Methodological remarks, concepts, definitions

The scope of health services is included in the Act LXXXIII of 1997 on the benefits of the compulsory health insurance and the Government Order 217/1997 (XII.1.) regulating the implementation of this act.

This chapter presents the data of those concluded financing contract.

Financing contract: is concluded between the financing institute (NIHIFM) and the service provider for health service.

To define the indicators regarding financed services (per services, station), we count their average number per month.

Ledger data: the expenses accounted financially from 1 January to 31 December of the given year. The 6.1. chapter contains ledger data.

Chapter 6.2. to 6.11. are containing date of service providers which concluded financing contract with NIHIFM relating to the performance of the period from 1 January to 31 December.

As of May 1, 2012 the institutions completing tasks of inpatient special care or inpatient and related outpatient special care, which tasks were carried out in the frame of the public health service belonging to the responsibility of the local government, are state-owned. The Act XXXVIII of 2012 disposed of the above.

Average-funding introduced due to the COVID-19 pandemic

In 2020, as a result of COVID-19 pandemic, the number of patíents and procedures was significantly reduced at providers, for which the performance-based funding system no longer provided adequate coverage. In order to ensure the stable, contínuous operatíon of the health care providers and to maintain the functíonality of the instítutíons and to cover their fix costs average-funding has been introduced on the majority of publicly financed healthcare services. Average-funding is based on the calculated average of three-month financing fee paid to the healthcare provider in the pre-emergency period.

Periods affected by average-funding in 2020:

Mars - August2020: In determining of the average-funding of healthcare providers, payments on appropriatíon from Estímates legal títle, Operatíng expenditure, Reductíon of waitíng lists, Extra financing, High-value medicaments financing and Specialty care financed by special rules were not taken into account. In these cases, funding contínued to follow the general pattern based on performance, in all other forms of care average-funding was decisive.

October - December 2020: As a result of COVID-19 pandemic average-funding has been restored in the field of inpatíent and outpatíent specialty care, general practítíoners' service, dental care, patíent transportatíon, home special nursing and home hospice care. Financing all other forms of care including the payments on appropriatíon from Reductíon of waitíng lists, Extra financing, High-value medicaments financing, Specialty care financed by special rules legal títles were financed in accordance with the normal financing rules.

The tables in Chapters 6.2. to 6.11. show the amount of funding actually paid as for the funding amount for 2020.

Regarding the fact that a significant period of 2020's funding was attained by average-funding, performance-based funding indicators (the amount of funding per case, per interventíon, etc.) were not calculated.

Services and on-duty services of general practitioners

Source of data: monthly change report, report of itemized patient turnover, and report of occasionally care of the general practitioner's service, which are forwarded to the National Institute Health Insurance Funds Management.

General practitioners' service dispose over regional care: provide care to entitled those who registered at this service which determined and marked zone by local government. In emergency case give the care to entitled people who chosen other general practitioner, if they can't visit the doctor they have chosen.

Mixed type of general practitioners' service: providing care for adults as well as children.

Central on-duty services of general practitioners: defined on time or continuous primary emergency treatment of affected general practioners territory population, cooperating with at defined territory provider Ambulance and Emergency Services.

Financial support as entrepreneurial for basic care: Government Decree No. 229/2001. (XII. 5.) on the financial support of general practitioners, family paediatricians and dentists providing basic cares, which made it possible for the providers to claim financial assistance at buying equipment and real estates for the use of providing services, was repealed on 1 January 2006. - Decree No. 329/2005. (XII. 29.) - however the rules of the Government Decree above should be still applied for valid and updated contract made before 2006. New equipment support being lunched in 2011 (Government Decree No. 216/2001. (X. 19.) on the financial support of general practitioners, family paediatricians and dentists providing basic cares).

Overhead support: Providers operating GP services with obligation to provide in-area care are entitled to 130.000,- HUF overhead support per services. [In section of 14 of Goverment Decree No. 43/1999. (III. 3.) on detailed regulations of health care services financed by the Health Insurance Fund.]

District nurse service, mother, child and youth care

Source of data: contractual performance data of the district nurse services and school doctors.

