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Institutional Analysis of Hungarian Hospitals and the Possibilities of Corporatization

Janos M. Rethelyi, Eszter Miskovits and Miklos K. Szocska

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Health, Nutrition and Population (HNP) Discussion Paper

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Organizational Reform in the Hungarian Hospital Sector: *Institutional Analysis of Hungarian Hospitals and the Possibilities of Corporatization*

János M. Réthelyi^a, Eszter Miskovits^b and Miklós K. Szócska^c

^aJunior Fellow, Health Services Management Training Centre, Semmelweis University, Budapest, Hungary

^bSenior fellow, Health Services Management Training Centre, Semmelweis University, Budapest, Hungary

^cActing Director, Health Services Management Training Centre, Semmelweis University, Budapest, Hungary

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Abstract: The organizational reform of public hospitals is part of the health policy agenda worldwide as a reaction to inefficient and low quality performance in public institutions. A central theme of these reforms is the possibility of improving performance in public settings in corporatized forms i.e. under semiautonomous circumstances. Central and East European countries face the problem of an oversized and hospital-based health care system inherited historically from the former centralized totalitarian political system.

The authors analyze the Hungarian Hospital sector in terms of recent changes and the effect of these on organizational modalities shown earlier to play a crucial role in the performance of public hospitals. Organizational theory and the “organizational modality - incentive regime” model is used to describe incongruencies and general incoherence in the everyday functioning of Hungarian hospitals. Finally the possibilities and long-term effects of corporatizing and marketizing changes are examined according to recent political and legislative changes and a corresponding case study. Summary in 300 words maximum.

Keywords: hospital sector; institutional analysis; corporatizing reforms.

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

Correspondence Details: János M. Réthelyi; 1022 Budapest, Kútvölgyi út 2.; Tel: (+36) 1-4887616; Fax: (+36) 1-4887610; Email: rethelyij@emk.sote.hu Web: www.emk.sote.hu

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FOREWORD

This Discussion Paper provides insights into recent hospital reforms undertaken in Hungary during the economic transition of the 1990s, with an emphasis on organizational changes such as increased management autonomy, corporatization, and privatization. The material presented tries to answer three questions: (a) what problems did this type of reform try to address; (b) what are the core elements of their design, implementation and evaluation; and, (c) is there any evidence that this type of reform is successful in addressing problems for which they were intended?

The role of the hospital in the health care system has evolved significantly during the past 100 years. At the turn of the 20th Century, hospitals in many countries were still a provider of “last resort” feared and to be avoided if at all possible since the chance of leaving alive were slim. In his famous work on hospital *The hospitals, 1800-1948*, Able-Smith describes the hospital as

At the beginning of the 21st Century we find a totally different story. In developed countries, the hospital has become the “Cathedral” of modern medicine, revered and coveted by many. Many local communities want their own hospital. Once built, hospital beds are almost impossible to close. Emotions run high when discussing the downsizing, privatization or closure of local hospitals. Many politicians have lost their jobs in the process of undertaking such reforms.

Despite much attention and emphasis on primary care as a first point of contact for patients, hospitals also remain an important source of critical health care services in developing countries, providing both basic and advanced care for the population. They are once again often the provider “of last resort” for the critically ill and poor. Yet they also often comprise the largest expenditure category of the health system.

As a result, of these trends, hospitals are often the target of health sector reforms aimed at improving efficiency, quality, and consumer responsiveness, as well as broader reforms in financing of the health care delivery system. In many countries reforms in the hospital sector are often part of decentralization and restructuring of government-owned service delivery systems. Such reforms include altering the incentive regime that managers within the organizations are exposed to, and changing the external policy environment, governance structures, funding arrangements, and competitive pressures.

Reforms of this type, which are now commonplace throughout the world in the infrastructure, telecommunications and transportation sectors, include: (a) increasing the management autonomy of the organization (autonomization); (b) transforming the hierarchical bureaucracy into parastatal corporations that are exposed to market-like pressures (corporatization); and (c) outright divestiture of the organizations from the public sector (privatization). They are often referred to as “new public management” or marketizing reforms.

Influenced by the lessons learned from the problems and reforms tried in other sectors, many health care policymakers have concluded that public hospitals’ performance problems are similarly grounded in the rigidity of hierarchical bureaucracies, the lack of control by managers over day-to-day operations of their facilities, and absence of performance-based incentives. Having successfully applied new public management techniques and marketizing reforms in other sectors, a natural next step is for policymakers to apply similar reforms to the health sector.

