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The short story of co-payments for health care services in Hungary – lessons for neighbouring countries

Key words: co-payment, user fee, Hungary, Central-Eastern Europe, patient payment policy

■ Introduction of co-payments in CEE

While in Western-European countries co-payments for using health care services are widely spread, this is a relatively new issue for most of the Central-Eastern European (CEE) countries. Their story goes back to political changes – the collapse of the communist regimes in the early 90s. Before, during the communist era all kinds of services were covered by the states, and patients could use services free of charge.

Slowly more and more countries were pressed to introduce co-payments for using health care services (in addition to co-payments for pharmaceuticals and dental care) to cover public deficits and control health-care spending. However the introduction of co-payments in these countries often met with a cold reception and political resistance by the population [1].

First the Baltic countries (in the early 1990s) then Bulgaria (in 2000) introduced user fees for health care services shortly after the change of the regime. In these countries the system of co-payments for health care services has been working for more than ten years now [2, 3].

In 2003 Slovakia introduced co-payments for health care services, however fees were abolished by the new government which came into power in 2006 [4].

Hungary had the same experience as Slovakia a few years later: co-payments were introduced in 2007 and abolished one year later in 2008 as a result of a population referendum.

Czech Republic introduced co-payments in January, 2008 with the intention to reduce excessive utilisation of services and generate additional revenue for the health care system. However, the decrease of the measure of the fees and the expansion of exemption categories are still a regular object of policy discussion [5].

The introduction of co-payments is also proposed to take place in January 2011 in Romania.

In countries where user fees have not been introduced yet, like in Poland and Ukraine the issue is continuously on the carpet, and there is an active policy discussion about it.

In this paper we present the case of the introduction (and abolishment) of co-payments in Hungary to serve as a lesson for other CEE countries. First, we introduce the Hungarian health care system, then the introduction of co-payments for health care services in Hungary (goals, design, effects). Finally we give some policy recommendations how to establish sustainable patient payments policies.

■ The case of official patient payments in Hungary

Background

Hungarian health care system

Hungary has an insurance-based public health care sector funded by income-related social health insurance contributions paid for by employees and their employers. Self-employed individuals pay the full contributions. The health care providers are financed by the only health insurance fund, the National Health Insurance Fund Administration (NHIFA).

General practitioners work as private entrepreneurs and partially play the role of gate-keepers to specialised care: their referral is needed to visit a specialist except for some services (e.g. gynaecology, urology, ophthalmology, dermatology and otolaryngology) and for hospital admission. Their services are reimbursed on a capitation base combined with fee-for-service reimbursement. Medical specialists work either in private practices or in hospital units. They are paid via fix on salaries when providing out-patient services. A fee-for-service point system works as a basis for financing the out-patient specialist

care. Hospital in-patient care is provided mainly by state hospitals although private clinics also exist. The hospital funding is based on diagnose-related groups reflecting the type and quantity of hospital care provided. In 2007, the number of outpatient care institutes was 426. Currently, there are 77 territorial hospitals which offer basic hospital care and 37 “high priority” hospitals (university clinics and national medical institutes), which represent the highest level of health care services (tertiary care).

In Hungary, the public expenditure on health is slightly lower than the European average, but higher than many Eastern European countries. The total health expenditure accounted for 7.4% of GDP in 2007. The OECD Health Data 2010 suggest public expenditure on health of about 1359 \$ (PPP) per capita, which represents about 70.40% of the total health expenditure.

Changes in 2007

The Hungarian government started on the reform of healthcare in 2006. The reform measures had fiscal reasons arising from the Convergence Programme¹ to decrease the deficit of the government budget and to meet the European Union criteria for countries in transition to join the Euro zone (known as “Maastricht Criteria”) [6–8].

The continuous deficit of the NHIFA was one of the reasons for the Hungarian government to consider health care reforms as a part of the Convergence Program of Hungary. NHIFA’s deficit varied between 3.4% of the

total revenue of the Fund in 1994 and 31.2% in 2005 [9]. The health care reforms in 2006–2007 aimed to secure the revenue of the NHIFA and decrease the expenditure on curative health care and pharmaceuticals.

According to the Convergence Program of Hungary the reduction of expenditures on curative-preventive care as a percentage of GDP as well as a significant reduction of the growth rate of pharmaceutical subsidies was required in order to improve the government balance. Nevertheless, the more efficient use of funds based on requirements of cost efficiency and long term financial sustainability was necessary, and incentives had to be created for providers and households to become more cost sensitive [7].

As a result of the reform arrangements from 2006 to 2007 the total health care expenditure as a percentage of GDP decreased from 8.1% to 7.4%. Also the share of public expenditure of total health care expenditure decreased from 72.6% to 70.4% [1] (see **Figure 1**).

