DOI: 10.12700/THTO.2025.02.04

ISSUES OF GENERAL PRACTITIONER FINANCING IN HUNGARY AND AUSTRIA

Gábor Gyarmati

Óbuda University, Keleti Károly Faculty of Business and Management, Hungary,
gyarmati.gabor@kgk.uni-obuda.hu

Abstract: Healthcare, and within that, general practitioner care, has traditions. The goal is to provide for members of society. In Europe, this goes more along the lines of joint burden bearing. The histories of Austria and Hungary are intertwined. However, their financing systems differ. There are differences in the sources of funding between the two countries' systems. The role of state funding is more important in Hungary, while in Austria, local funding is more important. The Austrian population is increasing slightly, whereas the Hungarian population is decreasing. This was followed by an increase in the number of general practitioners in Austria and decreasing in Hungary. In patient care in the Austrian system, the doctor is interested in performing the diagnostic tests locally, whereas in the Hungarian system, due to funding, the doctor is not interested in having them performed but rather sends the patient to central laboratories, which overloads the system. Both systems have advantages and disadvantages. There is no absolutely good solution for financing.

Keywords: *general practitioner, health financing, health care system, Hungary, Austria*

Introduction

The World Health Organization (WHO) drafted a constitution on the functioning of the health system in 1946, to which 170 countries have so far adhered. It contains the following points: health is more than the absence of disease. It includes a state of complete physical, mental, and social well-being; health is not the absence of disease or infirmity. This is because it is limited to the physical level. Health is defined as a right, that is, the presence of the highest attainable state of health would be defined as one's own (WHO, 2024).

It is one of the fundamental rights of all people, regardless of race, religion, political belief, and economic or social status. According to this, it is the basic property and right of the members of humanity. On the level of individuals, to have peace on Earth, it is necessary to satisfy basic needs. The health of all people is fundamental to achieving peace and security. To achieve this, cooperation at the individual level is required on the one hand, and cooperation between states on the other. There is also a connection between the states. If a state moves forward in this area, it helps other states achieve their goals. A state's performance in promoting and protecting health is valuable to all other individuals and states. The inequality of different countries, especially at the level of health, is a risk that comes with the fact that in the case of infections, the danger appears for everyone, that is, health must be ensured for everyone in order not to pose a danger for everyone. The

healthy development of a child is of prime importance for everyone. This also means physical, spiritual, and mental health. Developing the ability to live harmoniously in a changing environment is essential. Sharing, disseminating, and passing on the benefits of medical, psychological, and related knowledge is essential for all people to achieve and maintain a healthy state. Providing the population with adequate knowledge and active cooperation is extremely important for improving people's health (WHO, 2024).

They accepted the basic principles that correspond to the healing ethics maintained over the centuries, but they also tried to consider the requirements of the operation of modern medicine (Baráth, 2008). It is important to highlight some of these central points:

- within the framework of the mandatory solidarity principle insurance, everyone contributes to the basic and guaranteed quality healthcare service,
- the service structure meets real health needs and "consumer" needs, it handles morbidity and demographic changes flexibly,
- the effectiveness and efficiency of the procedures are adequate,
- the system of services, the possibility of using them and the fate of public money spent in the health sector are transparent,
- health care operates in a financeable system, and the efficiency of the resources devoted to health care increases.

The informed opinion and active cooperation of the public are of paramount importance for people's health. The financing and burden-sharing of healthcare is based on several types of models. The first important objective is to create a socially based, solidarity-based risk-sharing community to ensure that the insured, regardless of their current income situation, can access the quantity and quality of healthcare they need and can afford on a social scale. This system has been in use for decades and should continue to work. This is based on an important principle. And that is solidarity. The rationale for the need for solidarity is still present. There is an inverse relationship between the personal income of the population and their personal health needs. The costs of healthcare are such that only a solidarity community on a societal scale can spread them. Changes in health status cannot be planned in advance and can only be partly influenced by the individual (Kincses, 1994).

