SEMMELWEIS UNIVERSITY BUDAPEST
HEALTH SERVICES MANAGEMENT TRAINING CENTRE

Recent Attempts to Address Informal Payments for Health Care: the Case of Hungary

Equity and Efficiency Effects of Out-Of-Pocket Payments in Europe

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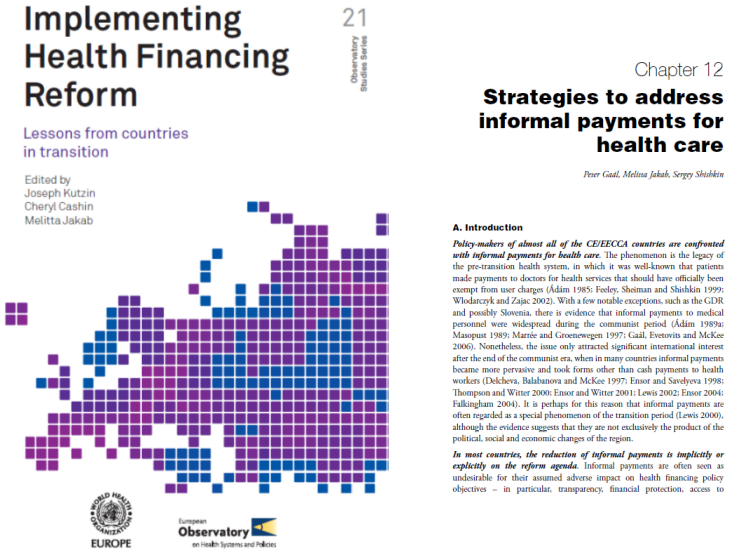
The policy relevance of informal payments for health care

- What is informal payments for health care and why bother?
  - General consensus on what is considered informal payments (IP) in practice, but no widely accepted definition:
    - corrupt? illegal? informal?
  - Why should policy makers be worried about IP?
    - the impact of informal payments on the performance of the health system: equity, effectiveness, efficiency
    - the scale of the phenomenon: extent and magnitude
- Research study (1997-2004): addressed these two questions
  - IP = additional payments: formal OOPs are stipulated in the terms of entitlement for health care, IPs are made in addition to these
  - Impact of IPs on health systems performance depends on the motivation for informal payments: gratitude or coercion?
    - FFS vs. donation: study shows that motivation is multifaceted – there are external or internal pressures to pay behind gratitude payments
    - Scale: varies widely among former communist countries: Hungary 1.5%-4.5% of THE, but unevenly distributed: 90% goes to medical doctors
- Conclusion: there is every reason to worry about IP

1 How to address IPs for health care: what works and what not?

- WHO study on health financing reforms in former communist countries:
  - Kutzin J, Cashin Ch, Jakab M (eds): Implementing Health Financing Reforms: Lessons from countries in transition. 2010
  - Strategies to address informal payments for health care
- Comparative analysis of 4 countries:
  - Kyrgyzstan
  - Tajikistan
  - Russian Federation
  - Hungary



2 How to address IPs for health care: what works and what not?

- Key findings of the study: success factors
  - comprehensive and well sequenced policy instruments (not individual measures in isolation)
  - clear and realistic entitlements (benefit package)
  - restructuring of the delivery system, but reinvestment of efficiency gains (remuneration of health workers)
  - adequate and stable (predictable) public funding
  - absence of blaming culture
- Hungary: reform attempts generally failed in terms of IPs

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The case of Hungary

- In general we violated the most important principles
- Although we had a well sequenced and comprehensive health reform
- We did not provide clear and realistic entitlements
- Efficiency gains realized as a result of payment reforms and delivery system restructuring were taken away from the health sector (fiscal stabilization of the state budget)
- Public financing of health care has remained inadequate, unstable and erratic:
  - long periods of austerity were coupled with short periods of increased spending
  - Example: 50% pay rise of health workers in 2002 (vc. 5% increase in each year)

2 The case of Hungary

- In particular attempts to formalize informal payments failed, because they did not address the root cause of IPs
- Measures of the government of 2006-2010:
  - introduction of user charges for all patient doctor encounters in outpatient care in 2007 (abolished later in 2008 as a result of a national referendum)
  - quite high user charge for the free choice of hospital and medical doctors: 30% of NHIFA payment for care (NHIFA tariff), maximum 100 000 HUF (close to average net monthly salary)
- Both measures failed:
  - formal user charges add to the burden of IPs if the causes of IPs (real or perceived shortage) are not tackled (ability to pay)
  - user charges for free choice is not a bad idea, but has been implemented badly:
    - patient payments had become the revenue of the hospital not the medical doctor (patients and doctors had no interest to shift from IP to formal OOP)
    - patient payments had to be deducted from NHIFA payment (hospitals has no interest to collect user charges, because they did not receive more money)

The case of Hungary

- How should the policy modified in order to succeed?
  - much more moderate charges
  - made in addition to NHIFA payment not as its replacement
  - substantial part of the revenue should go directly to the medical doctor, who treat the patient
  - payment should be subject to no (or at least light) taxation
  - medical doctors, who treat "ordinary" patients should also receive some additional payment (from the NHIFA), in order to avoid any negative consequences on access to care (requires some additional public money)
- This is what the current health government in Hungary is considering, but:
  - tampering with OOPs in health care is a highly political issue
  - requires increased public spending (or at least the reinvestment of efficiency gains)

Final notes

- OOPs are generally not a key policy instrument to increase efficiency

	Treatment provided	**No treatment**
Need for care	*Met need*	Unmet need
No need for care	*Met unneed*	Unmet unneed (SID)
Option 1: care coordination (case & disease mgt) Costs increase and decrease	*Option 2: non-selective restriction of care (OOPs, Output limit)* *Costs decrease*	Option 3: capacity expansion Cost increase

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Final notes

- IPs in post-communist countries however are an issue, for which the informal to formal shift would be beneficial, if formal OOPs replace and not add to the burden of IPs
- To be successful one of the key policy principles is to reinvest the efficiency gains of restructuring, which is one of the most difficult to achieve in times of economic and financial crisis, in the age of austerity