Territorial district nurse service: district nurse services provided on persons have address in provided territory by local government. Provided tasks are defined in the par 3 of Ministry of Health, Welfare and Family decree No. 49/2004.

Youth care: the health visitor is provided youthcare on 6-18 years old and over 18 years old full-time secondary education participant. (appendix 3 of decree No. 26/1997 (IX.3.).

School doctor services: The number of provided child and students by part time worker general practitioners (paediatricians) it could be no more than 800 persons in student education institute on 3-18 years old as well as over 18 years old full-time secondary education participant. If the number of full time health visitor is much more, the number of provided student by doctor it could be no more than 2400 persons. Full time school doctor had to be hired for each 800 persons in the education institute for the handicapped (appendix 2 of decree No. 26/1997 (IX.3.) on the task of school doctors).

Dental care

Source of data: performance data of the dental care services that are forwarded to the National Institute Health Insurance Funds Management.
The annual data include the corrections made until the end of the year, modifying the respective month.

Number of cases: one case is the appearance of one patient within a calendar day regardless of the number of services provided for him/her.

Number of interventions: number of services provided for the patient during one appearance.

Financial support as entrepreneurial flat rate for basic care: vide “GeneralPractioners' care”.

Outpatient specialty care

Source of data: he data of outpatient consultations and special outpatients' department and from 2000 the monthly performance data on microbiological analysis carried out by the consulting places providing occupational health care service as well as Policy Administration Services of Public Health of the County (Capital City Budapest) Government Offices (up to 2011 regional institutions of National Public Health Medical Officer's Service) as the part of outpatient specialty care and forwarded to the National Health Insurance Fund Administration. From 2002 the figures include the performance data of specialty care of care centers and practice laboratories, from november 2011 data contains all data of care centers.
The annual data include the corrections made until the end of the year, modifying the respective month.

The accounting of performance of January 2004 fell into a new performance volume limited (framework) financing scheme of outpatient specialty care [In section 27 of Government Decree No. 43/1999 (III. 3.) on detailed regulations of health care services financed by the Health Insurance Fund].
Care in care center: From 1 november 2011 treatments and services provided in care centers are reported and financed in the same finance system as services of outpatient specialty care.

Outpatients' specialty department: outpatient specialty care managed by hospital, special hospital where a service unit provides special outpatient care working within the organization of hospital, special hospital but is separated from that in definite consultant hours.

Number of cases: one case is the appearance of the patient at the consultation within a calendar day regardless of the number of services provided for him/her.
In case of laboratories or other health care services that analyse samples one case is the examination of one sample.

Number of interventions: number of services provided for the patient during one appearance.

Supporting the program for reducing waiting lists: beyond the regular annual programs, institutions maintaining waiting lists can provide health care to the patients being on the waiting list for the longest period charged to extra sources. [In section 28/C and 29/B of Government Decree No. 43/1999 (III. 3.) on detailed regulations of health care services financed by the Health Insurance Fund].

Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

Source of data: the performance data of service providers carrying out CT and MRI examinations that are forwarded to the National Health Insurance Funds Administration.
The annual data include the corrections made until the end of the year, modifying the respective month.

The tables of chapter include the data of payment category 1 (care provided on the basis of Hungarian insurance) exclusively.

The accounting rules of CT and MRI examinations went through basic changes from 1 April 2004; the multipliers based on the age of machines and the duration of examination have been abolished. The maximum performance of service providers has been determined according to the number of examinations possible to carry out. As a result of the modification the accountable quantity of contrast media, the accounting order of substitution has been regulated accurately as well as the rule-book and the values of some examination in scores has been modified significantly. From 1 October 2005 the financing rules of outpatient specialty care are applied to the accounting of CT, MRI examinations. The rules of financing with performance limit (framework) are defined in section 27 of Government Order 43/1999 (III. 3.) on detailed regulations of health care services financed by the Health Insurance Fund. Following the introduction of financing with performance limit (framework) the rule-book and the value of certain examinations in scores has been modified significantly.

Dialysis

Source of data: monthly performance data of services possessed of financing contract.
The annual data include the corrections made until the end of the year, modifying the respective month.

Station: the site of the service provider concluded financing contract, where the dialysis is carried out. One provider usually has more stations.

