The social welfare (SW) part of the Hungarian reimbursement drug provision system is a subsidy item granted by the state in order to decrease the access and chronic drug expenditures of socially underprivileged people, which means the overrating of co-payment expenses up to the limit defined by the general practitioners, and the patients’ monthly drug quota is set up based on this process. This overpayment amount of co-payment by the state is called “payer co-payment”. This kind of subsidy can be applied based on subjectively rights and cost-inedicated (diabetic patients) or on the extent of the monthly income and drug expenses. The maximum monthly limit of the chronic drug quota is 40 EUR, the available quota for acute diseases is 20 EUR per year. The authorities continuously keep a record of the entitlement and drug quota of the entitled persons.

The regulation and financing way of the SW drug provision system has changed several times in different extents since 2006. The purpose behind the clarification of the former soft legal regulation was to shift the system to a more efficient and more transparent state. Changes in the law with the most significant impact were introduced in 2006-2007, whereby among others patients’ drug quotas was established, available product range was widened both in quantity and in reimbursement categories, the application and decision-making process and its control were clarified and tightened. Market position of SW segment within the whole reimbursed pharmacy drug market is significant quota was established, during 2006, whereby among others patients’ drug quotas was established, and the product range was widened both in quantity and in reimbursement categories, the application and decision-making process and its control were clarified and tightened. From the patients’ aspect the available product range expanded. Considering the changes and bracketing in SW market trends, changes in law may serve as explanations to make conclusions, SW system is regulated by Act 81 of 1993, and act XVIII. of 2005. In course of the study calculation we applied 300 EUR/HUF/Ft rate.

Methods

Time series and aggreagated market trend data in demand, reimbursement outline, sales and quasi co-payment turnover derived from the monthly published data by the Health Insurance Fund Administration (HIFÁ). Number of SW entitled persons (public data available until 2012) derive from the database of the Hungarian Central Statistical Office (KHAT) and the KIT-TIK (Territorial Information System). Real-world data concerning the demographic and monthly volunteering patterns derive from the financing database of the HIFÁ. To assess changes and bracketing in SW market trends, changes in law may serve as explanations to make conclusions, SW system is regulated by Act 81 of 1993, and act XVIII. of 2005. In course of the study calculation we applied 300 EUR/HUF/Ft rate.

Results

Figure 1. displays the age structure diagram of SW population in 2010. Considering the part share of entitled persons under 16 age may derive from the above mentioned subjective right. Figure 2. displays the part share of these persons, who had filing to treat different months in each years, this part may be considered as high as the availability of the SW drug provision system. The intensity of the number of entitled persons is improving, in addition considering the decreasing number of entitled persons, it may lead to the assumption, that those persons remained in the system, who had larger needs the SW subsidy in part of. In case of females the intensity level is higher.

Number of SW entitled persons decreased after regulating in law the application, assessment and decision making process, the implementation of registry system, continuous monitoring and control of claim of entitled persons and the prescribing patterns of general practitioners, thus it stagnates from 2008.

Conclusions

Based on changes in laws and regulations, and the altered SW market trends it may be enouraging, that SW system begins to move in a more optimised state. From the patients’ aspect the available product range expanded. Considering the list of TOP10 active ingredients, generating the highest reimbursement outflow, the order totally changed from 2006 to 2013. While in the year of introduction of reimbursement of generic products, the 10 greatest reimbursement outflow classes (TOP10) was used, in 2013 a different range of active ingredients was included in TOP10, particularly respiratory, antiinfective and insulin therapies. The list reflects that the end of the 2006 period patient’s access to innovative changes was processed.

The prescribing patterns of these products implied additional burden to the fund due to the increased reimbursement outflow besides the usual copayment. To reflect the objectivity of a bigger picture of SW system, it is an opportunity to get a more complete overview of SW patients’ prescribing, who are treated with non-innovative products from the dependency database of HIFÁ’s medical databases, specialists’ prescribing patterns, therapies, switches, co-morbidity, cluster analysis. It may worth comparing the prescribing system with other European subsidy systems to observe the costoptimal best practice. In course of assessing patient’s patient level may serve more information for healthcare decision makers to optimise reimbursement of resources, also considering patient rights.