Hungarian general practitioner financing

A historical review

The General Workers' Sickness and Disability Fund (General Fund) was founded on 3 April 1870 in the capital city of Budapest with 19 members. It was initially a subdivision of the Pest-Buda Workers' Training Association but became independent in 1871. The aim was to create a sickness and invalidity benefit fund. Needy workers received life insurance, which provided compensation in case of illness and disability. Unfortunately, this was unnecessary. It also provides support in the event of unemployment. The aim was to enable workers to maintain this funding. Its income was the contributions paid by the members, and the Minister of the Interior also contributed to the costs when it was founded. The amounts paid by low-wage workers could not be used to fulfil the tasks of the disability fund, so this function had to be deleted from the statute.

The General Treasury strove to become a national organisation as soon as possible, so branch cash registers were established in rural settlements. Despite several reorganisations carried out over more than 120 years, it can be said to be the predecessor of the National Directorate General of Social Insurance (Kiss, 1991).

Hungary introduced a compulsory social security system in 1891. It was third in Europe, the first two being Germany and Austria. Hungary was a member of the Austro-Hungarian Monarchy. From then on, we can discuss a compulsory health insurance system. Law XIV of 1891 helped workers in the industry in cases of illness. This was a novel finding at that time. The scope of the act was extended to Europe. It provides sickness and health insurance. Workers covered by the 1884 Industrial Act were obliged to take out insurance regardless of sex, age, or nationality. Employees of state institutions, legislative bodies, municipalities, and public enterprises were not obliged to join, but employees in agriculture were not obliged to do so either. Entry was voluntary. Funds operating in the spirit of the law are municipal bodies that were managed, supervised, and controlled by the competent industry authority according to their seat, and were under the supervision of the Minister of Internal Trade. The funds' sources of income were the contributions of members who were required to join, one-third of whom the employer was obliged to cover from its own funds, and two-thirds were deducted from the member's salary (Besze, 1998).

Under social security legislation, health services may be provided by a doctor or health service provider who is licenced to do so and has a contract with the National Health Insurance Fund. This also requires that he/she carry out an activity which is included in the activities defined by the Health Insurance Fund and is eligible for financing. It is important to point out that it is not the patient who pays the provider, but the health insurer. The payment is based on the financing report reported by the doctor. Funding is settled by contract in accordance with legal requirements. A financed service is defined in the financing contract as a health service actually provided under the compulsory health insurance scheme, for which no other person is or may be obliged to reimburse. The purpose of the system for receiving and processing performance reports is not only to support the financing of the healthcare provided, but also to facilitate the retrieval of patient life histories and to allow systemic risk analysis (NEAK, 2018).

Health care system in Hungary

It provides general medical care for those entitled to health insurance. This is based on the residence and being viewed by a general practitioner. The aim of the scheme is to ensure continuity of healthcare. The primary health care service is organised as a general practitioner (GP) and general paediatrician (GP). It is important to note that everyone has the right to choose a general practitioner or general paediatrician (GP), including persons with full capacity to act, minors with limited or no capacity to act, and adults with partial or full legal capacity to exercise rights relating to healthcare through their legal representatives. It is the responsibility of the local authority to create conditions for the provision of general medical care and define the area to be covered (street directory). The GP performs his/her duties based on an agreement with the municipality. However, the requirements for doctors are not set by the municipality but by law. It describes the

content, professional, personnel, and equipment requirements. The activity of general practitioners is subject to an operating licence issued by the district (metropolitan district) office of the Metropolitan and County Government Office in the field of public health. The operation of the general practitioner service is financed by the National Health Insurance Fund Management through the Health Insurance Fund (NEAK, 2021).

The financing of primary health care provided by general practitioners, general paediatricians, and dentists under the Regulation on the activities of general practitioners, general paediatricians, and dentists is carried out by the statutory body. This is a contractual obligation. To conclude the contract, the funder declares that the doctor undertakes to provide care on an ongoing basis under the conditions laid down. If the number of persons registered with a general practitioner who is not subject to a territorial obligation to provide care is less than 1,200 in the case of an adult or mixed population, or 600 in the case of children, the amount of funding is paid on a pro rata basis. NEAK concludes a financing contract with a doctor to finance the GP service with a territorial coverage obligation.

A financing contract may be concluded for a new general medical service with a territorial coverage obligation if the provider

(a) a population of between 1,200 and 1,500 persons aged 14 years and over (hereinafter referred to as an adult district), or

(b) 1,200 to 1,500 inhabitants without age limit (hereinafter referred to as 'mixed district'), or

(c) 600-800 inhabitants aged 0-14 years (hereinafter referred to as 'children's district') (43/1999. (III. 3.)