Initially, the reform of choice was to give hospitals some degree of management autonomy. Limited success with this type of reform in some settings led policymakers to go a step farther by transforming some of their state-owned hospitals into public corporations. The path-breaking reforms of this type, which occurred through the creation of Hospital Trusts in the United Kingdom (UK) and Crown

Health Enterprises in New Zealand, drew worldwide interest. Soon many developing countries such as Hong Kong, Malaysia, Indonesia, Tunisia, and Argentina attempted similar reforms. Often they were accompanied by parallel reforms in the overall health policy framework, provider payment system, and competitive market environment.

The debates surrounding these reforms have been lengthy, heated, and rarely enriched by evidence gleaned from rigorous evaluation of experiences. Much of this debate centered on whether independent hospitals can play a positive role in a well-functioning health system. Polemics over this issue obscure the reality that in many industrial countries that have a traditionally paid for health services through social insurance, inpatient services have always been provided through a mixture of public, semi-autonomous parastatal, nongovernmental, and private hospitals.

Since the hospital sectors in all the European countries that use such mixed delivery systems are part of socially responsible health care systems, it is clear that independent hospitals can play a productive role in a well-functioning health system. Hence, the end-point of these reforms is not really at issue. What is at issue is when it makes sense to move from an integrated public system, to system with independent hospitals, and how to do so. What kinds of changes and improvements can these reforms bring? How can policymakers assure that these improvements will actually be forthcoming? How can they move from a rigid integrated delivery system, with hierarchical control of hospitals, to a better performing system that relies on indirect mechanisms to guide substantially more independent service providers.

This Discussion Paper examines such “marketizing” organizational reforms that rely on a combination of increased decision rights of hospital managers and market-based performance pressures. Other Discussion Papers attempt to crystallize key questions about objectives, design, implementation, and evaluation of such reforms. All highlight several important areas for further investigation:

- the institutional and contextual requirements for and constraints to “marketizing” organizational reforms (e.g., what works at different income levels, stages of health systems development, cultural settings, market environments)
- a direct comparison of autonomized, corporatized and privatized units to see which reform creates a more workable hospital system in different contexts
- policy options for reforming public hospitals in situations of extreme government failure (is there any evidence that improved management of integrated hierarchical systems do better in this context than if governments were to introduce organizational reforms, complex as they may be)
- the nature of the parallel reforms in management, policy oversight, resource governance, resource allocation/purchasing arrangements and market environment that are needed for successful reform
- ways to achieve more rigorous and on-going monitoring and evaluation of the reforms to ensure that policymakers will use the lessons learned and that these will be available to countries that have not yet ventured down the organizational reform path.

For additional research on this topic, readers may also want to consult *Innovations in Health Care Delivery: The Corporatization of Public Hospitals* by Alexander Preker and April Harding, Eds.

Alexander S. Preker

Chief Editor
HNP Publications
World Bank

April Harding

Senior Economist
Health, Nutrition and Population
Human Development Department
World Bank

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1. OVERVIEW OF CHANGES IN THE HUNGARIAN HOSPITAL SECTOR

The hospital sector in Hungary has undergone a series of structural, regulative, financial changes over the last decade during a period of dramatic political and economic change (Orosz and Holló [1]). In 1990 parallel with the political changes the majority of hospitals, previously functioning as central budgetary units were transferred to the Local Governments (Municipalities) as owners, and became autonomized organizations. The legal background of this transfer was fixed in the new Hungarian Constitution (Act XX of 1949 on the Constitution of the Republic of Hungary amended by Act XXXI of 1989 [2]) defining the public responsibility of health-care provision and the Act of Local Government (Act LXV of 1990 on Local Government [3]), in which the obligation of Health Care was delegated to the local governments as owners. The minority, but still a significant part of hospitals are owned by the state and supervised by the respective ministries or government agencies, such as the National Institutes for specialized medical areas, the medical universities and the ministerial hospitals. Although functioning as budgetary units, the ownership and management structure of these hospitals are rather similar to those at the local level.

