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User fees for public health care services in Hungary: Expectations, experience, and acceptability from the perspectives of different stakeholders

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ABSTRACT

Objective: The introduction of user fees for health care services is a new phenomenon in Central-Eastern European Countries. In Hungary, user fees were first introduced in 2007, but abolished one year later after a referendum. The aim of our study is to describe the experiences and expectations of health system stakeholders in Hungary related to user fees as well as their approval of such fees.
Method: For our analysis we use both qualitative and quantitative data from focus-group discussions with health care consumers and physicians, and in-depth interviews with policy makers and health insurance representatives.
Results: Our findings suggest that the reasons behind the unpopularity of user fees might be (a) the rejection of the objectives of user fees defined by the government, (b) negative personal experiences with user fees, and (c) the general mistrust of the Hungarian population when it comes to the utilization of public resources.
Conclusion: Successful policy implementation of user fees requires social consensus on the policy objectives, also there should be real improvements in health care provision noticeable for consumers, to assure the fees acceptance.

1. Introduction

The application of patient cost-sharing in health care is occupying political discussions in Europe, since its importance as a tool to control the increasing public spending on health is rising considerably. This is also the case in EU member states from Central Europe that joined the EU in 2004, namely Hungary, Slovakia, and the Czech Republic. In these countries, cost-sharing for commodities (e.g. pharmaceuticals and medical devices) and payments for services that fall (partly or fully) outside the health insurance funds, have long been applied, and constitute a notable share of total health expenditure [1–3]. However, these countries also have experience with user fees for primary, outpatient and inpatient services covered by social health insurance. Such user fees have been recently introduced in the Czech Republic. In Slovakia and Hungary, user fees for services were implemented and abolished shortly after their introduction [4,5]. Experiences from these Central European countries show that the introduction of user fees for health care services meets strong opposition by political opponents and the general public [6]. Their unpop-

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ularity is often explained by social perceptions rooted in the communist period, which holds that public health care services should be free for all [6,7].

In this article, we focus on the case of Hungary, where user fees were introduced in 2007, but abolished one year later as the result of a referendum where more than 80% of the voters supported the abolishment. The aim of our analysis is to describe the experience and expectations of the stakeholders in the Hungarian health system (consumers, providers, policy makers and insurers) regarding user fees as well as the approval of these fees. To achieve this aim, we analyze data collected during focus group discussions and in-depth interviews in 2009 in Hungary. Our results provide insight into the causes of opposition to user fees in Hungary expressed during the referendum in 2008. Our analysis also serves as an instructive case study for other countries in the region and contributes to the establishment of sustainable patient payment policy. To the best of our knowledge, no article so far has been published on this topic (neither for Hungary nor for other Central European countries).

2. Background: the case of user fees in Hungary

The introduction of user fees for health care services (called visit fee) was part of the reform arrangements carried out by the government in 2007 comprising the Convergence Program of Hungary. The goal of the program was 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") [8,9]. According to a Hungarian policy paper known as "The Green Book of Health Care", the main goals of the introduction of the visit fee were to decrease unnecessary use of health care services and to convert the informal payments into formal health care charges [10]. This policy paper referred to the high number of visits per patient in Hungary compared to the European average, and the negative equity effects of informal payments, which are still a notable source of income for health care personnel. In 2001, informal payments were estimated to be between 64.8 and 203.6 million Euros, which amounted to 1.5–4.6% of the total health expenditure [11].

The visit fee was introduced in February 2007 for GP, outpatient specialist, inpatient and dental care. The charge for co-payments was 300 HUF (~1.1 Euro)[1] for each visit to a GP and outpatient specialist with a referral, and 600 HUF (~2.2 Euros) in the case of using outpatient specialist care without a referral. In inpatient care, a charge of 300 HUF (~1.1 Euros) was introduced per day of hospitalization. In case of unnecessary use of emergency care, 1000 HUF (~3.7 Euros) had to be paid. The beneficiary was the provider institution, or the physician in case of GPs. Children under the age of 18 and users of certain health care services (e.g. emergency care, some chronic care/treatments, prenatal and preventive care) were exempted. Moreover, a limit was introduced and defined by a maximum of 20 visits/days hospitalization per year. The payments after these 20 visits/days hospitalization a year were reimbursed by the state.

However, the system of visit fee worked for only one year. In April 2008, the payments were abolished as a result of a referendum initiated by the opposition. Participation in this referendum was high (e.g. higher than in the parliamentary elections in 2010). About 50.5% of the population who was entitled to vote, took part. In total, 82.4% of the voters supported the abolishment of the visit fee for physician visits, and 84.0% of voters supported the abolishment of the user fees for hospitalizations [12].

Evidence shows that during the period of visit fee, health care utilization decreased by 15–20% in GP and outpatient services as well as days spent in hospital [13–15]. However, we have to highlight that other elements of the complex reforms could have also contributed to the decrease in the number of visits and days spent in hospital. This could have included the change of the prescription system (i.e. physicians were allowed to prescribe medicine for a longer period, as a result fewer patients' visits were required) and the structural reform of inpatient care (namely the decrease of acute bed capacity by 25%, which might have also contributed to less hospitalizations) [16]. The amount of revenue generated by the user fee was estimated to be about 22 billion HUF in 2007, i.e. 4–5% of public health care expenditure.

3. Methods

The analysis in this article relies on a mix of quantitative and qualitative research methods to describe the expectations and experiences of health system stakeholders in Hungary toward user fees, as well as the approval of such fees. The mix of qualitative and quantitative methods enables us to map different types of attitudes, opinions, and emotions toward the introduction of visit fee.

3.1. Data collection

For the purpose of the study, focus group discussions and in-depth interviews were carried out in 2009 in Hungary, as part of an international research project. The objective was to study the opinions and attitudes of health system stakeholders, namely health care consumers, providers, insurers and policy makers, toward user fees. We included various population and professional groups to account for different backgrounds and interests.

Data among policy makers and health insurance representatives were collected via face-to-face semi-structured in-depth interviews: 3 interviews with policy makers and 4 interviews with health insurance representatives working at different levels of the health care system. On average, each interview took 1–1.5 h.

Data for health care consumers and providers were collected via focus group discussions. The objective was to assure the homogeneity of participants in each focus group to be able to share and discuss own experiences and opinions. As a result, 8 focus group discussions were organized: 5 focus groups with health care consumers and 3 with health care providers. Consumer groups included working individuals, families with children, pensioners,

[1] Exchange rate: 270 HUF = 1 EUR.