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THE CRIMINALISATION OF INFORMAL PAYMENTS IN HUNGARIAN HEALTHCARE: LEGAL CHANGE AND SOCIAL ATTITUDES

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ABSTRACT

This article examines the criminalisation of informal payments in Hungarian healthcare, with particular attention to the legal uncertainty that preceded the 2020 reform, the logic of the new anti-corruption framework, and the social attitudes surrounding its enforcement. It analyses the former judicial treatment of "hálapénz", the legislative shift introduced by Act C of 2020, and the broader question whether criminal law can effectively eliminate a practice that has long been socially embedded. Drawing on questionnaire-based research, the article also explores public knowledge of the current regulation and attitudes towards the punishability of informal payments. It argues that criminalisation may narrow the scope of the practice, but that its long-term reduction is likely to depend on broader structural improvements in the healthcare system, including legal clarity, institutional trust, and the perceived fairness and quality of care.

KEYWORDS Informal payments; Hungarian healthcare; criminalisation; legal consciousness; anti-corruption law

1. Introduction

Informal payments in healthcare have long been a deeply embedded feature of the Hungarian medical system. The institution commonly referred to as gratitude payment or parasolvency developed during the state-socialist period and remained socially entrenched for decades. Its scale is illustrated by a 2014 estimate of the Hungarian Central Statistical Office, according to which households spent approximately HUF 8.3 billion on such payments (HCSO, 2015).

The practice was widely perceived as a routine element of medical care, often framed as a socially accepted supplement to treatment rather than as a legal or ethical problem. This changed fundamentally with Act C of 2020 on the Legal

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Status of Health Service Employees, adopted on 6 October 2020. The Act, introduced alongside a comprehensive wage reform, sought to eliminate informal payments in state- and municipality-run healthcare institutions. It also amended the corruption offences contained in Act C of 2012 on the Criminal Code, with the result that, from 1 January 2021, both the giving and the acceptance of gratitude payments became subject to criminal sanctions.

This legislative shift raises a broader question concerning the limits of criminal law. Although the system of informal payments was widely regarded as ethically objectionable, it had also become a longstanding social practice within Hungarian healthcare (Nagy, 2020; MOK Elnökség, 2020). Criminalisation may be justified where serious social harms are involved, yet the ultima ratio character of criminal law requires caution. The effective elimination of parasolvency therefore depends not only on legal prohibition, but also on an understanding of the social causes of the practice and the obstacles to its lasting disappearance.

This article examines the uncertain legal situation prior to the current regulation, as well as the legal-policy and social considerations that underpinned criminalisation. It also draws on legal-consciousness research to assess social attitudes towards the abolition of the gratitude payment system and considers the interpretive and regulatory questions that may arise in the future.

2. Conceptual and Terminological Framework

Informal payments in healthcare are difficult to define with precision because they combine legal, social, and ethical dimensions. In Hungarian discourse, the term gratitude payment (hálapénz) often carries a more neutral or even positive connotation, while parasolvency more accurately reflects its function as undeclared supplementary income connected to medical care. In international terminology, the phenomenon is usually described as an informal payment or under-the-table payment, expressions that more clearly emphasise its unofficial and legally problematic character (Ferencz & Nyerges, 2020).

Hungarian professional and judicial sources have also approached the concept differently. The Hungarian Medical Chamber's ethical framework distinguishes between a voluntary, unsolicited payment given after treatment and other forms of benefit linked to the provision of care (HMC, 2022). By contrast, criminal-law relevance turned primarily on the distinction between a genuinely voluntary post-treatment payment and an advantage that was requested, expected, or effectively compelled.

This distinction was clarified in Hungarian case law. The Curia held that a payment may be regarded as gratitude payment only if it is given after the healthcare service has been provided, voluntarily, and without prior request. A

benefit given in advance, or one provided in response to explicit or implicit solicitation, does not fall within that category (Bhar.III.6/2015/20., 2015). Judicial interpretation also made clear that solicitation includes not only direct requests, but also indirect forms of communication, such as hints, references to customary practice, or other behaviour capable of undermining voluntariness (Bfv.III.63/2025/11., 2025).