In 1990 178 hospitals operated 104,600 beds resulting in 9.84 active hospital beds per 1000 inhabitants. Due to the centrally planned bed reductions and fusion of hospitals during the mid-90s in 2000 150 hospitals operated 84,200 active beds resulting in 8.41 beds per 100 inhabitants. The number of hospital staff did not change dramatically since 1990, the number of physicians per 1000 population grew from 3.17 to 3.61 in 1999, the number of nurses per 1000 population grew till 1998, reaching 3.85, and started decreasing afterwards due to transsectoral labor migration. (Gaál et al. [4]) Hospital employees enjoy the status of public servants and their employment is regulated by the Act on Public employees. The law regulates many aspects of the employment including payments, benefits and hiring-firing procedures.

The executive directors of hospitals are appointed by the owners of the institutions. Though the ranks of management are mainly dominated by medical and nursing professionals, in recent years new professions like economists, lawyers, engineers have entered middle and top management positions and the training of hospital managers has gained importance.

The public perception of service quality in health-care institutions as a whole has changed substantially in the last decade due to the deterioration of institutions and poor management. Quality management has been introduced in several hospitals, with mixed results. In several cases the introduction of quality management systems in hospitals was only a loosely coupled reaction to envisioned governmental regulation, rather than a counter-reaction to quality problems.

Financing of health-care institutions was taken over by the Health Insurance Fund 1988, which became an autonomous semi-public financing organization. The introduction of DRG-based casemix-funding in 1993 for acute in-care services resulted only partially in the envisioned improvement of efficiency. Although the average length of hospital stay fell from 9.5 to 6.7 days between 1992 and 2000, on the other hand the number of admissions rose from 21.8 to 24.4 per 100 population between 1990 and 1996. The explanation of this increase is the financial incentive of hospitals to increase funding by the number of cases (supplier-induced demand). This tendency was fuelled by the fall of the real value of DRG points [5].

In terms of their finances the funding of hospitals has gradually decreased in the past years. The Health Insurance Fund expenditure on acute care services decreased by 16% between 1994 and 2000. Parallel to this tendency the overall debts of the hospital sector gradually increased between 1998 and 2001 and reached 4% of the annual Health Insurance Fund expenditure, although the overall accumulation funds increased as well. These data shed light on the uneven financial situation of hospitals, some accumulating debts, others accumulating funds [6].

While the Health Insurance Fund finances the costs of operations of hospitals, the owners are legally responsible for the capital costs. The costs of depreciation for the hospital sector were never identified and were never contributed to neither the insurance fund nor the budget of municipalities. The payment of other capital costs like infrastructure developments are paid by the respective local governments or other resources from the central state budget. The allocation of these development funds is accidental and uneven.

The responsibility for poor financial performance has not been defined during the recent changes, because of the mixed ownership and management structure of Hungarian hospitals. Hospitals' directors blame the owners for not financing the capital costs sufficiently, while the local governments point at high operational costs and inefficient functioning. Both the owner and the management claim that the Health Insurance Fund does not provide the real operational costs. Thus, a mutual blaming culture has developed between the various actors.

Although it is obvious that these changes have definitely stirred up the legal, financial and organizational environment of hospitals, the changes were not consistently followed in other crucial fields of the health-reform. Organizational structure, financial management, and organizational behavior have remained unchanged in many health-care institutions.

2. "VARIOUS AND INCOHERENT": ORGANIZATIONAL ANALYSIS OF HUNGARIAN HOSPITALS

The organizational modality – incentive regime model introduced by Harding and Preker (Harding and Preker [6]) defines five major organizational modalities that impact on the performance of organizations. These are the decision rights of the management, the right of residual claimant, the market exposure, accountability of the organization and the social functions delegated to the organization. The spectrum of health-care organizations ranging from traditional budgetary units to autonomized, corporatized, and finally privatized units lie on different sections of these organizational modalities which define different incentive environments. (Fig. 1.) Moving from the "budgetary unit" end of the spectrum to the "privatized" end, in general direct control mechanisms are replaced by indirect and regulative mechanisms and incentive regimes.