The most important reform measures included the followings [11]:

- Structural changes in inpatient care.

The structural change in inpatient care was the establishment of a system of high priority and territorial hospitals on the one hand. Currently there are 77 territorial hospitals, which carry out basic care, and 37 high priority hospitals – university clinics and national medical institutes, which represent the highest level of health care services.

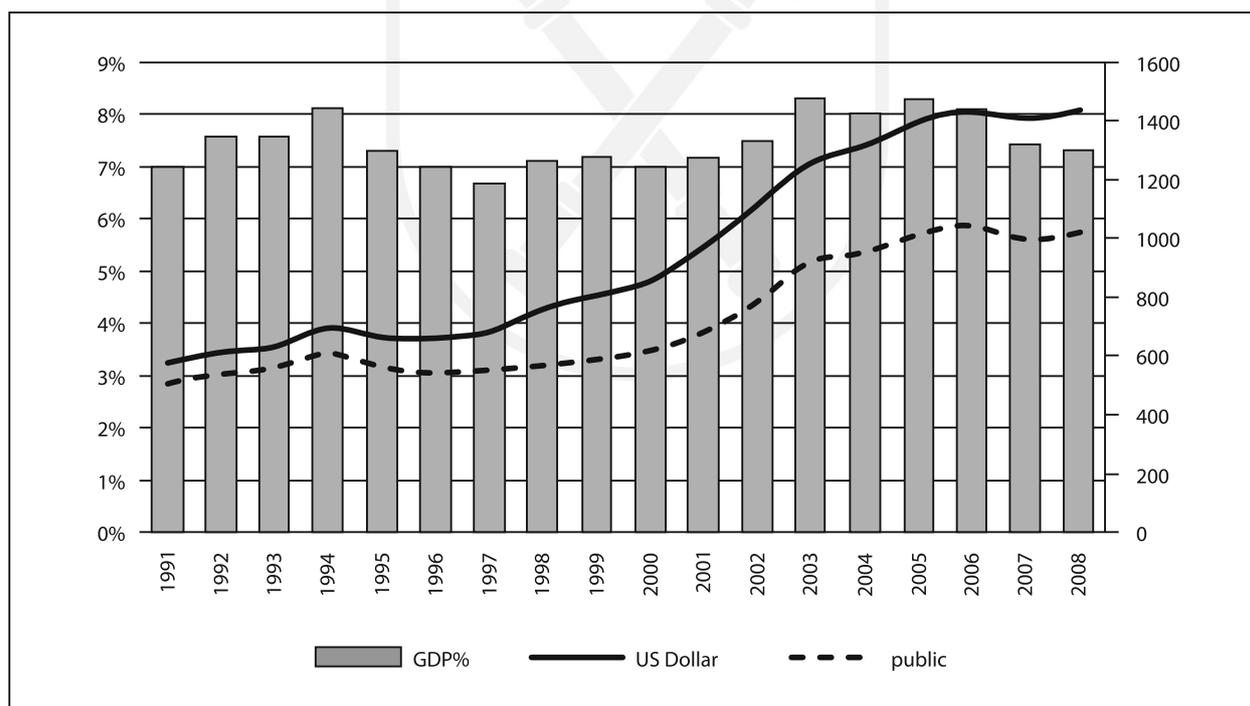


Figure 1. Expenditure on health, Hungary.

Source: OECD Health Data, 2010.

¹ In line with the requirement of EU membership, Member States submit stability programmes, and Member States, which have not yet adopted the euro submit convergence programmes to the Commission and the Council each year. The Hungarian Government, on the invitation of the Council, prepared an adjusted convergence programme update, out of the regular timetable, in September 2006.

On the other hand, the number of acute hospital beds was decreased, while the number of beds for chronic inpatient care was increased. Acute bed capacity was cut by 16 000 beds (~ 27%), while chronic bed capacity increased by 7500 (~31%) [12].

- The checking of citizens' eligibility for insurance coverage (eligibility is conditioned on legal status).
- Act on the secure and efficient supply of pharmaceuticals and medical aids and on the general rules of pharmaceutical trade adopted by Parliament in November 2006.
- The introduction of co-payments (visit fee for primary care, outpatient specialist care and in inpatient institutes for each day of care).
- The establishment of Health Insurance Supervisory Authority.

Also, the transformation of the health insurance system was the focus of reform arrangements during 2006–2007, however the idea of replacing the single-payer insurance model by several Health Insurance Management Funds have never materialised in practice, the Act on Health Insurance Management Funds, was revoked by Parliament in May, 2008.

The introduction of co-payments

The introduction of co-payments for using health care services was also the part of reform arrangements during the period of 2006–2007. However, co-payments were abolished one year after their introduction as a result of a population referendum initiated by the opposition. In the following section we will present the goals of the introduction, the design of co-payments and the experiences of the one-year period.