For the purposes of criminal-law analysis, the most relevant distinction is between unsolicited payments made by the patient after treatment and payments requested by the healthcare provider (Kincses, 2004). The former historically occupied an ambiguous legal and social space, while the latter much more clearly resembled a corrupt exchange. Since the healthcare institution determines the lawful fee for treatment, medical personnel involved in publicly funded care are not entitled to request additional payment from patients in connection with their work.

In practice, however, the boundary between voluntary and requested payment was often difficult to identify. Physicians did not always make explicit demands; in many cases, the expectation of payment was conveyed indirectly. Patients might believe that payment was necessary to obtain better treatment, shorter waiting times, access to a more favourable procedure, or even access to care itself (Nagy, 2022). This explains why the legal distinction between voluntary gratitude and illicit solicitation remained unstable in practice, despite its doctrinal importance.

3. The Pre-2021 Criminal-Law Framework

Before the adoption of the 2020 reform, the legal status of informal payments in Hungarian healthcare was uncertain and internally inconsistent. It was not clearly settled whether the giving or acceptance of such payments amounted to bribery under criminal law. For that reason, the pre-criminalisation period is essential to understanding both the later reform and the arguments that supported it.

Historically, Hungarian law had long treated the acceptance of illicit advantages by physicians as problematic. Earlier criminal legislation prohibited public officials, including physicians acting outside private practice, from requesting or accepting undue benefits (Király, 2016). Yet the later development of parasolvency created an ambiguous legal and social environment in which informal payments remained widespread despite the general anti-corruption framework (Ambrus, 2020).

Under the former Criminal Code, the key issue was whether the accepted advantage was linked to a breach of duty. The earlier version of the passive

bribery provision did not criminalise every advantage accepted by an employee of a public or economic body, but primarily those connected to the violation of official obligations (Gellér, 2022). This distinction contributed to the exceptional treatment of informal payments in healthcare, where certain forms of post-treatment payment were tolerated socially even if they remained difficult to justify legally.

Subsequent legislative amendments did not eliminate this uncertainty. Although the law later introduced the requirement that the advantage be "unlawful," judicial and scholarly opinion remained divided as to whether this materially narrowed criminal liability (Inzelt, 2017; Gál, 2014; Hollán 2014). In practice, the decisive distinction increasingly turned on whether the payment had been requested, expected, or linked to the performance of the medical service. Requested payments, especially where connected to publicly funded treatment, were more readily treated as bribery, while voluntary post-treatment payments occupied a more ambiguous position (Gellér, 2022).

The structure of the current Criminal Code, which entered into force in 2013, further intensified the debate. The provision on passive bribery no longer made breach of duty part of the basic offence, which led some authors to argue that all forms of informal payment had effectively been criminalised (Tóth, 2014). Hungarian case law confirmed that healthcare providers who requested payment in connection with services financed by public health insurance could incur criminal liability for bribery (Bfv.III.1.336/2019/9., 2020). By contrast, on the side of the patient, active bribery generally required proof that the advantage was given in order to induce a breach of duty; without such purpose, criminal liability was less readily established.

Taken together, the pre-2021 framework was marked by doctrinal instability. Requested or solicited payments were increasingly treated as unlawful advantages, while genuinely voluntary post-treatment payments remained more difficult to classify. This uncertainty was one of the principal reasons why the legislature ultimately chose to intervene expressly through the 2020 reform.

The legal ambiguity surrounding informal payments was reinforced by labour-law regulation. Under Act I of 2012 on the Labor Code, employees may not accept remuneration from a third person in connection with their employment without the employer's prior consent (Ferencz & Nyerges, 2020). This rule was highly controversial in the context of informal payments in healthcare, because it raised the question whether employer consent could render such payments lawful (Horváth, 2012).

