alcohol

([130]) European Health Interview Survey, 2014. (ELEF 2014); Nemzeti Egészségfejlesztési Intézet: Egészségjelentés 2015 (46.o.)

consumption/year in Hungary (recorded and unrecorded) is in case of men 20,4 litre and in case of women 7,1 litre ([131]). Among the European Union member states, Hungary is on the 5th place with an alcohol consumption of 14,15 litre/person/year (total consumption) ([132]).

System characteristics

Coverage

The health care system operates within the scheme of a social security system based on societal solidarity. A Bismarckian model of insurance has been established: the main feature is the right to benefits in exchange for contributions. Health insurance contributions and direct government transfers provide the funding for cash benefits and benefits in kind. Health insurance contributions are proportional to income: In case of employees it amounts to 7% of the gross salary (3 % cash benefits, 4 % benefits in kind). The health care system covers virtually entire population (less than 1% is not covered). Membership is compulsory for all residents.

Gainfully employed and assimilated persons are insured against all risks: employees (including the public sector), the self-employed (including members of co-operatives), several assimilated groups, and beneficiaries of income subsidy, job-seeker benefit and job-seeker aid paid prior to retirement.

Various groups of the not gainfully employed population are entitled to health care benefits: Minors permanently resident in Hungary, persons who have fulfilled the minimum retirement age and whose monthly income does not exceed 30% of the minimum wage, homeless people, prisoners, full-time students, pensioners, beneficiaries of various benefits, allowances, or income supports, persons placed in residential institutions providing personal care, restrained persons, persons whose need has been recognised by the local government (including income supports of the unemployed), social supports, persons whose ability to work is reduced at least by 50%. For those who fall under this category, the central budget transfers a monthly amount of 5,790 HUF/person as health service contribution into the Health Insurance Fund (HIF).

Self-employed persons who perform activities in a complementary way or their joint ventures, and otherwise not insured or entitled persons are obliged to pay a health care contribution (in case of continuous residence in Hungary for a year - HUF 7,050 per month). Financing for groups covered without contributing is provided by the central budget in terms of a fixed per capita fee. Dependant close family members or their spouses are also obliged to pay health care contribution unless they are socially entitled, which must be justified by the local government (and their obligation can also be undertaken).

Persons not insured or not entitled to health care can enter into contractual arrangements with the National Health Insurance Fund Administration (NHIFA - Országos Egészségbiztosítási Pénztár) for entitlement to health care services. In case of adults, the contribution amounts to half of the minimum wage, in case of minors and students 30% of the minimum wage (only for benefits in kind –not necessary Hungarian Certificate of domicile).

The government elected in 2010 opted for a systematic move on the way to a national health service by further centralising the allocation of capacities; establishing a new hierarchical system of actively managed patient routes; organising more effective competition of generics in public purchases of pharmaceutics; and making steps towards replacing contributions by taxes.

Administrative organisation and revenue collection mechanism

The health care budget is made up of three components: (1) the budget of the HIF derived from health insurance contributions and earmarked health care tax (72% in 2016); (2) direct government transfers from the central budget (21% in 2016) and other incomes (7% -social tax, incomes from pharmaceutical companies, accident tax, public health product tax).

([131]) http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_3.pdf?ua=1

([132]) http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf - Annex 1 ADULT PER CAPITA ALCOHOL CONSUMPTION IN THE EU, CANDIDATE COUNTRIES, NORWAY AND SWITZERLAND (2009)

In addition, local government budgets are derived from local taxes and from the central government grants for investment. The budget-setting processes at different levels are practically independent, apart from central government subsidies for regional and local levels.

A key principle is the institutional separation of capital and recurrent costs, which applies to all sub-sectors. While investment is decided upon and financed by either local or central government, the HIF covers recurrent costs only.

Since 2012, the hospitals owned by the capital, cities and counties are state-owned. Dual financing still prevails, so recurrent costs are financed by the Health Insurance Fund, while capital costs by the maintainer. However, as the National Healthcare Service Center (earlier: National Institute for Quality- and Organizational Development in Healthcare and Medicines) fulfils maintenance and supervisory duties over state owned health institutions.

Restructuring was launched in 2011, and the operation of the new structure started as of 1 July 2012. The basic principle of the new structure is to centralise specialised care with high costs and relatively low patient numbers. Forms of care with higher case numbers, being less specialised and less costly should be provided close to the population. A change of function or profile refining was introduced for 58 service providers. 4.3% of inpatient care capacities was closed. In line with changes in structure, function and integration, a number of economic interventions aiming at improving effectiveness were introduced - essentially contributing to sustained institutional functioning. Consequently, a part of resources made available could be reallocated to financing outpatient care.

In 2011, the "Semmelweis Plan" reorganised the health care system. The new structure basically centralised the administrative functions and system management under the responsibility of the State Secretariat for Health Care of the Ministry of Human Resources (MHR) and related institutions such as the National Institute for Quality- and Organizational Development in Healthcare and Medicines (at present: National Healthcare Service Center), the National Centre for Patient Rights and Documentation and the Office of Health Authorisation and Administrative Procedures. Epidemiological and other public health issues belong to the National Public Health and Medical Officer Service and its affiliates.