The financing is based on the contract between the healthcare provider and NEAK, and the data provision (performance report) submitted to the health insurance company containing the services provided by the healthcare provider within the framework of the relevant legal provisions. The healthcare provider may be entitled to maximum monthly financing for the number of months for which it has provided services based on its current contract. Based on Government Decree 43/1999 (III. 3.) on detailed rules for financing health services from the Health Insurance Fund and NM Decree 9/1993 (IV. 2.) on certain issues of social security financing of specialised health care financing of health services takes place (1) on the basis of expenditure, (2) on the tasks to be performed, (3) on the count of cases served, (4) per head quota, (5) on the performance ratios of the services provided, (6) with respect to certain services, on the quantity of its performance unit, and (7) on the combination of the previous point-based system.

The elements of financing are (1) fixed fee (determined by taking into account the population of the district to be served, the number of dispensaries, and the disadvantaged situation of the settlement), (2) regional additional fee (remuneration to be paid based on the type of settlement served by the family doctor service, taking into account the characteristics of the location of the population living in the area of the family doctor, additional fee to cover the costs of visiting patients by a doctor), (3) performance-based fee (calculated by taking into account the number (age) of insured persons registered for the

family medicine service, the qualification multiplier of the doctor providing the family medicine service, and the degression factor, (4) outpatient remuneration (remuneration to be paid for emergency treatment of insured persons who have not registered for the service) additional compensation for skilled workers (in the case of a skilled worker employed for at least 20 hours per week, with the fact that the additional skilled worker fee must be used to supplement the salary and income directly due to the skilled worker), (5) equipment and real estate subsidy fee (overhead subsidy for operators of general practitioner services with regional care obligations), and (6) remuneration based on the results achieved in the indicator system legal relationship verification fee (NEAK, 2018).

Austrian general practitioner financing

The GPs' income consists of two parts: the fee for the services and the fee based on the number of cases. Individual services make up a significant part of the total fee. Each service has a separate fee. When patients visit the office, they usually provide several unique services. A person treated in a given quarter is considered a case, regardless of how often they come to the particular contracted clinic. If a patient visits the office several times per quarter, it remains a case. If a person returns in the next quarter, they become a case again. The number of cases (case number) and the fee per case (case value) are important comparative values for many doctors on the basis of which they evaluate their economic performance. The basic service fee (per-case flat rate) is a per-case flat-rate amount settled when the patient's e-card is inserted for the first time in the quarter, regardless of other treatment services (Gesundheitskasse, 2024).

Figure 1 shows a comprehensive picture of the Austrian supply system. A significant part of expenses is financed from tax revenues, which represent the second largest source. According to the system, this accounted for 30.8% of all expenditures and 40% of public expenditures (Statistics Austria, 2017).

It is equal to the sum of the contributions of the federal government, provinces or municipalities to the costs of inpatient care and LTC, public health and prevention, and contributions to the SHI funds for unemployment and maternity benefits. The other leg of the funding is related to health care. The health tax is managed and distributed at the federal level by the Federal Health Agency (Bundesgesundheitsagentur, BGA) and at the state level by the nine state health funds (LGF). Private contributions also reach a significant amount. They represent the third largest source of income, representing a total of 25% of all expenses according to known statistics. The OOP is the measure of healthcare expenses out of all expenses of approx. They represent 20%. This is higher than the EU average. On the other hand, the level of voluntary health insurance can be said to be small. They represent about 5% of the whole (Statistics Austria, 2017).