The dominant judicial position rejected that conclusion. The Curia held that employer consent under labour law could be relevant from a disciplinary or

employment-law perspective, but it did not remove the unlawfulness of the advantage for the purposes of criminal law. In other words, labour-law permission could not function as a statutory authorisation excluding criminal liability (Bhar.III.6/2015/20., 2015).

Although scholarly opinion was divided on this issue before criminalisation (Hollán, 2014; Inzelt, 2017; Móricz, 2020, Pincési, 2023), the matter has since become much clearer. From 1 January 2021, parasolvency-type payments qualify as unlawful advantages, and employer consent cannot serve as a basis for excluding criminal responsibility. The earlier labour-law debate is therefore mainly of historical significance, but it illustrates the fragmented and contradictory regulatory environment that existed before the explicit criminal-law reform.

4. The 2020 Criminalisation Reform

Although several post-transition governments attempted to curb parasolvency in Hungarian healthcare (Ádám, 1986), the first decisive reform was introduced by Act C of 2020 on the Legal Status of Health Service Employees. The Act accepted the Hungarian Medical Chamber's proposal to combine a substantial wage reform with the elimination of informal payments and thereby brought an end to the previously uncertain legal framework. To ensure coherence across the legal system, the reform also removed gratitude payments from the category of lawful income under tax law. The lawful, efficient, and transparent use of public funds is a fundamental requirement of public governance (Hottó, 2025).

The reform amended the Criminal Code by creating a specific bribery-related offence for the healthcare sector. From 1 January 2021, any person who gives or promises an unlawful advantage in connection with healthcare services to a healthcare worker, or to another person in relation to such worker, may incur criminal liability, unless a more serious offence is made out (CC, § 290, para. 6). The significance of this amendment lies in its clear policy choice: in the field of healthcare, the legislature adopted a zero-tolerance approach to informal payments. As a result, the giving of money or other unlawful advantage is punishable even where it is not linked to a specific breach of duty.

This new offence is subsidiary in nature. Cases that already satisfied the general elements of active or passive bribery – most notably where the advantage was given, requested, or accepted in order to induce a breach of duty – continue to fall under the ordinary bribery provisions. At the same time, the healthcare-specific rule functions as a privileged offence, since it carries a lower penalty than the general bribery offence. Its purpose is therefore not to replace the

general anti-corruption framework, but to criminalise a broader category of conduct that had previously remained only partially covered.

On the passive side, the reform linked criminal liability to the concept of "unlawful advantage" as defined by Act CLIV of 1997 on Health (CC, § 291 para. 6). In this respect, the Criminal Code effectively became dependent on sector-specific regulation. Under the Health Act, healthcare workers may neither request nor accept any monetary payment, in-kind consideration, or other advantage in return for healthcare services (Ambrus, 2021). The only exception concerns small gifts in kind of limited value, given under strictly regulated conditions. These provisions make clear that money cannot qualify as a lawful gift, even if the amount is relatively modest.

From a practical perspective, the reform transformed the legal assessment of informal payments in healthcare. What had previously been treated as a socially tolerated but legally ambiguous practice became an expressly prohibited form of unlawful advantage. The reform thus resolved a long-standing contradiction in Hungarian law by aligning criminal law, healthcare regulation, and tax law around the same normative conclusion: parasolvency is unlawful.

5. Detection and Enforcement after Criminalisation: Integrity Testing and Judicial Review

The practical significance of the post-2020 reform lies not only in the formal criminalisation of informal payments, but also in the mechanisms through which the prohibition is detected and enforced. Once the legislature adopted a zero-tolerance model, the central question ceased to be whether hálapénz could still be accommodated within a legally exceptional category and became instead how the newly prohibited conduct could be uncovered in practice.