CAPD (Continous Ambulatory Peritoneal Dialysis): a dialysis treatment done at home and secures the continues elimination of water and retention substances.

***EPO (erythropoietin*)**: The glycoprotein hormone is a cytokine for erythrocyte precursors in the bone marrow (this hormone regulates red blood cell production), produced by the kidney. The EPO treatment of predialysed patients has been paid by the Health Insurance Fund since 2007.

Home special nursing, Home hospice care

Source of data: the data of individual accounting sheets and monthly summarizing report of the home special nursing and home hospice care providers, that are forwarded to the National Institute Health Insurance Funds Management.
The tables of the yearbook don't contain the statistically negligible corrections.

Visit: curative activity performed at the home or the residing place of the patient for the order of the patient's attending physician and done by a person who has vocational qualification to carry out that task. The treatment with more services within one calendar day is regarded one visit.

Patient: the number of people given care to during the year, regardless of the number of times he/she becomes beneficiary by order during the year.

Special nursing degrees
Complete nursing: needed by the patient, who is not able to perform three or more basic activities of the everyday life (nutrition, washing, getting dressed, stool and urine voidance, independent change of position) without other person's support and needs special nursing;
Partial nursing: necessary for the patient, who is not able to do at least two basic activities of the everyday life without other person's support and needs special nursing due to his/her illness;
Self-supporting patient: who is able to perform the basic activities of the everyday life without other person's support but he/she needs to be taken special care of due to his/her illness/chronic illness, for example: stomatological treatment, throat cleansing, treatment of leg ulcer, care of wound created by operation, parenteral nutrition and drug treatment.

The **home hospice care** was introduced on 1 September 2004, its financing unit is a day, which includes being continuously at service beyond the care provided at home.

Inpatient care

Source of data: - NSSP (National Statistical Data Survey Programme) No. 2155, Report: "*Statement of hospital beds and patient turnover*" data of patient turnover,
- monthly reports on the performance of inpatient care.

Data of patient turnover:
Number of hospital beds in operation at the end of the year: the number of hospital beds that can be used during the care, which are available and eligible to get occupied by patients permanently. It excludes the number of hospital beds permanently out of use (for more than 6 months) on 31 December.

Average number of hospital beds in operation: the weighted mean of hospital beds in operation reflecting the transferred to

another ward in the same hospital and who have died.

Number of patients discharged from hospital wards: total number of patients have been discharged or have been refferred to another ward in the same hospital or deceased.

Number of one day care cases: number of patients whose nursing time didn't reach 24 hours and received one of the interventions defined in the Appendix 9 of Ministry of Welfare Order 9/1993 (IV. 2.) on certain issues of social hospital bed s minus the number of days of recess.
Dental care profession has only one day care, which dispose of 0 hospital beds in NIHIFM contract registry.

Number of achiveable nursing days: calendar days of the period concerned multiplied with the number of authorized hospital beds minus the days lost due to breaks.

Number of performed nursing days: in case of active care all nursing days of patients left in the current year (if he/she was admitted in the previous year and left in the current period including the part of nursing, that was provided in the previous year). In case of chronic patients the nursing days of the current period of persons left during the year or staying in the hospital at the end of the year.

One nursing day is the whole day care (24 hours) provided for an inpatient. The day of admission and leaving together considered one nursing day. One nursing day is the nursing time of all inpatients, if it doesn't reach 24 hours (patient admitted, but deceased within 24 hours, live-born transferred within 24 hours after the birth, cases considered one day nursing case, emergency treatment etc.)

Average length of stay: in case of active care the number of performed nursing days divided by the number of patients discharged from wards, in case of chronic care the number of nursing days of the whole care for patients left in the current year divided by the number of persons discharged from wards in the period. If the care is chronic, this figure differs from the ratio of performed nursing days and the number of discharged patients.

Occupancy rate of beds: the number of performed nursing days divided by the number of performable nursing days and multiplied by 100.

Mortality rate: the number of deceased divided by the number of discharged patients and multiplied by 100.

Data of financing:

Classification standpoints of financing: these standpoints of inpatient care are in Appendix 7 of Government Order 43/1999 (III.3.) on detailed regulations of health care services financed by the Health Insurance Fund.

