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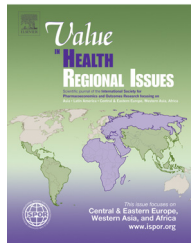

The Hungarian Care Managing Organization Pilot Program

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ABSTRACT

Objectives: The aim of this article was to provide a description of the Hungarian care managing organization (CMO) pilot program and its environment, incentive structure, and preliminary outcomes. The need to change the behavior of doctors to increase the effectiveness and cost-effectiveness of the system was the key rationale for the Hungarian CMO pilot program. **Methods:** After an application process, nine CMOs were entitled to enter into the system in July 1999. By 2006, there were 14 CMOs covering 2.1 million people. The Hungarian CMO program tried to combine the advantages of both the US managed care programs and the UK general practitioner fundholding system, within the constraints and opportunities of a Central-European country committed to a single-payer health insurance system. **Results:** The revenue of CMOs derived from a risk-adjusted capitation. The capitation formula was weighted only by age and sex. The expenditures of the CMOs included all the health expenditures on their patients that occurred in any part of the health care system. The average savings rate for all CMOs for the fiscal years 1999 to 2007 was 4.94%. The highest rates of savings were realized in chronic and acute inpatient care and medical devices. The pilot was discontinued in 2008 without a comprehensive evaluation of the experience. **Conclusions:** We can conclude that this pilot had a significant contribution to the modernization of the Hungarian health care system.

Keywords: care managing, health care reform, health insurance, Hungary, managed care, risk selection.

Introduction

Managed care is a generic term describing any health care system that integrates the financing and delivery of medical care [1]. The term "managed care" became more popular in the past decade outside of the United States, and there have been several efforts to introduce managed care tools or managed care–like programs in many other countries [2–5]. The implications of managed care and the growing popularity of consumer-driven health plans are discussed in the international literature [6–10]. All forms of managed care attempt to control costs by modifying the behavior of doctors [11,12].

Cost control and changing patients' behavior could be considered as advantages, whereas difficulties with choosing a physician who is "out of network" and delaying costly medical intervention might be risky disadvantages of managed care.

Many important reforms took place in the Hungarian health care system in the past 25 years, including a care managing organization (CMO) pilot program introduced in 1999. We aim to provide a description of this program, its environment, incentive structure, and preliminary outcomes.

The Hungarian Health Insurance System

The Hungarian health system is a solidarity-based national health insurance system with compulsory participation for every citizen. There is one purchaser, the National Health Insurance Fund Administration (NHIFA; Országos Egészségbiztosítási Pénztár). The employers and employees pay health insurance contribution to a single fund that is complemented by general budget transfers.

The central government owns most inpatient health care providers. All health care providers have a service contract with the NHIFA, which is a prerequisite for any payment made by the NHIFA to providers. The NHIFA uses a mix of payment methods

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for providers at different levels of care. Most of the revenues of the general practitioners (GPs) come from a capitation fee. For outpatient care, a fee-for-service payment system is used. Since 1993, acute inpatient care has been paid by a diagnosis related group (DRG) system (the Hungarian term "Homogén Betegségcsoportok" translates to "Homogeneous Disease Groups"). This adapted DRG payment system covers all Hungarian acute care hospitals.

All health care providers (GPs, outpatient specialists, and inpatient care) submit monthly reports to the NHIFA. For both the outpatient specialist and inpatient care, this report contains detailed information on each patient treated in the institution (personal data, diagnosis, treatment, etc.). There is a centralized database that contains the data of each patient treated in any outpatient department or inpatient institute of Hungary. The patients are identified according to a unique social insurance personal identification number (társadalombiztosítási azonosító jel). With the help of the social insurance personal identification number and the use of this nationwide central database service, patients can be tracked within the whole country. Further characteristics of the Hungarian health care system can be found elsewhere [13–22].

Key Characteristics of the CMO Pilot Program

The Hungarian CMO pilot program could be considered a public sector–managed behavioral health care arrangement [23]. Although, as the Hungarian State Audit Office noticed [24], the specific aim of the CMO pilot program was not precisely defined, it had its implicit goals [25], as did other managed care programs [26]. It aimed to monitor and coordinate care through the entire range of services; to emphasize prevention and health education; to encourage the provision of care in the most appropriate setting and by the most appropriate provider; to promote the cost-effective use of services through aligning incentives; to strengthen the primary care and outpatient care; and to improve the quality of care.