Goals of the introduction of co-payments for health care services

The idea of the introduction of co-payments for health care services was first communicated toward the public in 2006 when the government published a paper, called "The Green Book of the Hungarian Health Care" [13], to summarise their proposed arrangements in the health care system during the period of 2006–2007, like the transformation of the insurance system, the structural reform of inpatient care, changes in the system of pharmaceutical subsidies and the establishment of the Health Insurance Supervisory Authority.

According to the published paper, the main goals of the introduction of patient payment were:

- a) to formalise informal patient payments;
- b) to decrease the unnecessary use of health care services.

As for the first aim – formalising informal payments, the policy paper argued that "Co-payment exists in Hungary, but in an illegal form: in the form of informal payments, which is the most unfair way of financing the health-care system. Informal payments cause the highest burden for the most vulnerable population groups, and inhibit them from using health care services. Our main

goal is to replace the amount of informal patient payments with a smaller amount of legal co-payments" [13].

As for the second goal – the decrease of unnecessary utilisation of health care services – the Green Book referred to the high number of patient-physician visits in Hungary comparing to other European countries: "In Hungary the number of visits is two times higher than the Western-European average. In some cases these visits are not really reasonable" [13].

Besides these two communicated goals, the Convergence Program of Hungary declared that co-payments are expected to serve as an instrument to regulate demand, increase cost-consciousness of patients, and improve most efficient use of public resources. The document also mentioned that co-payments would provide additional financial resource for health care system at the same time. 30–40 Mrd HUF (111–148 million euro)² was expected from the introduction for the first year, which accounts approximately for 5% of the budget of curative preventive care. Cost-saving was also expected in health care expenditure due to the expected decrease of the number of visits and prescriptions [7].

Main arguments against the introduction of visit fee

After the publication of the Green Book in July, 2006, political discussions started on the proposed arrangements, and some papers commenting on the proposed arrangements were published [14, 15] Also, political discussion continued after the introduction of the visit fee. Those who were against the implementation of co-payments argued that the introduction was an unfounded decision and questioned whether the goals of the introduction of co-payments were relevant in Hungarian context, or doubted that this arrangement was the best way to reach the goals mentioned above.

The main arguments against co-payments were the following:

- The health state of the Hungarian population is below the European average, and in some aspect also behind other CEE countries.
- In Hungary the problem with utilisation of health care services is quite the opposite: most of the population goes to see the doctor at the very last moment.
- Most of the cases providers induce the utilisation of health care services (e.g. controls, prescriptions, tests).
- Those with lower income are more price-sensitive than those with higher income, so those who cannot afford to pay co-payments will be crowded out of using health care services.
- The collection of the fees will generate more cost than the benefit, so in this way, co-payments cannot provide additional resource for health care system.
- The collection process would extend the waiting time of patients and cause more administrative burden for physicians.
- Small amount of co-payments have no potential to deal with informal payments: co-payments cannot

² Exchange rate: 270 HUF = 1 EUR.

substitute informal payments, as they are not capable to compensate personal attention of the physician. In this way the introduction of co-payments would induce a double financial burden for the population.

- Out-of-pocket health care expenditures already have a high share in total health care expenditure.

The facts

Informal payments

We have evidence about the existence of informal payments in Hungary. According to previous research in 2003 every four patient paid informally for health care services on average 48 euros per year. Informal payments are the most widespread at hospital care, where half of the patients pay informally, while in GP and out-patient care every 6th or 7th patient paid informally [16].

After the collapse of the communist regime, in the last 20 years, several Ministry Committees were set to estimate the magnitude of informal payments in Hungary and make proposals for the solution of the problem. Their proposals focused on ethical issues and the transferability of informal payments to taxed legal income. However none of the endeavouring could reach appreciable results, not even the increase of salaries of health care workers in 2002 [16].

Service utilisation and health status

As for the high number of physician-patient contacts, according to OECD data the number of physician contact was really one of the highest among OECD countries, on average 12.9 per capita in 2006. In the Czech Republic and in Slovakia the situation is quite similar with 13 and 11.3 visits per capita [10] (see **Figure 2**).