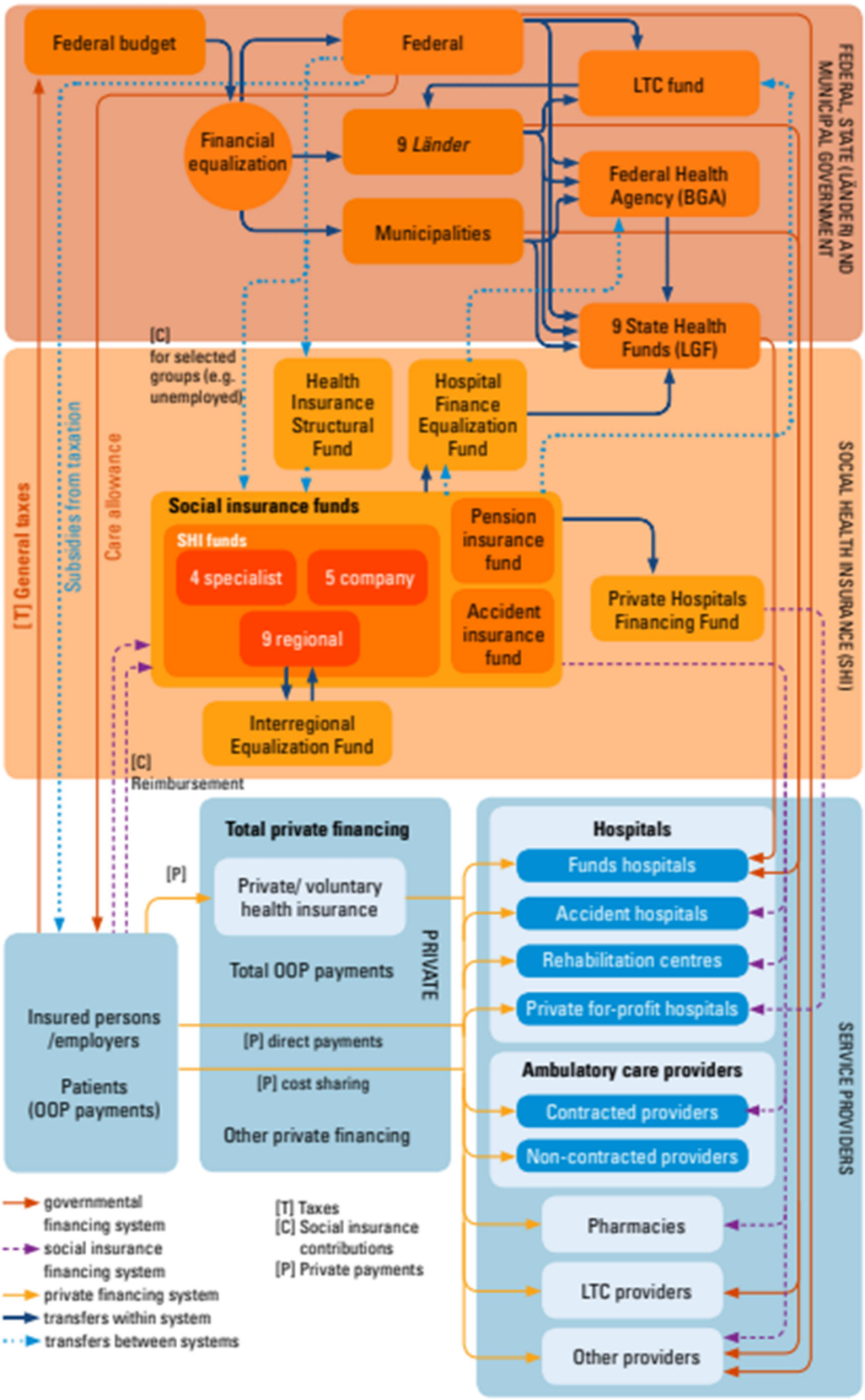

Figure 1 Financial flows in Austrian health care system

Source: Statistics Austria 2017

DOI: 10.12700/THTO.2025.02.04

Based on Figure 2, it can be seen that general practitioner care is financed by the 18 sickness insurance (SHI) funds. Furthermore, long-term care (LTC) services are mostly funded by provinces and local governments. The contribution of the federal government is independent of the number of cases; they contribute a fixed amount to the costs on a monthly basis. Rehabilitation after accidents is also supported by pension insurance, accident insurance and health insurance, among others. All other remaining parts are covered by health insurance (Health System Review, 2018).