A key instrument of post-criminalisation enforcement is the Hungarian mechanism of integrity testing (megbízhatósági vizsgálat). This mechanism was introduced into Act XXXIV of 1994 on the Police with effect from 1 January 2011, and its scope was later extended so that, from 1 January 2021, it could also be applied to persons employed in the new healthcare service relationship. The purpose of integrity testing is to create a controlled situation in which compliance with professional duties may be observed, including in corruption-prone contexts. In the healthcare setting, this has obvious relevance to the detection of unlawful advantages linked to medical treatment. The practical attraction of the mechanism is equally clear: offences involving informal payments are often difficult to uncover through ordinary reporting channels, since both sides of the transaction may have an interest in concealment.

At the same time, the use of integrity testing in this field raises delicate fair-trial concerns. Its legitimacy depends on whether the authorities merely create an opportunity to reveal an existing willingness to engage in corruption or instead cross the line into inducement. In analytical terms, the distinction is between detection and provocation. If the tested person retains a real possibility of acting lawfully, the case for the use of the mechanism is stronger. If, however, the scenario is shaped in a way that exerts pressure, persistently offers money, or otherwise steers the individual towards the offence, the fairness of the process becomes far more doubtful. In cases involving informal payments, this issue is especially sensitive, because the factual setting itself may easily resemble the very social practices that the law now seeks to eradicate (Csák & Czebe, 2025).

Domestic constitutional review did not reject the extension of integrity testing to healthcare personnel. In 3484/2022. (XII. 20.) AB, the Constitutional Court accepted the new regulatory framework and treated the anti-corruption objective, including the suppression of informal payments in healthcare, as constitutionally legitimate. At the domestic level, therefore, integrity testing has been regarded as an available enforcement tool within the broader restructuring of the healthcare sector.

The European Court of Human Rights has nevertheless introduced an important qualification. In Szelényi and Others v. Hungary, decided on 3 February 2026, the Court examined the Hungarian integrity-testing framework as applied to categories of state employees that included healthcare personnel and found a violation of Article 8 of the Convention. The judgment did not call into question the legitimacy of combating corruption or eliminating informal payments in healthcare. Rather, its criticism was directed at the quality of the legal framework governing covert surveillance within integrity testing. In the Court's view, the domestic regime did not provide sufficiently precise safeguards against arbitrariness and therefore failed to satisfy the requirements of legality and necessity in a democratic society.

For the purposes of the present article, the significance of Szelényi is a cautious but important one. It does not follow from the judgment that integrity testing as such is incompatible with the Convention, nor that the criminal-law response to informal payments is illegitimate. What the judgment does suggest is that the future use of integrity testing in healthcare cannot be assessed solely from the perspective of anti-corruption effectiveness. It must also be examined in light of foreseeability, proportionality, and adequate procedural safeguards. Accordingly, integrity testing may remain a central instrument for the detection of informal-payment offences, but its continued use in this field is likely to depend on a more carefully delimited legal framework.

6. Comparative and International Perspectives

Informal payments in healthcare are not unique to Hungary. Comparative research has shown that they have been a persistent feature of many post-communist health systems in Central and Eastern Europe and parts of Central Asia, where they have often been linked to underfinancing, shortages, weak institutional trust, and the enduring social expectation that access to care must be supplemented by personal payment (Lewis, 2000; World Bank, 2000; Liu & Sun, 2012; Williams et al., 2016). In the international literature, a distinction is often drawn between gratitude money and broader informal or under-the-table payments, the latter terms emphasising the unofficial and potentially corrupt character of the transaction more clearly than the Hungarian expression hálapénz (Delcheva et al., 1997; Vian & Burak, 2006; Stepurko et al., 2017; Giannouchos et al., 2020).