The management of the provision of service and patient pathways is split between the level of NUTS3 administrative units and the higher level of health-regions and nationally. Service providers, including outpatient and care centres manage patient pathways at lower levels.

All agents within this system are linked to the HIF, which is in charge of managing the finances of the health care system. The emergence of new institutions in the management of patient pathways means that the importance of the HIF as a central institution in the health sector has been reduced. Its role has been further eroded by the partial devolution of responsibilities to a new network of government offices at NUTS3-level (known as “government windows”).

The level of expenditure on the administration of such a system, where entitlements are not linked to contribution payments and virtually the entire decision-making power rests with the Ministry of Health, is not high. Public and total expenditure on health administration and insurance as a percentage of GDP (0.11% and 0.11% respectively) is well below the EU average (0.27% and 0.47% respectively in 2013).

Role of private insurance and out of pocket co-payments

In 2013, private expenditure accounted for 36.4% of total health spending, considerably more than in the EU on average (22.6%). Also very large in comparison to the EU average is the share of out-of-pocket payments (27.5% vs. 14.1% in the EU).

Types of providers, referral systems and patient choice

Health care provision is the state's responsibility. The delivery system is organised on the basis of "territorial supply obligation", which assigns the responsibility to different levels of government according to the principle of subsidiarity (the service should be provided at the lowest effective level of organisation). This way, municipalities are responsible for providing primary care, while

responsibility for secondary and tertiary health care services is the central government's responsibility. Nevertheless, even if obliged by law to provide a given level of care, the local authorities are not obliged to deliver it. Each level is allowed to outsource service delivery to private providers. Moreover, the owner of health care facilities (whether private or public) is obliged to keep it in working order, i.e. to cover capital costs, which is particularly relevant in case of state-owned equipment and facilities being used by private providers to deliver subcontracted services.

Control, coordination, supervision and delivery of public health services are the responsibility of the central government which provides the services through the National Public Health and Medical Officer Service, in some cases in cooperation with the other institutions.

Provision of primary care is within the area of responsibility of the municipalities. They may provide it through salaried doctors or contract the delivery to independent physicians, who need to have relevant qualifications and a "practice right" to be eligible. The "practice right" is the right to perform the professional activities, which can be sold and bought by another qualified physician. By establishing the territorial reach of the primary care districts and the number of practices in each of them, local governments can control the amount and type of care provided to the population. Patients can freely choose a family doctor and change him/her once a year. Doctors cannot refuse the patients who live in their primary care district, but are allowed to refuse patients from other districts.

A number of reforms have been enacted over the last decade to provide incentives to take up the posts of physicians and nurses. The reforms have not produced visible results so far. Although slightly higher than a decade ago, the number of practicing physicians (321 per 100 000 inhabitants in 2013), practising nurses (643 in 2013) and in particular general practitioners (34 in 2010) is still well below the EU respective averages in the respective years (344, 837 and 78 per 100 000 inhabitants).

Although there is an official referral system and family doctors formally act as gatekeepers, the payment system includes no incentives to provide definitive care and avoid unnecessary referrals. Consequently, the number of referrals to specialists and hospitals is high. Only the 2007 reform (reducing impatient capacity of hospitals by setting up a few regional universal hospitals and medical clinics, strengthening of the referral system and introducing a formal transparent system of waiting lists) has allowed the authorities to limit hospital overutilisation. Indeed, the number of acute hospital beds per 100000 inhabitants is, at 399, above the EU average of 356. It has fallen since 2011 (414). Inpatient discharges per 100 inhabitants fell from 24.4 in 2004 to 19.9 in 2011 (EU average: 16.5).

Responsibility for secondary and tertiary care is shared among different levels of local and regional government. Formally, the state (through the National Healthcare Service Center) owns large multi-speciality county hospitals providing secondary and tertiary inpatient and outpatient care to the acutely and chronically ill. However, municipalities and central government also play a role, the former being responsible for polyclinics (outpatient specialist care), dispensaries (outpatient care for the chronically ill) and state-owned hospitals (secondary inpatient and outpatient care), while the latter own – through specific ministries – a number of acute and chronic hospitals. Dialysis and home care have in comparison a significant share of private ownership.

Treatment options, covered health services

Local authorities are required by law to provide services at a given level of care.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Family doctors can be employed according to four different schemes: (1) municipality employee paid on the basis of a monthly salary; (2) family doctor under a contract using public equipment and paid a capitation fee from the HIF; (3) family doctor being an independent provider with no municipal contract and no territorial supply obligation (large majority of the GPs); he/she is entitled to a capitation fee from the HIF only if he/she has minimum threshold of registered patients; (4) "freelance medical doctor", not being subject to public employee regulations, but not having a status of self-employed private entrepreneur either;

he/she receives an out-of-pocket payment directly from the patient.

Capitation fees paid under schemes (2) and (3) are adjusted to the age structure of the patients covered: children and elderly weigh most, working age population least. Moreover, in order to avoid negative impact of the excessive practice size on the quality of care, a threshold of the number of patients is set above which the capitation payment is only partial.