	1980	1990	2000	2005	2010	2015
Current health expenditure (in € million)	5 417.9	10 615.9	19 659.7	24 243.1	29 793.6	35 076.9
Government/compulsory schemes	67.2%	74.4%	75.5%	75,1%	76.1%	75.6%
Government schemes	–	–	–	29.2%	31.7%	30,8%
Compulsory contributory health insurance schemes/CMSA	–	–	–	45.9%	44.5%	44.8%
Voluntary schemes/household out-of-pocket payments[1]	32.8%	25.6%	24.5%	24.9%	23.9%	24.4%
Voluntary health insurance schemes	–	–	5.3%	5.0%	4.7%	4.9%
Household out-of-pocket payments	–	–	17.8%	18.6%	17.7%	17.9%
NPISH financing schemes	–	–	1.2%	1.2%	1.3%	1.4%
Enterprise financing schemes	–	–	0.2%	0.2%	0.2%	0.2%

Figure 2 Sources of revenues as percentage of current expenditure on health (current prices), 1980-2015

Source: OECD database, 2024

Austrian healthcare spending has grown steadily in recent years and continues to grow today. The role of the government is stable and significant. Voluntary funding also shows a stable and slight decrease. The various sources of income (SHI contributions, taxes, OOP and VHI) have remained relatively stable in the past period. The role of SHI contributions is the largest. In the observed period, they accounted for 44.8% of all healthcare expenditures and 60% of public expenditures. The payments are collected by the General Association of Austrian Social Insurance Institutions (HVB) and then transferred to SHI funds to cover the costs of healthcare providers (OECD, 2024b).

Comparison of Hungary and Austria

Looking at health spending in 2022 reveals significant differences between countries. The average for the 38 OECD countries was 9.2%. The Hungarian share of spending was 6.7% at that time, whereas Austria's share was 11.2%,, which is a positive deviation from the average (OECD, 2024b). These data are shown in Figure 3.

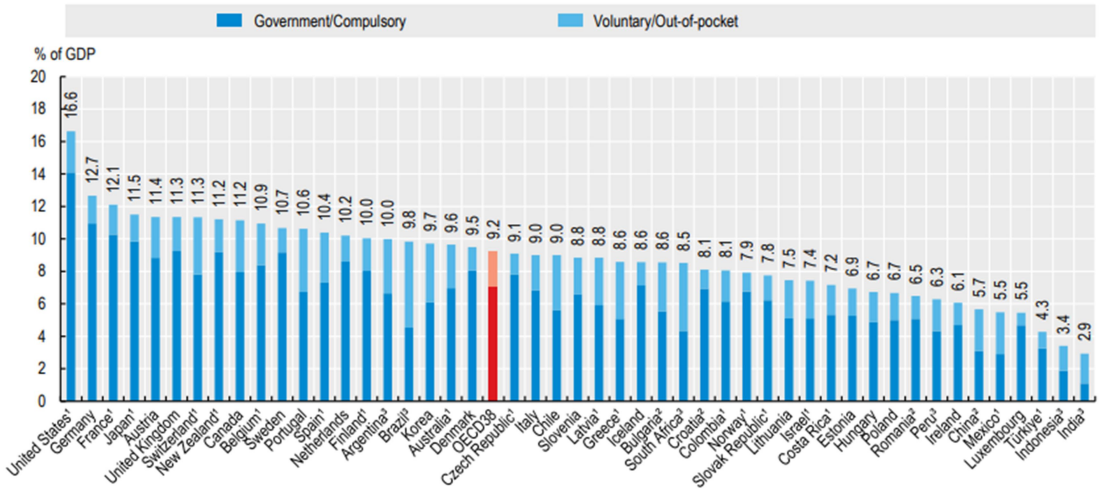

Figure 3 Health expenditure as a share of GDP, 2022 (or nearest year)

Source: (OECD Health Statistics, 2024b)

Figures 4 and 5 show health expenditure in millions of euros in the two countries. Between 2010 and 2015, the order of magnitude in Hungary did not change significantly. From 2016 onwards, however, we observe a more significant increase in expenditure. Unfortunately, data for 2022 is unavailable, which would have revealed the impact of significant inflation on expenditure.