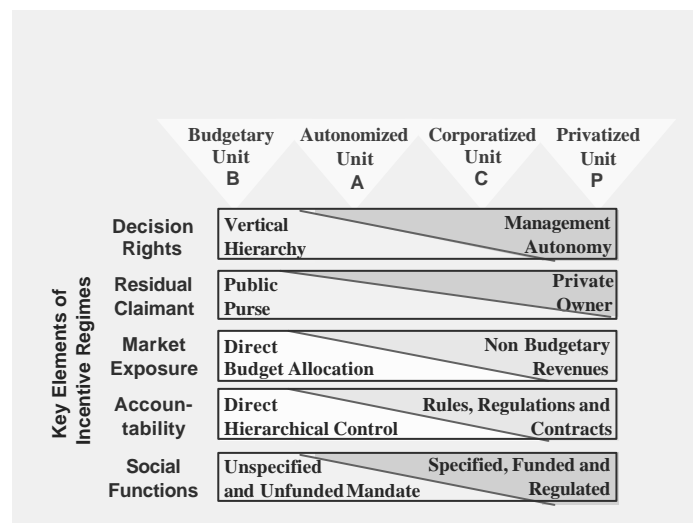


Fig. 1. Summary of organizational modalities influencing the performance of health-care organizations and marketizing reforms. (Courtesy of A. Preker)

The model was used to analyze corporatizing and marketizing reforms in the hospital sector of several countries of central and East Europe and throughout the world. It was concluded that consistent reforms incorporating all organizational modalities, and involving the corresponding incentives were successful and led to the sustainable improvement of hospital performance. Inconsistent reform efforts undermined the overall impact because of leaks or disincentives in the system.

According to this model of organizational modalities and incentive regimes Hungarian hospitals show several features at the corporatized or marketized end of the organizational spectrum, and some at the other extreme, typical of budgetary units resulting in an incoherent overall organizational situation.

The methodology used for the identification of results was documentary analysis, and qualitative data-collection during a focus group consisting of several hospital managers. The detailed description of the methods is omitted, as the focus of the study is to investigate a typical average hospital in Hungary, rather than providing an overall analytical-quantitative picture. We have summarized our findings according to the model in the following list.

1. **Management decisions:** Hospital managers enjoy a relative independence in labor decisions about hiring, promoting and firing staff, in the boundaries declared by the Act of Public employees. This law establishes restriction in the protection of employees, who enjoy certain benefits, and are protected from rapid dismissal. The number of the staff is the decision of the management, which has the right to contract non-permanent staff as well.

Independence in financial management is relatively high, as the performance-based funding is not earmarked by authorities. Individual salaries are defined as minimal payments in the Act of Public Employees, and the management can pay extra based on performance criteria. This is common if management control has been introduced in the hospital. However questions about capital investment usually require the approval of the local government board representing the ownership. Asset control is beyond the competence of hospital management, the owner government entity holding these rights.

Procurement of pharmaceuticals and other consumables, the outsourcing of services, is the decision of the management under certain value limits. Formal public bidding procedures are fixed legally above these limits.

In summary, the strategic financial management of the hospital is possible within legal and the owner-defined limits. However hierarchic and informal relations are profoundly present in management and clinical team structures, and often cause irrational decisions parallel with vested interests of the actors.

2. **Right of residual claimant:** Since the introduction of DRG-financing for acute in-care services hospitals have the right to transfer the residual on a yearly basis, but the same regulative background applies for using the transferred residual as for any investment. In most cases personal financial incentives are not incorporated in the system, a few hospitals have launched successful management control systems. In contrary to this medium level upside residual claimant status, the downside (deficit) residual claimant status is very low. The primary responsibility for any potential deficit lies with the owner and implicitly with the public budget. In case of necessary consolidation the owners question the responsibility of management and are directly involved in the negotiations to access consolidation assets e.g. loans or government funds.

3. **Market exposure**: The introduction of the DRG-based performance financing created a market situation for services provided by hospitals. Some hospitals showed quick signs of adaptation by increasing performance, and decreasing costs, thus improving efficiency according to the new system, others not being able to adapt financially produced huge amounts of debts. However if we define market exposure as the proportion of hospital income from payers with a meaningful choice between services, the market exposure of public hospitals appears fairly low, because of the passive contracting practice of the National Health Insurance Fund. Concerning the input market, the labor market in health care is more and more competitive, with decreasing number of nursing personnel available and the demand for trained physicians in the European Union. Public hospitals are excluded from the capital market, because the depreciation costs are not reimbursed either by the owner or the Health Insurance Fund. The lack of the possibility of bankruptcy and of market exit is a sign of incomplete competition.
4. **Accountability**: Hospital managements are accountable to the owners in using their annual budgets, thus direct (ownership related) accountability mechanisms function at a medium level on the organizational modality range. Direct accountability implies for internal decisions, such as spending, hiring, procurement and asset management. The way accountability is exercised differs according to the type of owner. Hospitals where ministries exercise ownership experience more direct interventions and are more exposed to political influence. Medical universities enjoy broader academic autonomy and sometimes show the signs of management irresponsibility accumulating debts. Hospitals are also accountable for DRG coding, and may face regular audits from the Health Insurance Fund.