The payment system in secondary and tertiary care depends on the type of institution and services provided. Outpatient specialist services are financed by fee-for-service points, whereby each procedure is assigned a number of points according to its complexity and requirement of services and providers report total monthly number of points to the HIF for reimbursement. The monetary value of a point is defined in advance, and part of the sub-budget is put aside at the beginning of each year to compensate for possible 'excessive' provision of services. The sustainability of outpatient budget is achieved by a so-called performance volume limit. In the beginning of each year, based on previous years' data, the performance volume limit is defined for every single outpatient health service provider. Performance volume limit for the year of 2014 was defined, in agreement with professional bodies. In 2016, 1 financing point equals to 1.50 HUF. Consequently, even if control mechanisms have been set in place, the fee-for-service payment scheme in hospitals could discourage treatment as an outpatient and encourage hospitals to treat as an inpatient for financial gain, rather than for the ideal treatment of the patient.

Inpatient services are reimbursed according to the DRG-based prospective payment system, except for a few high-cost interventions reimbursed on a case basis. State owned hospitals are paid by DRGs. In addition, there are income flows to hospitals for outpatient care, chronic care, laboratory care and wages. Hospitals report the total amount of completed procedures to the HIF which calculates their total value by multiplying the DRG points by the national base fee (value of one point) - set in advance for each year. The sustainability of financing inpatient care is also ensured by the performance volume limit. Currently one single weight-point equals 150 000 HUF. Chronic care is financed by a daily fee. Wages transfers are calculated by a monthly request of providers and it's financed by the National Health Insurance Fund Administration.

Finally, in order to improve the income situation of health workers, there was a wage increase started in 2012 year and was continued in 2013-2015.

The market for pharmaceutical products

Pharmaceutical spending accounts for 30.7% of total (public and private) current health expenditure and 20.2% of current public health care expenditure in 2013. Reimbursement is regulated while prices are (to some extent) freely determined by the market (even if decisions on reimbursement have impact on market operators' price policies). Prices of original drugs are established on the basis of external price referencing (comparison with the prices in the other EEA countries), while the maximum generics' prices are additionally linked to the original drug price. Reimbursement applies to two positive lists: one includes drugs which can be prescribed by any physician and are reimbursed at either 0%, 25%, 55% or 80%; the other includes drugs with special indications, to be prescribed by specialists and reimbursed at either 50%, 70%, 90% or 100%. Moreover, physicians are obliged to prescribe reference medicines.

The 2010-2012 reform of the pharmaceutical market launched in the context of the state debt reduction aimed at rationalising medication use and strengthening competition for generic drugs. The decision was made to improve the efficiency of the pharmaceutical reimbursement system in order to meet the needs of patients. In practice, this also meant cuts in the pharmaceutical budget. A number of austerity measures were introduced in order to meet the budgetary constraints. In particular these measures are:

- modified legal provisions regulating payment obligations for the pharmaceutical companies,
- enhanced generic competition,
- requirements for enforcing patient compliance,
- revision of pharmaceutical treatment protocols,

- re-contracting of volume agreements, and the
- introduction of prescribing by active substance.

As a result of these measures, a substantial decrease in prices of pharmaceuticals in outpatient care could be realised during recent years, and public expenses could be decreased without increasing the (even sometimes with decreasing) financial burden on patients. At the same time, a number of new innovative drugs could be included in the reimbursement scheme.

eHealth, Electronic Health Record

There is a relatively limited use of IT in the provision and organisation of healthcare.

Health and health-system information and reporting mechanisms/ Use of Health Technology Assessments and cost-benefit analysis

Further measures to improve quality will include implementing a monitoring and evaluation system based on defined indicators. Major IT development plans include establishing a database for the insurance system, developing a personal identification system, improving remote diagnostics and telemedicine.

Healthy lifestyle and disease prevention activities have received a lot of attention mainly through programmes aiming at improving the health status and quality of life of the population. Total expenditure on prevention and public health services as 0.2% of GDP is about the EU average (0.24% in 2011) while public. However, public expenditure on prevention and public health services as % total public current expenditure on health is in line with the EU average (2.4% vs. 2.5% in 2013).

Recently legislated and/or planned policy reform

To reduce shortages of medical staff, a comprehensive residency support programme was introduced in 2011 and was announced again for 2016. Beyond emigration, attrition puts further pressure on skills shortages. To address this challenge, wages of health professionals were increased substantially since 2012. However, they remain low in a European perspective.

Challenges

The analysis above shows that a range of reforms have been implemented in recent years like for example to improve hospital efficiency and inpatient care supply or to promote the healthy life of the population in particular. Therefore, Hungary should continue to pursue them together with new challenging reforms. The main challenges for the Hungarian health care system are as follows:

- To improve the long-term sustainability of health insurance system, to avoid negative consequences for access and equity. This may mean improving the basis for more sustainable and larger financing of health care (e.g. considering additional sources of general budget funds), with a better balance between resources and demand, between the number of contributors and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector, it is important that they are pooled together through the strong pooling mechanisms in place today.