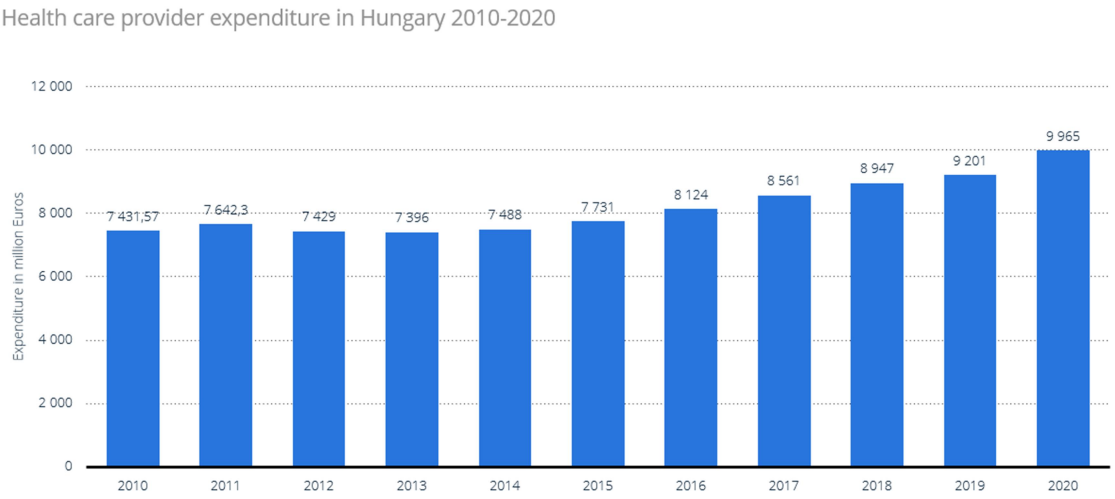

Figure 4 Health care provider expenditure in Hungary 2010-2020

Source: Statista (2024a)

In Austria, on the other hand, we are not talking about stagnation, but a steady increase year on year, with 4 times as much being spent on healthcare as in Hungary.

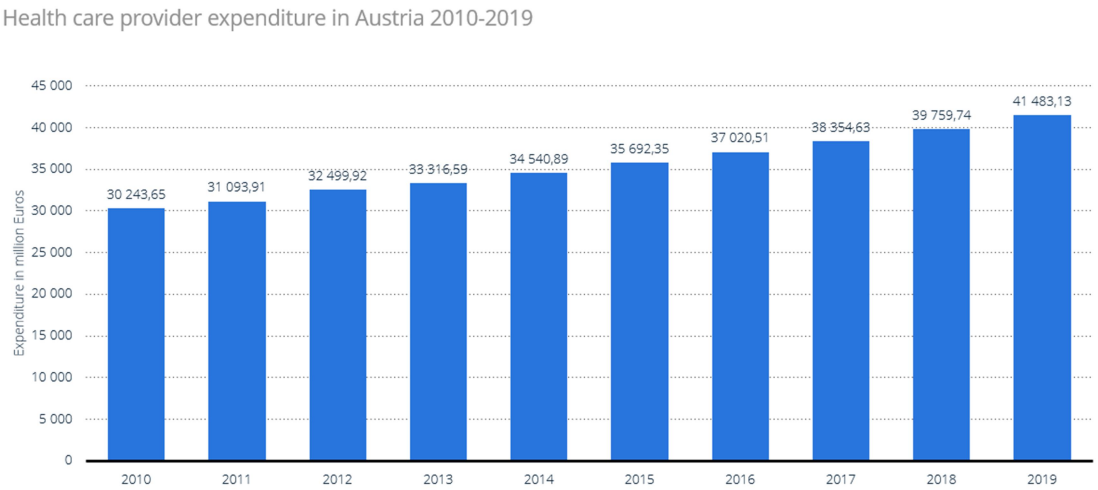

Figure 5 Health care provider expenditure in Austria 2010-2019

Source: Statista (2024b)

Surprisingly, Cuba has the highest number of doctors per 1,000 inhabitants of any country in the world. This is clearly a priority area for the Cuban system. This is followed by welfare states and developing states. So, in many cases it is not a financial issue, but rather a tradition or health policy. It could be an interesting study to look at the number of doctors per capita and other health parameters for a given country. Whether there is a correlation between the number of doctors and the quality of health. Austria is ranked 9th in the world with almost 55 doctors per 10,000 inhabitants, with people reporting a shortage of doctors. See Figure 6 for details.