Indirect (non-ownership related) accountability mechanisms function at a low level, although national accounting standards apply to public hospitals as well, but have no real impact on management decisions.

5. **Social functions**: The obligation of providing health-care services at the local level is a central idea of the Hungarian constitution, nevertheless social roles for hospitals are not precisely defined. Meeting public expectations in terms of service quality is not ensured in the present system. Traditionally the public expects hospitals to exercise social care responsibilities. Many times hospitals take patients on “social” and not only on medical indications. Another social function is the services Hungarian hospitals provide to Hungarian minority patients arriving from the neighboring countries. In the case of some hospitals this function is in considerable magnitude.

Specified social functions, such as teaching, research, emergency and burn services are appointed to different levels of the hospital system, but their funding is often insufficient or *ad hoc*.

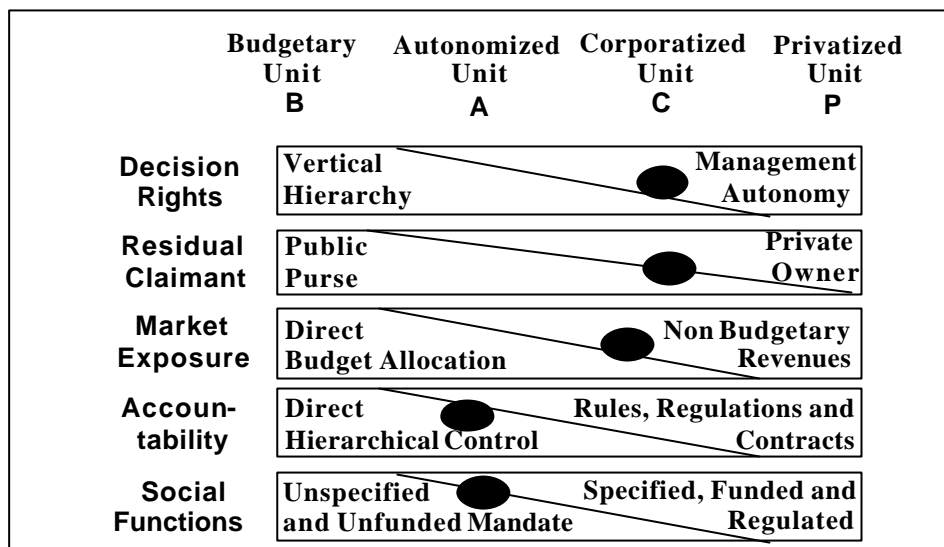


Fig. 2. The average situation of Hungarian hospitals on the 5 modality axes.

Summarizing our findings that are the result of a general description rather than a systematic analysis, Hungarian hospitals show large deviations and many varieties in their everyday functioning. The incentive environment and the regulative background do not ensure the flexible mechanisms of a mature competitive system that would result in better quality and improved efficiency throughout the whole hospital sector. The incongruence of organizational modalities undermines efforts to improve the performance of the hospital sector.

The varieties and extremities in the hospital sector can be partially explained by different management practices in the changing and unstable environment. Hospitals that function well in terms of their finances and organization, as well as improved service quality and health outcomes, can be assumed to have successful hospital management structures. On the other hand, constant fiscal problems, fragmented organizational structure, leadership failures, organizational resistance to change, poor services and low consumer satisfaction suggest poor management. These findings underscore the importance of both the systemized incentive environment and continuous management training in the hospital sector (Réthelyi et al [7], Szócska et al. [8]).

3. CORPORATIZATION EFFORTS IN HUNGARY: “THE ENDLESS TALE”

The Health Institutional Law (Act CVII of 2001 [10]), also called the Hospital Law passed late 2001, would have supported the corporatization of Health Institutions, aiming to increase efficiency and transparency, and to increase the market exposure of hospitals, and involving external capital. The Law would have had an impact on the legal status of medical doctors as well, decreasing the number of doctors working as public employees and supporting the contracting of self-employed physicians. The law is optional and not obligatory, thus hospitals have the possibility to remain in the ownership of the Local Governments or by a change of company form become public benefit companies (non-profit corporations).