- To foster effective coordination mechanism between public entities responsible for investment decisions and providers actually using health care facilities.

- To continue efforts to strengthen care coordination, by promoting the role of GPs and avoiding unnecessary use of secondary and tertiary care. On one hand, supply of human resources to the primary care sector should be fostered by providing an adequate set of financial (performance-related component added to the current capitation-based remuneration) incentives. On the other hand, control and organisational measures strengthening the referral system should limit the use of specialist and hospital care.

- To develop the mechanism of updating the hospital payment system (relationship between the actual costs of treatments and tariffs become outdated). A sector-wide survey has

been conducted recently in order to tackle this problem.

- To strengthen monitoring and control by modernising and developing information technologies as well as by supporting human resources involvement in the decision making process. To introduce effective mechanisms for assuring quality of care: clear definition of tasks and competences of the health care providers (especially in the area of emergency care), more stringent conditions for licensing and accreditation, consistent development and application of medical guidelines.

- To strengthen efforts to promote healthy lifestyles, in particular by preventing smoking, excessive alcohol consumption, unhealthy diet and physical activity. Public health has been underlined as a priority in the development of recent health strategy for the health system. In this framework, the public health programme should continue, the importance of medical screening should be stressed.

Table 1.13.1: **Statistical Annex – Hungary**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	75	83	91	91	102	108	94	98	101	99	101	9289	9800	9934
GDP per capita PPS (thousands)	17.3	17.3	17.6	17.8	17.5	17.3	16.0	16.5	16.7	16.2	16.3	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	4.1	5.0	4.2	4.1	0.3	1.1	-6.6	1.3	1.9	-1.2	1.4	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	17.4	0.7	7.1	1.8	-6.9	-1.7	-3.1	5.5	1.5	-1.9	2.4	3.2	-0.2	-0.4
Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	8.6	8.2	8.5	8.3	7.7	7.5	7.7	8.1	8.0	8.0	8.1	10.4	10.1	10.1
Total current as % of GDP	8.3	7.9	8.2	8.0	7.4	7.3	7.6	7.8	7.8	7.5	7.4	9.8	9.6	9.7
Total capital investment as % of GDP	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.4	0.7	0.6	0.5	0.5
Total per capita PPS	982	1038	1143	1204	1184	1221	1232	1324	1376	1397	1486	2828	2911	2995
Public as % of GDP	6.1	5.7	5.9	5.8	5.2	5.0	5.1	5.2	5.1	5.0	5.1	8.1	7.8	7.8
Public current as % of GDP	5.9	5.5	5.7	5.5	5.0	4.9	5.0	5.0	4.9	4.7	4.8	7.9	7.7	7.7
Public per capita PPS	659	679	755	790	749	780	770	811	877	873	944	2079	2218	2208
Public capital investment as % of GDP	0.2	0.3	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.4	0.2	0.2	0.1
Public as % total expenditure on health	71.1	69.6	69.9	69.7	67.3	67.0	65.6	64.8	63.8	62.5	63.6	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	11.5	11.2	11.2	10.7	9.9	10.0	9.9	10.2	10.4	10.9	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	97.0	97.0	97.0	96.0	96.0	96.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	26.4	25.8	25.8	25.0	26.3	26.4	25.9	27.0	28.0	29.1	27.5	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	10.1	10.1	10.1	10.1	10.1	10.0	10.0	10.0	10.0	9.9	9.9	502.1	504.5	506.6
Life expectancy at birth for females	76.7	77.2	77.2	77.8	77.8	78.3	78.4	78.6	78.7	78.7	79.1	82.6	83.1	83.3
Life expectancy at birth for males	68.4	68.7	68.7	69.2	69.4	70.0	70.3	70.7	71.2	71.6	72.2	76.6	77.3	77.8
Healthy life years at birth females	57.8	:	54.3	57.2	57.8	58.2	58.2	58.6	59.1	60.5	60.1	:	62.1	61.5
Healthy life years at birth males	53.5	:	52.2	54.4	55.1	54.8	55.9	56.3	57.6	59.2	59.1	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	158	147	130	121	119	114	113	111	223	219	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	7.3	6.6	6.2	5.7	5.9	5.6	5.1	5.3	4.9	4.9	5.0	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	2.25	2.10	2.16	2.08	1.95	1.89	1.88	1.91	1.88	1.94	1.94	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.10	0.09	0.08	0.08	0.08	0.09	0.09	0.09	0.09	0.14	0.15	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.96	1.87	1.83	1.81	1.63	1.55	1.60	1.76	1.75	1.73	1.74	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	2.29	2.31	2.56	2.56	2.35	2.32	2.51	2.65	2.75	2.49	2.26	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.33	0.35	0.33	0.35	0.29	0.28	0.29	0.18	0.19	0.19	0.19	0.31	0.31	0.32
Prevention and public health services	0.41	0.36	0.37	0.34	0.31	0.30	0.34	0.35	0.31	0.26	0.20	0.25	0.25	0.24