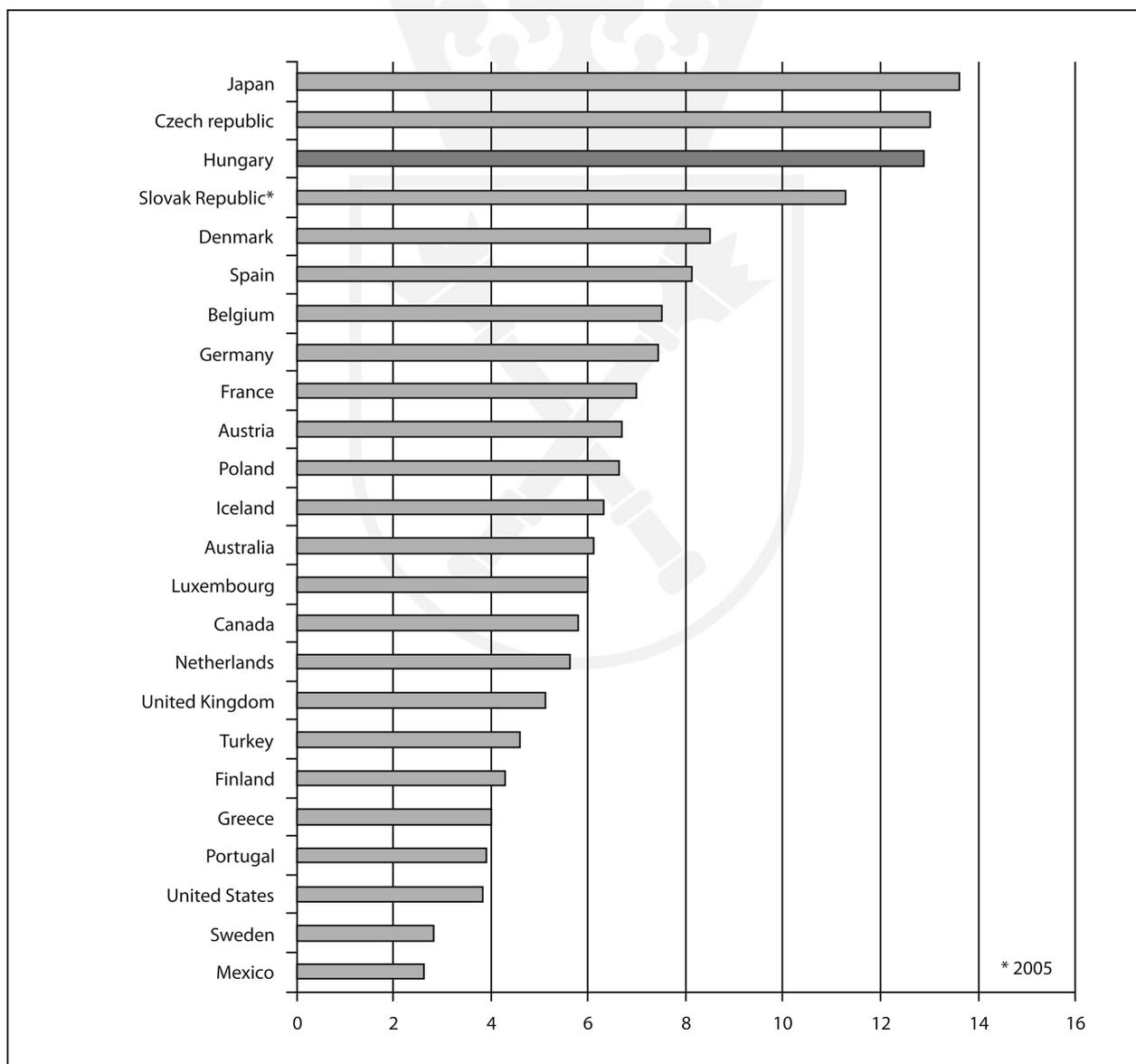


Figure 2. Doctor consultations per capita, 2006.

Source: OECD Health Database.

However at the same time life expectancy of the Hungarian population is more than 5 years below the OECD average. In 2007 it was 73.3 years comparing to the OECD average, 79 years [10] (see **Figure 3**) Hungary also leads in mortality statistics caused by cancer and cardiovascular diseases.

Out of pocket payments of Hungarian population

Private expenditure on health care accounted for 27–30% of the total health care expenditure during the period 2006–2008 according to OECD Health Data. Out-of-pocket payments (including official fees in a form of co-payments, and also informal payments) covered approximately 23–24% of the total health care expenditure during the period 2006–2008 (see **Figure 4**). The share



Figure 3. Average life expectancy in OECD countries 2007.

Source: Health Database 2010.