- *Active care*

From the viewpoint of financing a care is active, if it aims to restore the state of health as soon as possible. The length and the end of active care can usually be planned and in most cases are short;

- *Chronic care*

From the viewpoint of financing a care is chronic, if it aims to stabilize, maintain or restore the state of health. The length and end of care can usually not be planned and it typically lasts long.

- *Matrix hospital care*

The care happens in inpatient special care institute in clinical and operative unit on the basis of the permission of health state administration body. The hospital is not divided into department structure, but it performs the care according to the actual need.

The accounting of performance of January 2004 fell into a new performance volume limited (framework) financing scheme of outpatient specialty care [In section 27 of Government Decree No. 43/1999 (III. 3.) on detailed regulations of health care services financed by the Health Insurance Fund].

Homogenous groups of diseases (HGDs): the inpatient facility receives payment - in case of cares provided in its active care wards - on the basis of weight numbers assigned to each homogenous group of diseased included in Appendix 1of Ministry of Welfare Order 9/1993 (IV. 2.) on certain issues of social insurance financing of special health care. The methodology of classification of HGDs is published in the bulletin of the Minister of Health.

The factors of classification in term of defining HGDs of performed cases should be used with regard to the sequence set by the section 1 of Ministry of Welfare Order 9/1993 (IV. 2.).

Amount of waiting-lists reduction's support: vide “Outpatient specialty care”.

Specially financed inpatient specialty care

Source of data: monthly performance data of services possessed of financing contract.
The annual data include the correction (subsequent account because of lack of data or mistake in the report, data correction, supplement of unprocessed data because of technical reasons, correction after audit) made until the end of the year, modifying the respective month.

The list of ***disposable instruments and implantations falling under itemized accounts*** is included in the Appendix 1 of Ministry of Welfare Order 9/1993 (IV. 2.) on certain issues of social insurance financing of special health care.

The list of ***medicaments falling under itemized accounts*** is included in the Appendix 1/A of Ministry of Welfare Order 9/1993 (IV. 2.) on certain issues of social insurance financing of special health care.
In 2012 the circle of medicaments falling under itemized account are significantly increasing.

Instruments tender: Pursuant to subsection 4 of section 43 of Government Decree No. 43/1999 (III. 3.) the NIHIFM provides certain cardiologic, cardio surgery tools, all middle and inner ears implant listed in appendix 1 of Ministry of Welfare Decree No. 9/1993 (IV. 2.) by service providers to the patients.

The enumeration of ***surgical measures, interventions of great value, not yet spread nationwide*** is included in the Appendix 8 of Ministry of Welfare Order 9/1993 (IV. 2.).
The transplantations of great value (liver, heart, pancreas and lung) were financed by the Ministry of Health until 31 December, 2003, from 2004 the Health Insurance Fund financing them.

Transplantation: transferring living cells, tissue or organs from the donor to the recipient, in order to the transplanted substance to continue its function in the recipient's organization.

Patient transportation

Source of data: monthly performance data of services possessed of financing contract.

Useful kilometres: in case of individual patient transportation the shortest distance between the place of putting the patient in the vehicle and the place of arrival indicated on the patient transportation document. In case of transporting more patients the shortest way between the place of the first patient gets in and the last patient arrives, or it might be different, but from the viewpoint of transported patients the most favourable (fastest) way. Communicated data are excluding corrections (data default or additional account cause of false report, repairs of data, replacement of unprocessed data of technical causes, correction after audit).

The service provider receives a *km fee and complementary fee* of patient transportation after the transportation ordered by a doctor entitled to hospitalize the patient. Its amount is determined by the section 33, subsection 1 and 2 of Government Order 43/1999 (III. 3.) on detailed regulations of health care services financed by the Health Insurance Fund.

Ambulance service

Source of data: monthly performance data of services possessed of financing contract.

Ambulance service was finaced by the central budget from 1998 to 2003, and from 2004 is financed by NIHIFM.

Ambulance service: emergency treatment provided for a patient in need of immediate health care at the place he/she was found and the related transportation to the nearest health service provider and the care carried out during the transportation by the organization entitled to perform ambulance service.