The aim of the initiative is to create a favorable incentive environment for the outcome-oriented public benefit company organizational form and professional management teams without changing the ownership structure of hospitals. The envisioned consequences are the improvement of fund-raising, the reduction of perverse privatization, better management, stricter accountability, better defined social functions and the normalization of payments in the Health Care field (Fig. 3.). The equity considerations of the law put an emphasis on sustaining the public role of the Hospital sector. Pilot projects and the few cases of hospitals already functioning as public benefit companies were promising.

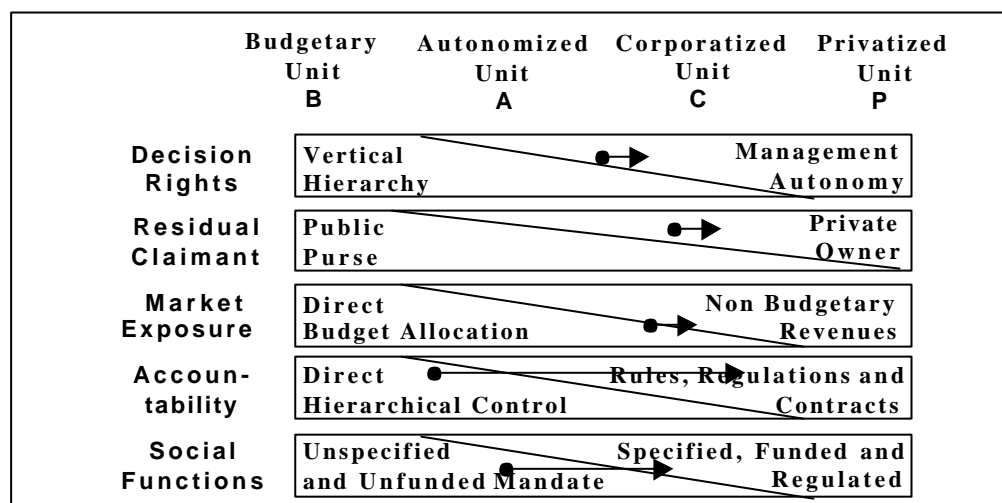


Fig. 3. The anticipated effects of the organizational reform in the Hungarian Hospital sector.

The parliamentary election in April 2002 resulted in the change of the right-central government to the socialist-liberal coalition in Hungary. The new government suspended the implementation of the law till further regulative steps. The idea of corporatization and the self-employment of physicians were declared by the Ministry of Health to remain part of the health reform agenda. The new government faces the same problems of efficiency, and capital involvement, and will have to set priorities in strategic questions as corporatization and privatization.

Two critical changes are suggested in the new proposals. First, the future corporatized hospitals may function in any corporative form (i.e. shareholdings), not only the non-profit public benefit company form. The other modifies the circle of potential owners of hospitals allowing investors from the pharmaceutical or other hospital related industries to enter the market as potential owners.

4. CASE-STUDY

A team of experts, including the staff of the HSMTC conducted a feasibility study about the transition of a major clinical institution from the autonomized company form to a corporatized unit [11]. Although political changes postponed the implementation of this project, the major conclusions shed light on the critical elements of such a process in general in the aforementioned political, economic, social and technological environment.

Critical success factors, the political expectations of the government, and the important players were identified in connection with the transition process. The three critical factors were the continuity of service provision (1), cost-sensitivity and improving efficiency (2), stable financial background and management (3), and consistent incentive regimes and quality performance (4). The political expectations were improving transparency (1), obligatory service provision (2), the protection of public property (3).

The most important actors in the transition process are the management, the owner and the staff, the Health Insurance Fund, the National Public Health and Medical Officer Service as the controlling authority, the Ministry of Health, and the patients. Any kind of change must be based on the consensus of all players. (Fig. 4.)

In order to meet the political expectations and fulfill the critical success factors the steps of implementation must follow a strict regulative and organizational pattern (Tab. 1). The following steps were planned as part of the feasibility study:

- Step 1. Communication of the project, meeting a consensus between the important actors
- Step 2. Approval and permission of the National Public Health and Medical Officer Service, and new contract with the Health Insurance Fund
- Step 3. Legal agreement with staff members about changes in employment status
- Step 4. Financial management structure, Management control, accounting, PR, Marketing
- Step 5. Dissolving of the old budgetary unit, founding of the new corporatized unit
- Step 6. Long-term strategic management of the corporatized unit

Political expectations	Step 1.	Step 2.	Step 3.	Step 4.	Step 5.	Step 6
Transparency	√			√		√
Service Provision		√	√	√		√
Protection of Public Property					√	
Critical success factors						
Continuity of services	√	√	√	√		√
Cost-sensitivity, efficiency	√			√		√
Financial background and management				√	√	√
Incentives, performance	√		√	√	√	√

Table 1. The fulfillment of political expectations, and critical success factors during the steps of implementation.