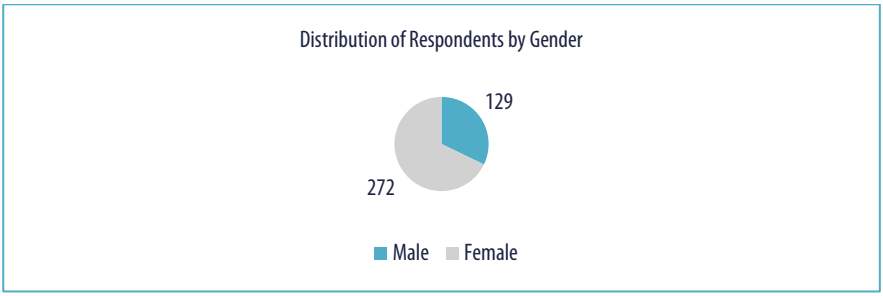
At the same time, some European systems demonstrate that healthcare can function with little or no reliance on such payments when financing is transparent and entitlements are clear. In Germany, compulsory health insurance is provided either through statutory or substitutive private insurance (Balázs, 2023), with statutory insurance covering roughly 90% of the population and offering the same broad range of benefits to those insured (Bundesministerium für Gesundheit, 2022); Germany also recorded the EU's highest current healthcare expenditure relative to GDP in 2024, at 12.2% (Eurostat, 2025). In the United Kingdom, the NHS Constitution states that access to NHS services is based on clinical need rather than ability to pay, and that NHS care should be free at the point of use except where charges are expressly provided by law (Tóth, 2024). These models do not eliminate all structural pressures in healthcare, but they significantly reduce the space for informal payment by making entitlement and financing more predictable.

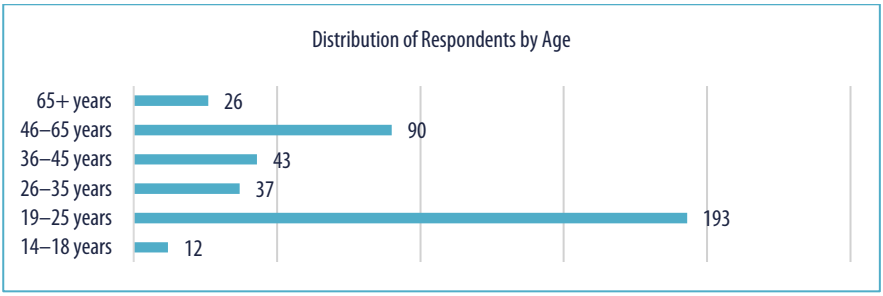
No international treaty regulates "gratitude payment" as a distinct legal category. Nonetheless, the broader international and European legal framework is relevant. The United Nations Convention against Corruption requires States Parties to criminalise core bribery offences, thereby providing the anti-corruption baseline within which payments made to influence healthcare services can be assessed. At EU level, Article 35 of the Charter of Fundamental Rights guarantees access to preventive healthcare and medical treatment under national laws and practices, while Directive 2011/24/EU seeks to facilitate access to safe and high-quality cross-border healthcare and to strengthen patients' rights to information and redress. Although these instruments do not directly regulate informal payments, they support the principles of equal access, transparency, and accountability that are incompatible with a system in which access to publicly funded care depends on unofficial payment.

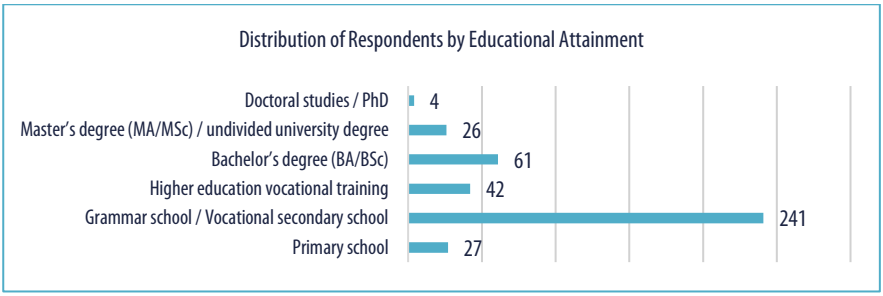
7. Public Legal Consciousness and the Social Limits of Criminalisation

To assess how the criminalisation of informal payments is perceived in Hungarian society, a questionnaire-based legal-consciousness survey was carried out. The purpose of the survey was twofold: first, to examine the extent to which respondents were aware of the current legal regulation of informal payments, and second, to explore their attitudes towards the criminalisation of the practice. This perspective is particularly relevant because law is a social institution whose effectiveness depends not only on formal rules, but also on the attitudes, habits, and expectations of those subject to it. The survey was completed by 401 respondents through Google Forms (see Figure 1). Although the sample cannot be regarded as representative, it offers useful insight into the persistence of older social understandings of parasolvency.