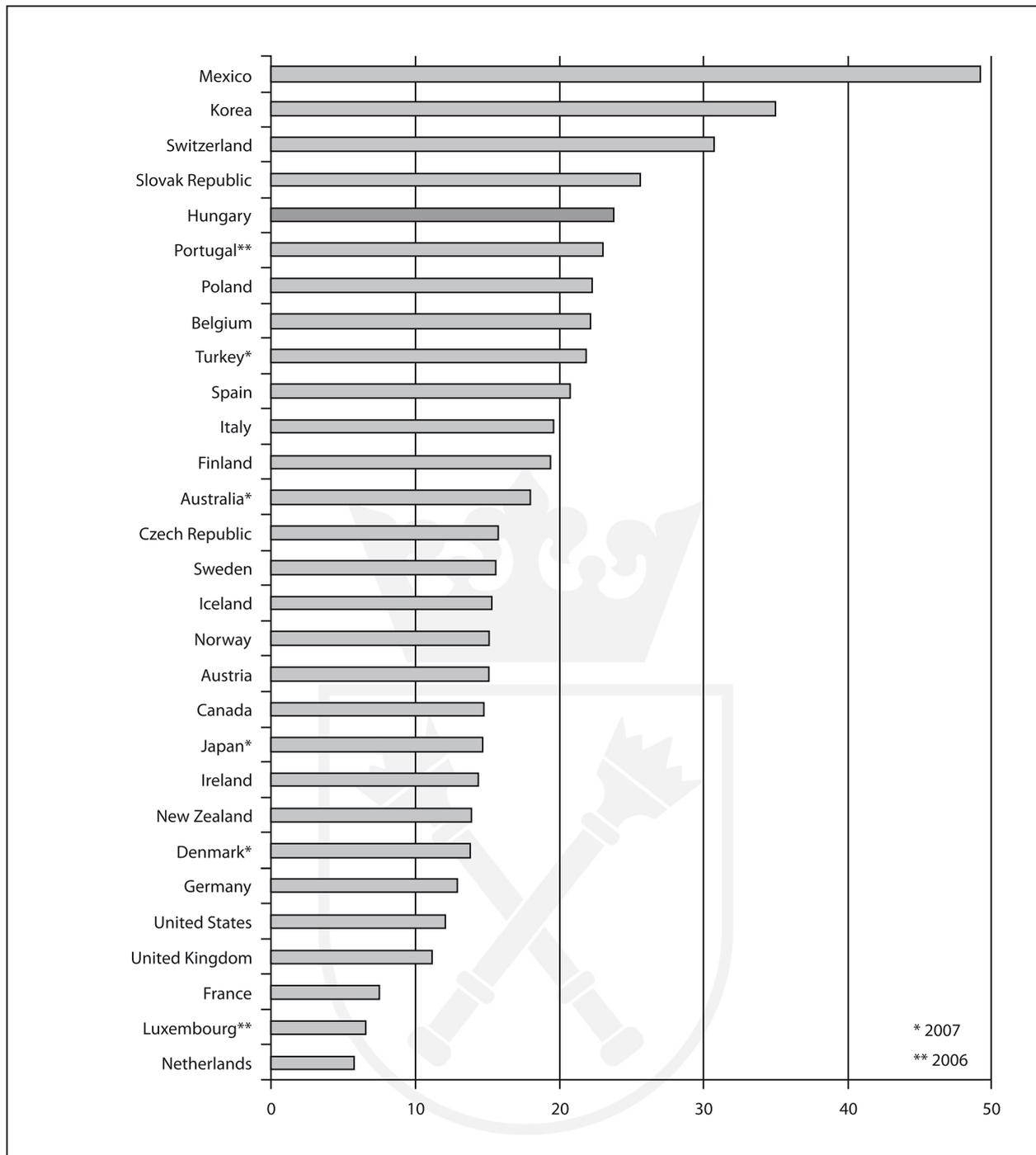


Figure 4. Out-of-pocket payments of OECD countries 2008.

Source: Health Database, 2010.

of out-of-pocket payments increased continuously after the change of the regime, from 11% in the 1990s [10]. This trend and these numbers are comparable to other CEE countries, however the share of out-of-pocket payments are relatively high compared to Western European countries.

The introduction of visit fee

The co-payments for health care services called “visit fee” were introduced in February, 2007 in GP care, out-patient care, inpatient care and dental care.

- **Amount**

The amount of patient payment was 300 HUF (1.1 euro) for each visit in GP care and out-patient-care if the patient had a referral from GP. In inpatient care the same amount of 300 HUF was introduced per day

in hospitals. A higher fee of 600 HUF (2.2 euro) was applied in case of choosing a GP where the patient is not registered or choosing GP services which is not in the patient's residence, or using out-patient care without a referral (after a half year it increased to 1000 HUF). 1000 HUF (3.7 euro) which should have been paid in case of unnecessary use of urgency care.

- *Limits and exemptions*

Children under the age of 18 were exempted. Also, users of certain health care services (e.g. emergency care, some chronic care/treatments, prenatal and preventive care) were exempted as well. A limit was introduced for the total amount of payments and defined in maximum 6000 HUF (22.2 euro) per year per service type. Limits were applied separately for GP, out-patient and inpatient care, the total amount of payment was limited at 15 thousands HUF (55.5 euro) per year. Patients had the right to ask for the reimbursement of payments after 20 visits or 20 days spent in hospital per year.

- *Beneficiary*

The beneficiary of the collected revenue was the provider institution (in case of primary care it means GP practices).