Health administration and health insurance	0.10	0.09	0.09	0.09	0.09	0.09	0.09	0.11	0.11	0.13	0.13	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	1.96	1.84	1.89	1.82	1.74	1.69	1.66	1.68	1.65	1.73	1.74	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.08	0.07	0.07	0.07	0.07	0.08	0.08	0.08	0.07	0.13	0.14	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.06	1.00	0.96	0.92	0.86	0.87	0.89	0.92	0.91	0.91	0.93	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.45	1.37	1.58	1.60	1.22	1.14	1.22	1.29	1.28	1.04	0.96	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.18	0.21	0.20	0.20	0.14	0.16	0.18	0.09	0.10	0.10	0.10	0.13	0.12	0.13
Prevention and public health services	0.27	0.24	0.24	0.22	0.20	0.19	0.19	0.20	0.16	0.13	0.12	0.25	0.20	0.19
Health administration and health insurance	0.09	0.08	0.08	0.08	0.08	0.07	0.07	0.11	0.11	0.11	0.11	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.13.2: **Statistical Annex - continued – Hungary**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	EU- latest national data 2011	EU- latest national data 2013
Inpatient curative and rehabilitative care	27.1%	26.5%	26.4%	26.0%	26.3%	26.0%	24.8%	24.4%	24.1%	25.7%	26.3%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.1%	1.1%	1.0%	1.0%	1.1%	1.2%	1.2%	1.2%	1.1%	1.9%	2.1%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	23.6%	23.6%	22.3%	22.6%	22.0%	21.3%	21.1%	22.5%	22.4%	22.9%	23.6%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	27.6%	29.1%	31.3%	32.0%	31.7%	31.9%	33.2%	33.8%	35.3%	33.0%	30.7%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	4.0%	4.4%	4.1%	4.3%	3.9%	3.9%	3.8%	2.3%	2.4%	2.6%	2.5%	3.2%	3.3%	3.3%
Prevention and public health services	4.9%	4.5%	4.5%	4.3%	4.2%	4.1%	4.5%	4.5%	4.0%	3.4%	2.7%	2.6%	2.6%	2.5%
Health administration and health insurance	1.2%	1.1%	1.1%	1.1%	1.2%	1.2%	1.2%	1.4%	1.4%	1.7%	1.8%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	33.5%	33.6%	33.2%	32.9%	35.1%	34.8%	33.5%	33.4%	33.5%	36.5%	36.6%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	1.3%	1.3%	1.2%	1.2%	1.5%	1.6%	1.6%	1.6%	1.5%	2.6%	2.9%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	18.1%	18.3%	16.8%	16.6%	17.3%	17.9%	18.0%	18.3%	18.5%	19.2%	19.5%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	24.8%	25.0%	27.7%	28.9%	24.6%	23.5%	24.6%	25.6%	26.0%	21.9%	20.2%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	3.1%	3.8%	3.5%	3.7%	2.9%	3.2%	3.6%	1.7%	2.1%	2.1%	2.0%	1.6%	1.6%	1.6%
Prevention and public health services	4.6%	4.4%	4.2%	4.0%	4.0%	3.9%	3.8%	4.0%	3.2%	2.7%	2.4%	3.2%	2.7%	2.5%
Health administration and health insurance	1.6%	1.5%	1.4%	1.4%	1.6%	1.5%	1.4%	2.3%	2.2%	2.4%	2.4%	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	EU- latest national data 2011	EU- latest national data 2013
MRI units per 100 000 inhabitants	0.26	0.26	0.26	0.26	0.28	0.28	0.28	0.30	0.30	0.28	0.30	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.9	0.9	0.8
CTS per 100 000 inhabitants	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.8	0.8	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Proportion of the population that is obese	18.8	:	:	:	:	:	:	:	:	23.6	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	30.4	:	:	:	:	26.1	26.5	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	13.1	13.1	12.9	13.2	12.6	11.6	11.5	10.8	11.4	11.2	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	325	334	278	304	280	309	302	287	296	309	321	329	335	344
Practising nurses per 100 000 inhabitants	577	578	595	620	595	615	621	622	621	632	643	840	812	837
General practitioners per 100 000 inhabitants	:	:	:	:	:	:	35	34	:	:	:	:	78	78.3
Acute hospital beds per 100 000 inhabitants	555	553	554	555	416	413	413	414	415	398	399	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	12.2	12.5	12.9	12.8	10.8	11.3	11.9	11.6	11.8	11.8	11.7	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	24.4	24.6	23.8	20.6	20.4	20.5	19.9	19.9	:	:	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	481	527	594	833	1,110	1,223	1,247	1,475	:	:	6368	6530	7031
Acute care bed occupancy rates	77.0	77.0	76.0	70.0	69.0	75.3	74.3	71.6	71.1	69.2	:	72.0	73.1	70.2
Hospital curative average length of stay	6.7	6.5	6.3	6.1	5.6	5.6	5.4	5.4	5.3	5.2	:	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	2.0	2.2	2.5	4.0	5.4	5.6	5.9	6.9	:	:	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	4.7	4.8	5.1	5.3	5.4	5.4	0.8	0.9
AWG risk scenario	4.7	5.0	5.6	5.9	6.1	6.2	1.5	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	9.9	9.8	9.7	9.5	9.3	9.2	-7.5	3.1

Sources: EUROSTAT, OECD and WHO

Hungary

Long-term care systems

2.13. HUNGARY

General context: Expenditure, fiscal sustainability and demographic trends

Hungary has a population estimated at around 9.9 million inhabitants in 2013. With a GDP of around EUR 101 bn, or 16,300 PPS per capita, it is below the EU average GDP per capita of EUR 27,900.