Figure 1: Sociodemographic data







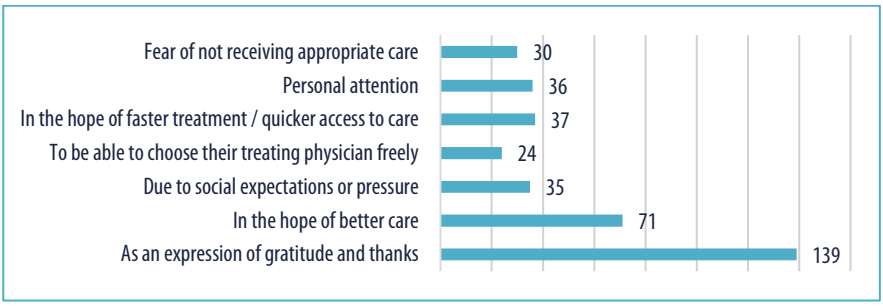
The initial hypothesis was that respondents would possess only fragmented knowledge of the current legal framework and that many would remain unaware that both the giving and the acceptance of informal payments have constituted criminal offences in Hungary since 1 January 2021. A further assumption was that respondents would be more likely to recognise as criminal those forms of conduct that had already been punishable under the pre-2021 framework, such as payments requested in advance by physicians. The results broadly support both assumptions.

7.1. Motivations Behind Informal Payments

Respondents most frequently identified gratitude as the primary motive behind informal payments (see Figure 2). This result is unsurprising given the Hungarian terminology itself, which frames the practice as a "gratitude payment." At the same time, the survey also revealed more problematic motivations. Many respondents regarded the expectation of better treatment, quicker access, or more personal attention as an important reason why patients or relatives offer money to healthcare workers. In this respect, informal payment appears not merely as an expression of thanks, but as a mechanism through which patients attempt to secure access to the quality of care to which they are already formally entitled.

This finding suggests that the persistence of informal payments cannot be explained solely by cultural habit or symbolic gratitude. It is also connected to mistrust in the healthcare system, fear of inadequate treatment, and uncertainty about the practical availability of equal care (Baji et al., 2015). In that sense, the system of parasolvency appears to have been sustained not only by the economic position of healthcare workers, but also by patients' insecurity and by entrenched social expectations.

Figure 2: Reasons for Giving Gratuity Payments

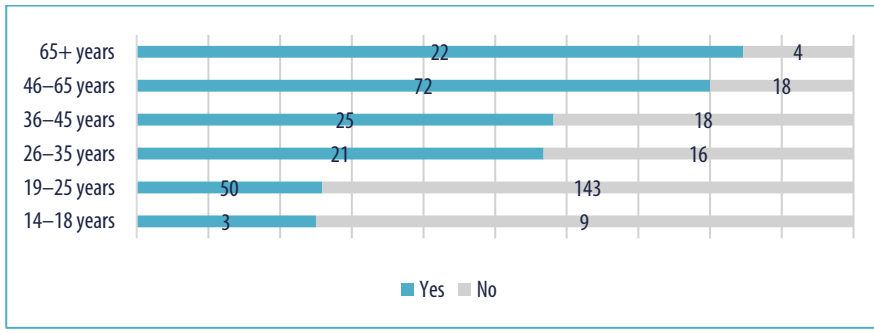


7.2. Payment Practices and Generational Differences

According to the survey, 48% of respondents had at some point given money to a healthcare provider, while 52% had never done so. The strongest variation appeared across age groups (see Figure 3). Among respondents under 25, only about one quarter had ever given an informal payment; among those aged 26 to 45, the figure rose to nearly 60%; and among respondents above 46, it exceeded 80%.