Abolishment

After 1 year, in April 2008 co-payments were abolished as the result of a referendum initiated by the opposition. In case of GP and outpatient care 82.4%, in case of hospital care 84.1% voted for the abolishment of co-payments. The referendum also concerned questions about other reform arrangements planned by the government, like the transformation of the single payer insurance model and the introduction of tuition at tertiary education. The results in these questions were similar.

(In 2010 a new government came to power, which is formed by the former opposition party, who initiated the referendum about co-payments. So far, this issue is no longer on the carpet.)

The effects of the introduction of co-payments

Decreasing utilisation

The introduction of co-payments in GP, out-patient and inpatient care resulted in a significant decrease of visits and inpatient care admissions.

- *GP visits*

During the 6 month period before the introduction of co-payments fee the average monthly number of visits to general practitioners was 5,615,723, during the 6 months period after the introduction of co-payments it decreased to 4,150,282, which represent a 26.1% decrease in the number of visits to general practitioners [17]. At the same time the decrease in case of children practices was not significant, as children under the age of 18 were exempted [18].

- *Out-patient visits*

During the 10 month period before the introduction of co-payments the average monthly number of outpatient visits was 5,846,279, while during the 10 month period after the introduction of co-payments it decreased to 4,720,650. This represents a 19.3% decrease in the number of outpatient visits [19].

- *Inpatient care*

During the 10 month period before the introduction of co-payments the average monthly number of admissions was 207,728, while during the 10 month period after the introduction of co-payments it decreased to 176,444. This represents a 15.1% decrease in the number of acute care admissions [20].

Due to the decrease of number of visits, at the same time the number of prescriptions and referrals decreased as well.

However, other elements of the health care reforms which were introduced at the same time could have also influenced the number of admissions. GPs were allowed to prescribe medication for a longer period of 3 months instead of the previously applied practice of 1 month. Also in in-patient care due to the structural reform the number of acute beds decreased by approximately 27% as mentioned above.

The equity effect of the introduction of co-payments has not been revealed yet. We do not have information whether visits and admissions, which failed to be realised were really unnecessary or not.

Only some results of a survey by GfK Hungária were published. According to the results of, to their question "Have you delayed your visit to the doctor because you were to pay co-payments?" 21% of the respondents living with monthly net income under 90 thousands HUF (333 euro)³ answered yes, while this ratio was 9% considering respondents with higher than 150 thousands HUF monthly net income (556 euro) [21]. On the other hand Mihályi, 2008 argue that the decrease of the number of GP visits did not significantly differ in different regions the country, and was not correlated with the poverty of the territory [18].

After the abolishment of co-payments we can see a slight increase in utilisation data, however utilisation has not reached the previous level. During the 7 month period after the withdrawal of co-payments the average monthly number of outpatient visits increased by 3.7% comparing to the 7 month period before. Also during the 7 month period after the withdrawal of co-payments the average monthly number of in-patient hospital admissions increased by 3.1% comparing to 7 months period before [8, 22].

Revenue and savings

The Ministry of Health published a handout on the effects and results of the introduction of patient payment [23]. The amount of the revenue was estimated⁴ for 22

³ Exchange rate: 270 HUF = 1 EUR.

⁴ More information can be found on the homepage of the Ministry of Health: <http://www.eum.hu/archivum/finanszirozasi/vizitdij-napidij-elso>

billion HUF (81.5 million euro) in 2007, 45% went to GPs, 29% to out-patient care institutions and 14% for hospitals, and the remaining 12% for urgency care, diagnostic, dental care (see **Table I**). Co-payments generated significant resources to GPs: 180 thousands HUF (~666.6 EUR) per GP praxis per month, which is a 25% increase of their budget. This can explain their protest against the abolishment of visit fee (later they were compensated).

Less attention was paid to in-patient and out-patient institutes. They were less lucky, as the collected revenue from co-payments were not as significant compared to their budget, moreover the decrease in utilisation also affected their budget as fee-for-service point system works as a basis for financing the out-patient specialist care and hospitals' fund are based on DRGs (NHIFA data shows that quotas were increased after the introduction of co-payments).

Ministry of Health estimated the amount of indirect cost-savings for 25.3 billion HUF (93.7 million euro) in curative preventive health care expenditure based on the decrease of the use of services, and 15 billion HUF (55.6 million euro) in pharmaceutical subsidies due to the decrease of the number of prescriptions. Together with savings on subsidies for medical aids and sick-allowance the estimated amount of total cost saving was 42.4 billion HUF (157 Million EUR) [23] (see **Table II**).