Health status

Life expectancy at birth for both men and women was, in 2013, respectively 72.2 years and 79.1 years and is below the EU average (77.8 and 83.3 years respectively). The healthy life years at birth for both sexes are 59.1 years (women) and 60.1 years (men) are also below the EU-average (61.5 and 61.4 respectively). At the same time, the percentage of the Hungarian population having a long-standing illness or health problem is far higher than in the Union as a whole (37% and 32.5% respectively in 2012). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2004, and is lower than the EU-average (7.8% against 8.7% in 2013).

Dependency trends

The share of dependents is expected to increase in this period, from 8% in 2013 to 11.7% of the total population in 2060, an increase of 47%, which is above the EU average increase of 36%. From around 0.79 million residents living with strong limitations due to health problems in 2013, an increase of 36% is envisaged until 2060 to 1.05 million. That is below the increase in the EU as a whole (40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care (LTC) as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.4 pps of GDP by 2060. ([392]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 4.2 pps of GDP by 2060. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run as the favourable initial budgetary position would mitigate the projected increase in age-related expenditure. ([393])

Overall, no significant short-term risks of fiscal stress appear at the horizon, though some variables point to possible short-term challenges.

Medium risks appear, on the contrary, in the medium term from a debt sustainability analysis perspective due to the still moderately high stock of debt at the end of projections (2026), and the sensitivity to possible shocks to nominal growth, interest rates and the government primary balance.

Low medium-term risks are, on the contrary, highlighted by the analysis of the sustainability gap indicator S1, largely due to positive projected developments on ageing. Overall, Hungary appears to face medium fiscal sustainability risks in the medium term.

No sustainability risks appear over the long run.

System Characteristics ([394])

Public spending on LTC reached 0.3% of GDP in 2012 in Hungary, below the EU average of 1% of GDP. 100% of the benefits were in-kind, with no expenditure on cash benefits (EU: 80 vs 20%).

19% of dependents are receiving formal in-kind LTC services or cash benefits for LTC, below the EU average of 53%. Overall, 1.6% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an

([392]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([393]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([394]) This section draws on OECD (2011b) and ASISP (2014).

increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 52.5% of public in-kind expenditure (EU: 61%), 47.5% being spent for LTC services provided at home (EU: 39%).

Long-term care is generally seen as a relatively small section of the social protection system in Hungary. However, over the last five years a rapid shift to publicly-financed home based care has taken place.

Hungary has no stand-alone LTC system. Instead, LTC services are provided either by the health care system or by the social care system. The two systems have a different legislation, financing mechanisms and services. They each have parallel institutional networks that include institutional and home care. There is only weak coordination between them despite some minor recent improvements due to the merging of the health care and social affairs portfolios under the supervision the Ministry of Human Resources.

Until recently the LTC system was still shaped by the organisational logic of central planning: centralisation (as fewer institutions are easier to control), a preference for institutionalised care versus home-based care and a lack of awareness beyond its immediate operational sphere. The main consequence was a dual structure consisting of a centralised institutional supplemented through the informal behaviour of individual and households. However, this has recently changed with a shift towards more home care.

The healthcare system provides services provided such as nursing care in nursing departments of hospitals and home nursing care. The social care system provides three main types of services: home care (including “meals-on-wheels” services), day care and residential care.

The LTC-system does not offer cash benefits for recipients to improve access to care. There is only one type of social allowance, the nursing fee, for those relatives with caring responsibility for a disabled family member.

Beyond this, the bulk of LTC provision is left to private households or the informal market.

Administrative organisation

Home care is organised at a local level, whether by social work centres, homes for elderly or special institutions. In general, the financial system of public LTC functions as a direct subsidy to suppliers of care. Services include help with daily activities supervision, social assistance and medical services. Home health care is organised by community nurses. Additionally, there also some day-centres and transitional accommodation.

Types of care

Long-term care in Hungary includes benefits in kind (institutional or home care) as well as one cash benefit (nursing fee, as explained above). The provision of LTC is regulated by legislation on social security, such as health care and health insurance, pension and disability insurance and social assistance. As shown in the statistical annex, most services are currently provided in an institutional setting.

Eligibility criteria, co-payments, out of the pocket expenses and private insurance

As explained above, the nursing fee is a social allowance provided to carers. Applications need to be based on the expert opinion of the GP treating the dependent person. Since January 2013 they can be submitted directly to the district office. The fee is paid to carers who provide LTC for severely disabled family members (including both the elderly as well as the severely disabled permanently ill young (minor) family members). In this way, the nursing fee is not only targeted to LTC of the elderly. Additionally, the social legislation allows local governments to give financial help to those caring for permanently ill family members aged over 18 but under 65.