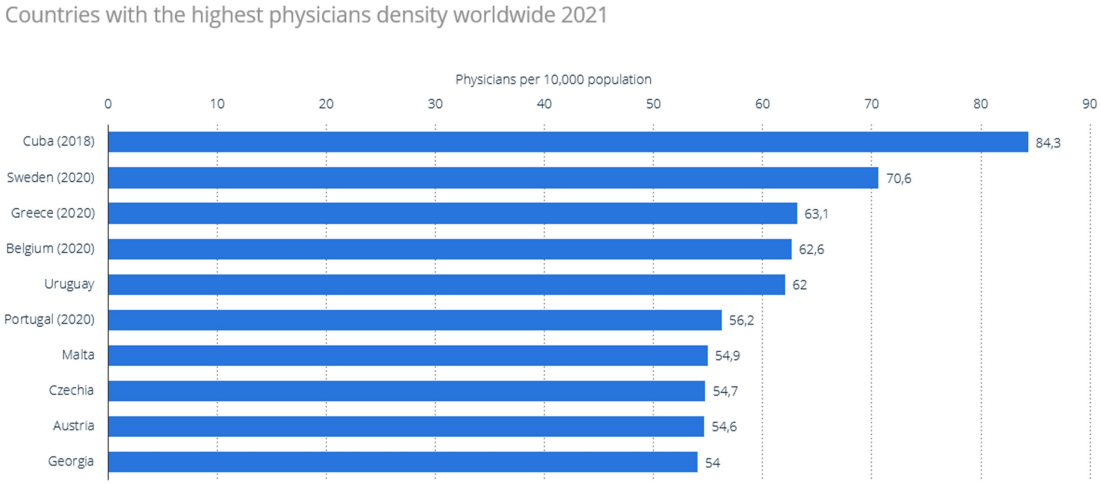

Figure 6 Countries with the highest physicians density worldwide 2021

Source: Statista (2024c)

Figures 8, 9, and 10 show the number of GPs. In Austria, adult and paediatric general practitioners are counted separately, whereas in Hungary they are shown together.

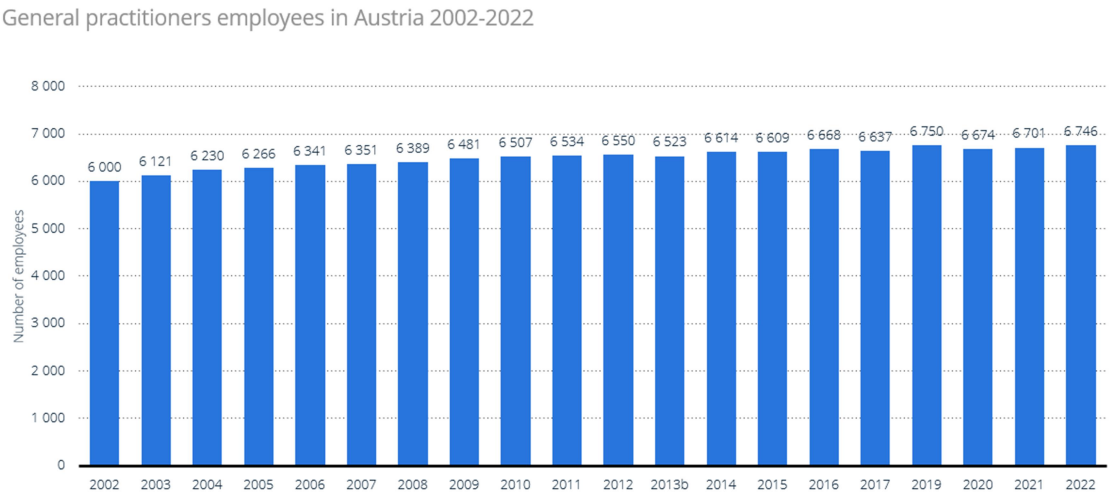

Figure 7 General practitioners employees in Austria 2002-2022

Source: Statista (2024d)

The number of general practitioners in Austria has been increasing year on year, reaching 6700. In Hungary, the total number of general practitioners, including paediatricians, is 5,700, and this figure is steadily decreasing. It should be added that Austria has a population of 9.1 million, and due to immigrants, the number of general practitioners is increasing year on year. In contrast, Hungary's population is decreasing, as is the number of general practitioners. The number of paediatric general practitioners is estimated to be around 2000 in Hungary.