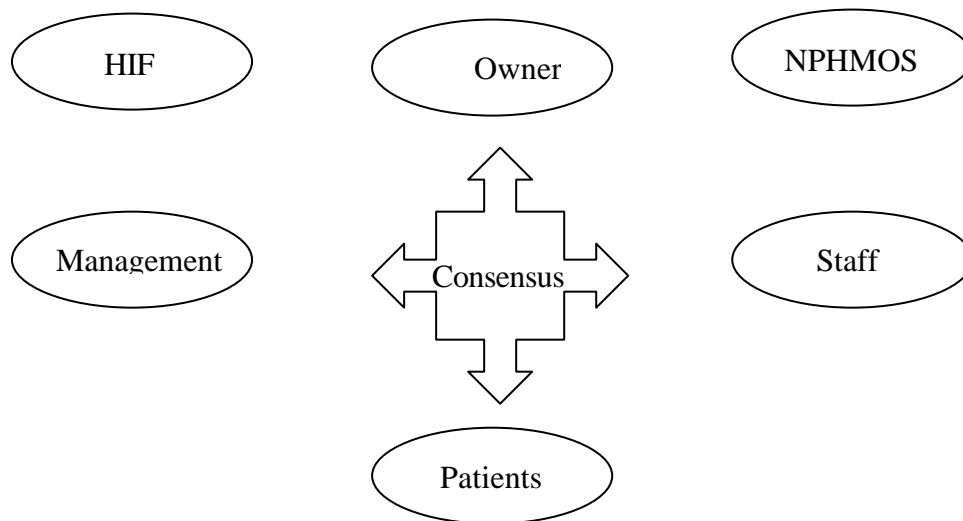


Fig. 4. Major players in the corporatization process (HIF – Health Insurance Fund, NPHMOS – National Public Health and Medical Officer Service)

Key decision points that have to be dealt with during the planning and the implementation phase, and the strategic management of the new institution are the following: The ownership structure of the new institution and involving external capital (1), management structure and corporate boards (2), changing the activity spectrum of the health-care institution (3), technological and equipment investment and the problem of depreciation (4). Decisions brought about these problems will have a major impact on the future of any hospital that is going through a corporatizing organizational change.

5. CONCLUSION: THE PERSPECTIVES AND PERILS OF CORPORATIZATION

The interrelatedness of health care priorities, organizational realities, institutional economy, political expectations and personal interests make the task of changing the hospital sector a complex and difficult process. The possible future scenarios for the corporatization process and the whole Hungarian health-care system are determined by key decisions to be made in the near future (Fig. 5.). The ownership structure and the organizational form of the corporatized unit will impact on the overall efficiency of the new hospitals. The possibility of privatizing public property raises questions about the obligation of providing health care and the public dominance of the Hungarian health-care systems.

The great perspective inherent in the corporatizing changes is the chance of redefining responsibility and the relationship of the owner and the professional management. This strategic redefining of responsibilities implies the introduction of new methods of quality and management control, and determining the strategic choices of hospitals and the necessary resources to reach these objectives [12].

The regulation about the incompatibility of hospital property and health-care suppliers raises questions about corruption and inefficient public fund handling. The private predominance in the system might drain public resources without careful regulation and strategic provider selection and purchasing of the National Health Insurance Fund.

In summary the strive for improving efficiency and quality must be balanced by equity and feasibility considerations during the process of corporatization to achieve the ultimate goals of health care, better health status, meeting expectations, and financial protection.

	Present state	Future state
Organizational form	Budgetary and Autonomized Hospitals	Public Benefit Companies Shareholdings
Management	Centaralized, hierarchic	Decentaralized, Professi onal management
Public-private status	Predominantly public	Remaining public dominance Private dominance
Problems	Inefficiency Low quality services	Corruption Equity problems Uneven performance

Fig. 5. Possible scenarios and problems during future corporatizing changes in Hungary

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Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org

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