Apart from these cash benefits services are funded directly. Private insurance schemes are not involved in the funding of LTC. The operational costs of providing LTC are financed by the "Health Insurance Fund" for health care and the central government budget for the social care component of LTC.

In addition, care providers are allowed to charge user fees. The exact amount charged differs depending on the service. The regulations stipulate

algorithms that take into account the personal income and real state assets of the recipient but do neither include other assets nor the availability of informal family carers. The fee can go up to 80% of monthly income for institutional care and 50 % for group homes for rehabilitation. Besides these according to the different providers the maximum fees are the following: for day care: max. 15% of monthly income; for day care + meals: max 30% of monthly income; for temporary care: max. 60%- of monthly income).

Unit costs of both residential and home care are low in comparison with the rest of the EU. In 2012 the financial support for residential care for a year was HUF 635,650, about EUR 2,200, around 22% of per capita annual GDP. In 2013 the method of calculation has changed. In contrast to the "per resident quota" in effect till 2012, since then the average wage of carers in residential homes is regulated by the government. The normative support per resident can be calculated according to further rules on residents per carer, with special multipliers for care intensity (1.0 for regular elderly homes, 1.18 for dementia care and 0.19 for special elderly care). As a consequence, the quota for regular care has increased slightly up to HUF 651,510, (about EUR 2,255 per annum). For home care, the corresponding figure was HUF 166,080, around EUR 575 or about 6% of per capita GDP, in 2012, cut back to HUF 145,000 (around EUR 490) in 2013.

Formal/informal caregiving

There is empirical evidence showing that family relations play a relatively important role in LTC for the elderly in Hungary. The 4th wave of SHARE (Survey of Health, Ageing and Retirement in Europe), for the first time including Hungary, found that the elderly in Hungary are by far the most likely to name their offspring among the confidants they can rely on and the second most likely to name their spouses (Stoeckel and Litwin 2013). This is confirmed by existing data for the provision of informal care. OECD "Health at a glance 2013" shows a relatively high proportion of the population aged 50 and over reporting to be informal carers. Additionally, the majority are women (the highest proportion within the OECD).

Prevention and rehabilitation policies/measures

Prevention and rehabilitation are provided through the health care system.

Recently legislated and/or planned policy reforms

Modification of the responsibility of institutions providing permanent accommodation and care

In the "Act III. of 1993. on Social Administration and Social Benefits" (regulates the responsibility of operate of social services. Before the enactment of the act, the responsibility for ensuring services providing LTC belonged to county authorities and local authorities of cities with county rights. The state took over the social institutions of county authorities in 2012 during a process of its debt consolidation. In parallel the legislative responsibility of operating institution providing long term care became the responsibility of the state.

The takeover process of residential social institutions took place in 2013, as the legislative responsibility of maintaining of residential institutions to people with disabilities, psychiatric patients and people with addictions became the responsibility of the state from 1 January 2013. Simultaneously therefore all institutions which earlier were maintained by local authorities were taken over by the state. The takeover gives opportunity for reforming of these institutions and for rationalising the available capacities and for ensuring an efficient and qualitative service.

Local authorities may continue to organise residential care service for elderly at a local level. For towns with county rights, and for the capital it is still a binding duty.

Replacement of social institutional capacities providing nursing and care for people with disabilities and supported living

In July 2011, the Hungarian Government adopted the Government Decree No. 1257/2011. (VII.21.) on the strategy for the replacement of social institutional capacities providing nursing and care for people with disabilities 2011-2041 (hereinafter:

DI strategy) and the implementation of governmental tasks. The main goal of the deinstitutionalisation is to ensure the full enjoyment of human rights, to increase the quality of life of persons with disabilities and at the same time to develop and modernise the structure of the provision of social services.

For the purpose of implementing the targeted developments and conversions in the first three-year period of the 30-year-long strategy, a tender of the Social Infrastructure Operational Programme (TIOP 3.4.1. A-11 'Replacement of residential institutions – social institutions component') was launched with the overall amount of HUF 7 billion. In the first two phases of the tender, six projects were submitted. Four of them were related to care homes for disabled persons and two of them to psycho-social care homes. The total amount of support received by the applicants is almost HUF 6 billion (EUR 19,344,327).

The operators who applied for subsidies for deinstitutionalisation had to clearly blueprint the implementation of the transformation of their institutions and services before its beginning; demands and needs of every service user had to be measured; the process of their preparation for changes and the structures of the tailor made services had to be designed.

The "National Body for Deinstitutionalization" (hereinafter called: the Body) was established to overview and approve the feasibility studies on the basis of the principles and objectives of the deinstitutionalisation (DI) strategy. The Body outlines preliminary professional evaluation criteria by submitting professional proposals on the feasibility studies. The Body determines the order of the implementation and takes part in the monitoring of the development. Furthermore, the Body makes comments on the concept of utilisation of the infrastructure remaining after the deinstitutionalisation process indicated in the proposals and outlines the Action Plan for restructuring the institutions in every three years. The Body ensures the full transparency of the implementation of the strategy. Persons with disabilities, civil services, advocacy groups, representatives of social and higher education, institutions of special education, other background institutions, service providers and senior civil servants take part in the activity of the Body.