Effect on informal payments

Two studies based on household surveys reported results on the effect of the visit fee on informal payments [16, 24]. The study of TÁRKI [16] indicated that fewer patients paid informally for hospital doctors in 2007 compared to 2003, while no change was observed in out-patient specialist care. The study of MEDIÁN [24] examined the amount of total informal payments of households compared to the total household expenditures on the visit fee. They found out that one year after the implementation of the visit fee, the total amount of informal payments by households decreased, though this decrease was not enough to compensate the household expenditures on formal patient payments on an aggregate level. Consequently, the total combined expenditure of households on formal and informal payments increased. However, it is also required to consider that decrease in health care utilisation could also cause the decrease in the total expenditure on informal payments.

Population attitude

Not surprisingly co-payments were not so popular among health care consumers. However according to previous results of project ASSPRO CEE 2007 [25], there were supporters of the system, who think that co-payments promote a healthier and more "health-conscious" life-style and cost-conscious behaviour which might lead to more efficient use of health care services. However, even "supporters" of co-payments recall negative experiences with the implementation of co-payments, mostly

Collected co-payments 2007.02.15. – 2007.10.31	Million HUF	Million euro
GP care	6,871.4	25.4
Out-patient care	4,449.7	16.5
Inpatient care (acute)	1,428.9	5.3
Dental care	881.3	3.3
Laboratory	724.8	2.7
Inpatient care (chronic)	454.1	1.7
Other	431.2	1.6
Total	15,241.4	56.4

Table I. Revenue from co-payments 2007.02.15.–2007.10.31.

Source: Ministry of Health, 2008 [23] (exchange rate 270 HUF = 1 euro).

Estimated cost-saving per year	Billion HUF	Million euro
Curative and preventive care	25.3	93.7
out-patient care	3	11.1
in-patient care (acute)	21.2	78.5
in-patient care (chronic)	1.1	4.1
Pharmaceutical subsidies	15	55.6
Medical aids and medical baths	1	3.7
Financial subsidies (e.g. sick-allowance)	1.1	4.1
Total	42.4	157.1

Table II. Estimated cost savings from co-payments for one year.

Source: Ministry of Health, 2008 [23] (exchange rate 270 HUF = 1 euro).

concerning the complex collection process and the negative attitude of health care providers.

On the other hand, most health care consumers did not believe in the policy goals that were assigned to co-payments. In particular, consumers doubted that the decrease of utilisation is necessary and did not consider co-payments as a useful instrument to replace informal payments. They rather felt that the situation of the Hungarian health care system was getting worse and insupportable, which forced the government to find more resources to avoid the collapse of the system. They considered co-payments as a life-belt, which could have provided some additional resource for the system to maintain or improve the quality of services.

The opinion of health care providers on co-payments was quite divided. GPs were the most supportive group of these fees, and considered them as an effective instrument in generating additional resource for their practice, as well as in reducing unnecessary use of health care services. On the other hand medical specialists and physicians working in hospitals complained about having only

additional work and high administrative burden of the collection of co-payments.

However, both providers and consumers agreed that the issue of visit fee became a political issue, which divided political parties and followers. Moreover they felt that the discussion of policy goals of the introduction of co-payments was missing.

What we do not know...

- Some data on the decrease of utilisation are available concerning the number of visits but we cannot really distinguish the effect of co-payments from the effect of other arrangements during the same period (e.g structural reforms in inpatient care, changes in prescription practice).
- The equity effects of the introduction of co-payments has not been revealed yet. We do not know which social groups were mainly affected by the fees.
- We do not know whether the attitude of the population toward informal patient payments has changed due to the introduction of co-payments.
- We know little about the incentives of health care providers generated by the introduction of payments.
- We have no information about the costs of the introduction of co-payments or the cost of the administration/collection process.
- We have no information about the utilisation of the collected revenue. We do not know how co-payments affected quality of services or health outcomes.

Experiences from other countries

Other CEE countries, namely Slovak and Czech Republic had similar experiences with visit fee concerning the design, the effects and population attitude towards co-payments. In all of these countries the issue of co-payments has had an important role in policy discussions and politics, which divide political parties.

Slovakia introduced co-payments for health care services in June, 2003. The fee was 20 SKK per physician visit, 50 SKK per day of hospitalisation, 60 SKK per ambulatory visits. Patients with chronic illnesses and vulnerable groups were exempted. According to estimations in the second half of 2003, following the introduction of cost-sharing, there was a 10% reduction in the number of outpatient visits compared to the same period in 2002, also the number of emergency visits dropped by 13%. However, in specialised outpatient-care and hospitals the decline was lower (2%, respectively). After a few years, a new government came into power in 2006 and abolished co-payments [4, 26].

In Czech Republic the system of co-payments for health care services had been introduced at the beginning of 2008 and was intended to reduce excessive utilisation of services and generate additional revenue for the health care system. The fee was 30 CZK per physician visit, 60 CZK per day of hospitalisation, 90 CZK per ambulatory visits. Children under the age of 6, patients with chronic illnesses and imperilled pregnant women were exempted.