The conceptual foundations of the Hungarian implementation of managed care is closer to what is called GP fundholding in the United Kingdom than to health maintenance organizations in the United States, but in terms of techniques used to control cost and improve efficiency, the US managed care experience provided the "toolbox" for reform. It is important to note that there are a number of characteristics of the Hungarian version of managed care that make it a very different system overall. For this reason, we will refer to the Hungarian managed care organizations as "care managing organizations" to signal the difference.

The Hungarian CMOs did not collect premiums. The system operated in a publicly administered noncompetitive national health insurance environment financed primarily through payroll tax. The CMOs did not decide on the level of contributions, nor on the package of services covered. Prices (tariffs) were centrally set by the NHIFA. The pilot CMOs used the same payment mechanisms as did all other providers who were not participating. Opting out from the compulsory national insurance system is not allowed, in contrast to the experience of the exportation of managed care to Chile [8]. The Hungarian CMO model was similar to the UK GP fundholding system in that it provided a capitation budget for a provider who was, in turn, responsible to provide or purchase care for the covered population.

In the operation framework (Fig. 1), provider organizations applied to the NHIFA and had a virtual budget, an adjusted capitation account, determined by the size and characteristics of the population they cover. Enrollment was by the GPs and not the individual patients; therefore, there was no room for risk selection at the patient level. The GP enrolled the population in his or her list into the CMO pilot program. Patients who did not want to be enrolled into the CMO had the option to change their GP to another GP who was not involved in the managed care program. The CMOs were self-selected through an application process, and then systematically selected by the NHIFA. Generally, half the applicants succeeded to become CMOs.

The CMO took responsibility for arranging the whole spectrum of health services to a local or subregional population defined by being on the list of the constituent GPs. However, patients were still free to choose specialists and hospitals including those not contracted by the CMO. The NHIFA paid the actual provider of care for all services according to the national payment system, and then charged the virtual budget of the CMO for all paid services of the population covered by the CMO. Thus, it was not the CMO that paid other providers directly but the NHIFA against the virtual capitation budget of the CMO. The aim was to provide care at the least expensive level that is appropriate for the patient's condition. Typically, the CMOs run an integrated information system to monitor all patient-related clinical and cost data, and then to analyze performance against benchmarks. The source of information was mainly the central database of nationally collected activity information of all health care providers maintained by the NHIFA. It was a keen challenge for the

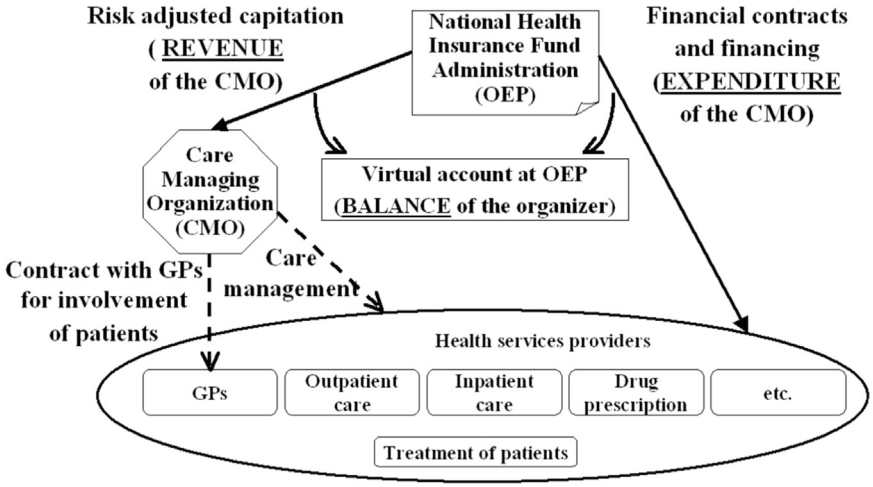

Fig. 1 – The structure of the Hungarian Care Managing Organization Pilot Programme.