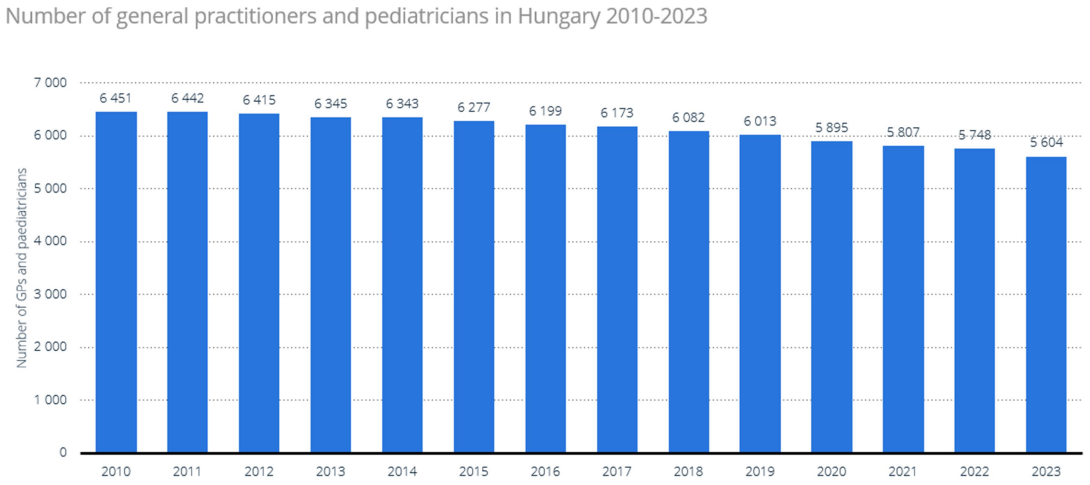

Figure 8 Number of general practitioners and paediatricians in Hungary 2010-2023

Source: Statista (2024e)

The number of paediatricians in general practice in Austria was 1628 in 2022. This figure has been steadily increasing.

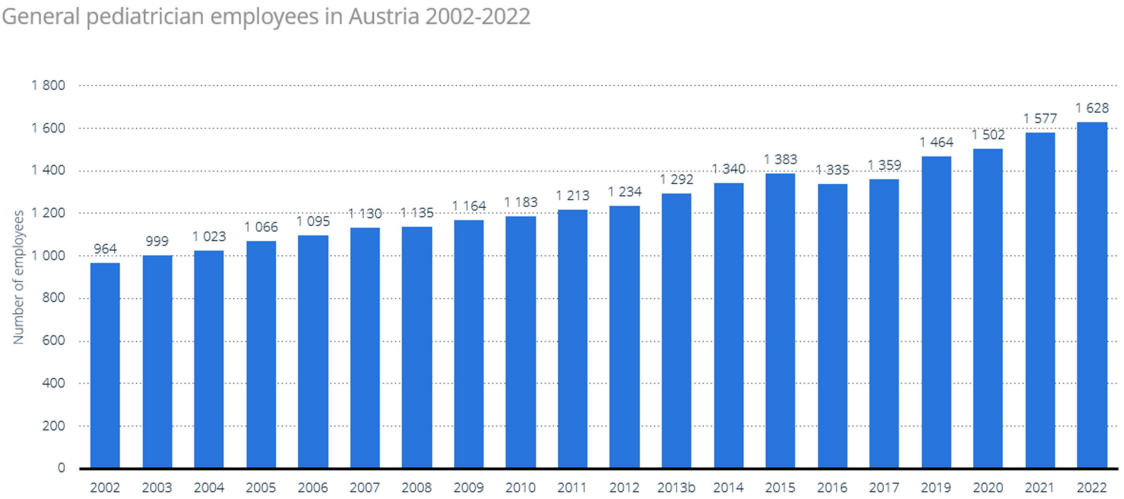

Figure 9 General paediatrician employees in Austria 2002-2022

Source: Statista (2024f)

Conclusion

There are differences in the source of funding between the two countries' systems. The role of state funding is more important in Hungary, whereas in Austria local funding is more important. The Austrian population is increasing slightly, while the Hungarian population is decreasing. The number of general practitioners is increasing in Austria and decreasing in Hungary. In patient care in the Austrian system, doctors are interested in performing the diagnostic tests locally. In the Hungarian system, however, due to funding issues, doctors are not interested in performing tests locally and instead send patients to central laboratories, which overloads the system. Both systems have their advantages and disadvantages. There is absolutely no good solution for financing.

Acknowledgement

I would like to thank Ingrid Szalay for her help, insights, information and sharing her experiences in Austria with me.

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