These results strongly suggest that parasolvency is linked to generational socialisation. Older respondents grew up in a system in which informal payment was widely regarded as a normal component of medical care, whereas younger respondents are less likely to perceive it as necessary and appear more inclined to choose private healthcare if dissatisfied with public services.

Figure 3: Distribution of Willingness to Give Gratuity Payments by Age Group



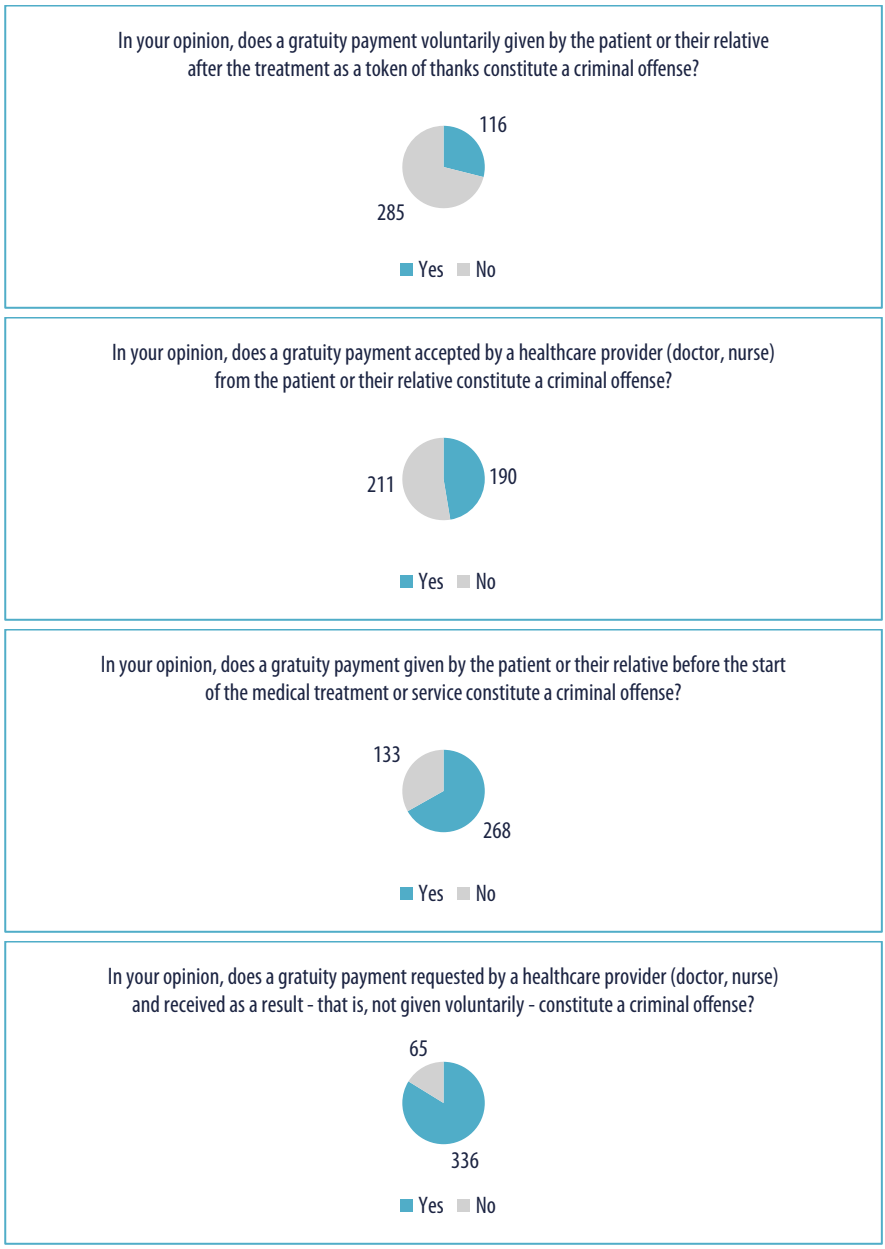
7.3. Knowledge of Criminal Liability

The survey also tested respondents' assessment of different factual situations involving informal payments. The results showed a clear gap between current law and public legal consciousness (see Figure 4). Nearly 70% of respondents considered it lawful if a patient voluntarily gave money after treatment, even though this conduct has been criminalised since 2021. By contrast, respondents were much more likely to recognise the criminal nature of conduct that had already been punishable before the reform. Approximately 67% correctly regarded payment given before treatment as criminal, and 84% correctly identified a physician's prior request for payment as punishable.

These results indicate that older legal and social distinctions remain deeply rooted in public consciousness. The formerly tolerated category of post-treatment gratitude payment still appears legitimate to many respondents, even after its formal criminalisation. This supports the broader conclusion that legal consciousness adjusts more slowly than legislation changes, and that long-