The network of mentors set up by the support of the European funds is also important for the success of the implementation by ensuring counselling on the questions of replacement and by giving preparatory support for inquiring organisations.

The DI strategy is also promoted by the Social Renewal Operational Programme (TÁMOP 5.4.1/12 'Modernisation of social services') by giving communicational support for a more effective social inclusion.

In order to establish the legislative background of the strategy, supported living was introduced from 1 January 2013 as a new form of social services in the Act III of 1993 on Social Administration and Social Benefits.

Supported living is a flexible combination of various forms of housing and supportive services, where the housing and supportive services are separated from each other. The supported living service provides appropriate conditions for people with disabilities, psychiatric patients, persons with addictions and homeless people concerning housing and social services in accordance with the beneficiaries' age, health condition and self-care skills. The provided service is based on complex needs assessments (taking into account the necessary intensity of support, the existing abilities and the users' will) and it is modified in parallel with the possible changing circumstances.

The service provides: housing/living service; care management; support for follow up the persons' living conditions based on personal needs assessments; meals; nursing and care; development/rehabilitation, and services to help participation in social life.

After 1 January 2013, new institutional places providing nursing and care for people with disabilities, psychiatric patients or people with addictions can be established: a) In the case of large institutions only by providing supported housing; b) in the case of creating new institutions which can only be set up in houses described by legislative regulations on supported housing (flat for maximum 6 people or house for maximum 7-12 people).

Challenges

The main challenges of the system appear to be:

- **Improving the governance framework:** To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. to the provision of long-term care services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To set guidelines to steer decision-making at local level or by practising providers; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; To deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user cost-sharing on LTC benefits.

- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, by setting: (i) the need-level triggering entitlement to coverage; (ii) the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and (iii) the depth of coverage, that is, setting the types of services included into the coverage; To reduce the risk of impoverishment of recipients and informal carers.

- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** To establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care**: To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- **Improving value for money**: To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.13.1: **Statistical Annex – Hungary**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	75	83	91	91	102	108	94	98	101	99	101	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	17.3	17.3	17.6	17.8	17.5	17.3	16.0	16.5	16.7	16.2	16.3	26.8	27.6	28.0	28.1	27.9
Population, in millions	10.1	10.1	10.1	10.1	10.1	10.0	10.0	10.0	10.0	9.9	9.9	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.3	0.3	0.3	0.2	0.3	0.3	0.3	0.3	0.2	0.3	:	1.0	1.0	1.0	1.0	:
Per capita PPS	36.7	36.1	38.7	35.3	40.7	42.5	41.1	44.5	43.0	43.6	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.5	0.5	0.4	0.5	0.5	0.5	0.5	0.5	0.5	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	76.7	77.2	77.2	77.8	77.8	78.3	78.4	78.6	78.7	78.7	79.1	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	68.4	68.7	68.7	69.2	69.4	70.0	70.3	70.7	71.2	71.6	72.2	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	57.8	:	54.3	57.2	57.8	58.2	58.2	58.6	59.1	60.5	60.1	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	53.5	:	52.2	54.4	55.1	54.8	55.9	56.3	57.6	59.2	59.1	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	40.1	35.8	37.0	38.2	36.2	36.0	35.7	36.0	37.0	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	14.9	13.5	12.8	10.3	8.5	8.6	8.1	7.9	7.8	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	45	60	75	89	92	94	95	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	41	46	52	57	58	60	61	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.9	1.1	1.3	1.5	1.5	1.6	1.6	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	34	34	35	34	33	34	37	38	39	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.13.2: **Statistical Annex - continued – Hungary**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	9.9	9.8	9.7	9.5	9.3	9.2	-8%	3%
Dependency								
Number of dependents in millions	0.79	0.83	0.92	0.98	1.02	1.07	36%	40%
Share of dependents, in %	8.0	8.5	9.5	10.3	10.9	11.7	47%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.8	0.8	0.8	0.9	1.1	1.2	54%	40%
AWG risk scenario	0.8	0.9	1.3	2.1	3.1	5.0	564%	149%
Coverage								
Number of people receiving care in an institution	94,950	103,567	117,818	136,374	152,016	164,765	74%	79%
Number of people receiving care at home	60,730	66,314	75,394	87,373	97,457	105,584	74%	78%
Number of people receiving cash benefits	0	0	0	0	0	0	:	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	1.6	1.7	2.0	2.4	2.7	3.0	88%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	19.8	20.4	21.1	22.9	24.4	25.2	27%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	100.0	100.0	100.0	100.0	100.0	100.0	0%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.0	0.0	0.0	0.0	0.0	0.0	:	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	52.5	52.0	51.5	50.6	50.1	49.4	-6%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	47.5	48.0	48.5	49.4	49.9	50.6	7%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	41.2	38.2	35.0	33.2	32.6	31.8	-23%	-2%
Unit costs of home care per recipient, as % of GDP per capita	58.3	55.1	51.4	50.7	50.7	50.9	-13%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	:	:	:	:	:	:	:	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)