During its first year of implementation, the number of emergency visits dropped by 36%, ambulatory specialist visits by 15% and ambulatory specialist visits in inpatient facilities by 19%. In addition, the number of prescriptions fell by 28%. During the first year five billion Czech Crowns were collected from co-payments and the cost-savings due to this decrease were estimated to another five billion Czech Crowns in the system.

So far, due to the pressure of the new opposition (who called for the complete abolition of all co-payments in their campaign at the regional elections in 2008) the decrease of the measure and the expansion of exemption categories are still a regular object of policy discussion. In February, 2009 government exempted children under 18 from co-payments. For people over the age of sixty-five the maximum limit for user fees and co-payments were reduced from 5000 to 2,500 Crowns [5, 26–28].

Conclusion – lessons for other CEE countries and policy makers

We saw that the three CEE countries (Czech Republic, Hungary and Slovakia) had the same experiences with the introduction of co-payments. These fees were met with a cold reception by the population and also political resistance, which divided political parties and followers. Though, introduction of co-payments/increase of taxes will never be popular among the population, we have some recommendations based on Hungarian experiences to help develop sustainable patient payment policy. Hungarian experiences might serve as an instructive case study for other CEE countries as well.

Based on Hungarian experiences, the following steps are inevitable when developing a sustainable patient payment policy:

1. Preliminary research:
 - More studies would be required on policy goals (to reduce excessive utilisation, generate additional revenue, dealing with informal payments), whether they are relevant in country specific system.
 - Identification of the current situation.
 - Identification of the objectives and desired scenarios.
 - Identification of all possible alternative solutions in accordance with the policy goals and their anticipatory effects.
 - Research is necessary on the anticipatory effects of the chosen solution (effect on financing, utilisation, equity, quality, administration, attitudes from every stakeholder's perspectives).
 - Mapping of the incentives generated by the new fees and the interests of stake-holders (health care consumers, providers and policy makers) is necessary.
 - Identification of assessment criteria (and quality indicators) of the proposed system is necessary, to be able to monitor the processes and effects.
 - Not to forget that practices of other countries should not be copied, and must be adapted to country specific context.

2. Decision making:
 - Political consensus is required between political parties, to be able to get the arrangements across population's resistance.
 - Health care consumers and providers should be involved in the decision-making process. Social consensus on this issue is necessary before introducing formal patient payments.
3. Public discussion:
 - More policy and public discussion about policy goals is necessary.
 - Close communication with the public and health care providers is needed to clarify the objectives and content of a future patient payment model.

Acknowledgement:

The study is financed by the European Commission under the 7th Framework Programme, Theme 8 Socio-economic Sciences and Humanities, Project ASSPRO CEE 2007 (Grant Agreement no. 217431). The content of the publication is the sole responsibility of the authors and it in no way represents the views of the Commission or its services.

Abstract:

The introduction of co-payments for using health care services is a relatively new issue for most of the Central-Eastern European (CEE) countries. Some CEE countries, like Slovakia, Hungary and Czech Republic have similar experiences with the introduction of such co-payments. These fees were met with a cold reception by the population and also political resistance, which led to the abolishment of these payments in Slovakia as well as in Hungary. Our paper focuses on the experiences of Hungary, where co-payments for health care services were introduced in February, 2007 and abolished one year later as a result of a population referendum. Hungarian experiences can serve as a lesson for policy makers from other CEE countries to develop sustainable patient payment policies.

Streszczenie:

Krótką historią współpłacenia za świadczenia opieki zdrowotnej na Węgrzech – lekcje dla krajów sąsiednich

Słowa kluczowe: współpłacenie, opłaty za korzystanie, Węgry, Europa Środkowo-Wschodnia, polityka dopłat pacjentów

Wprowadzenie współpłacenia pacjentów za świadczenia opieki zdrowotnej jest stosunkowo nowym działaniem w większości krajów Europy Środkowo-Wschodniej. Niektóre z tych krajów, jak Słowacja, Węgry czy Czechy, mają podobne doświadczenia z implementacją dopłat. Opłaty te spotkały się z ograniczoną akceptacją zarówno społeczną, jak i polityczną, co w rezultacie doprowadziło do ich zniesienia na Słowacji, a także na Węgrzech.

Artykuł skupia się na doświadczeniach Węgier, gdzie współpłacenie za świadczenia opieki zdrowotnej było wprowadzone w lutym 2007 r. i zniesione rok później w rezultacie ogólnokrajowego referendum. Doświadczenia węgierskie mogą posłużyć jako lekcja dla decydentów politycznych z innych krajów Europy Środkowo-Wschodniej pomocna w celu rozwoju odpowiedniej polityki dopłat pacjentów.

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