established social norms may continue to shape behaviour and judgment even after a clear legal prohibition has been enacted (H. Szilágyi, 2020).

Figure 4: Situational questions

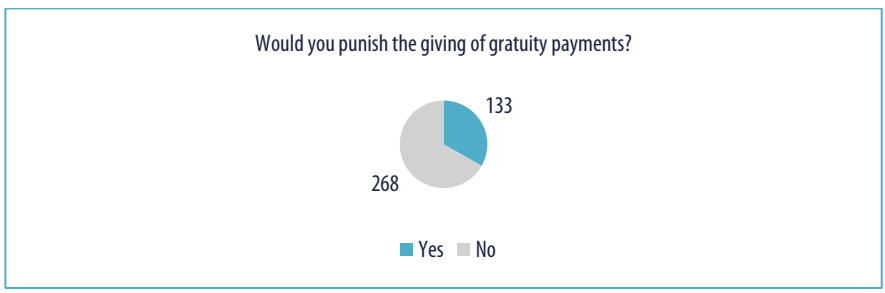


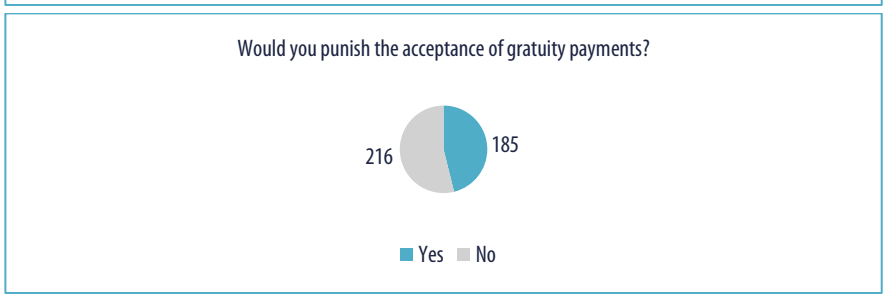
7.4. Attitudes Towards Criminalisation

Respondents' attitudes towards punishment also revealed substantial ambivalence (see Figure 5). Nearly 67% stated that the giving of informal payment should not be punished, and 54% took the same view regarding its acceptance. This is particularly striking given that the practice is now formally criminalised. The results suggest that many respondents continue to view the patient primarily as someone expressing gratitude or attempting to secure adequate treatment, rather than as an active participant in corruption. Physicians, by contrast, were judged more critically, presumably because respondents associated acceptance with financial gain rather than vulnerability or dependence.

Taken together, these findings show that the legal prohibition of informal payments has not yet been fully internalised at the level of public legal consciousness. While some clearly coercive or pre-arranged forms of parasolvency are widely recognised as criminal, the socially embedded idea of post-treatment gratitude payment remains resilient. From a policy perspective, this suggests that criminalisation alone is unlikely to eliminate the practice entirely. Lasting change also depends on broader shifts in social expectations, legal awareness, and trust in the fairness and quality of the healthcare system.

Figure 5: Situational questions



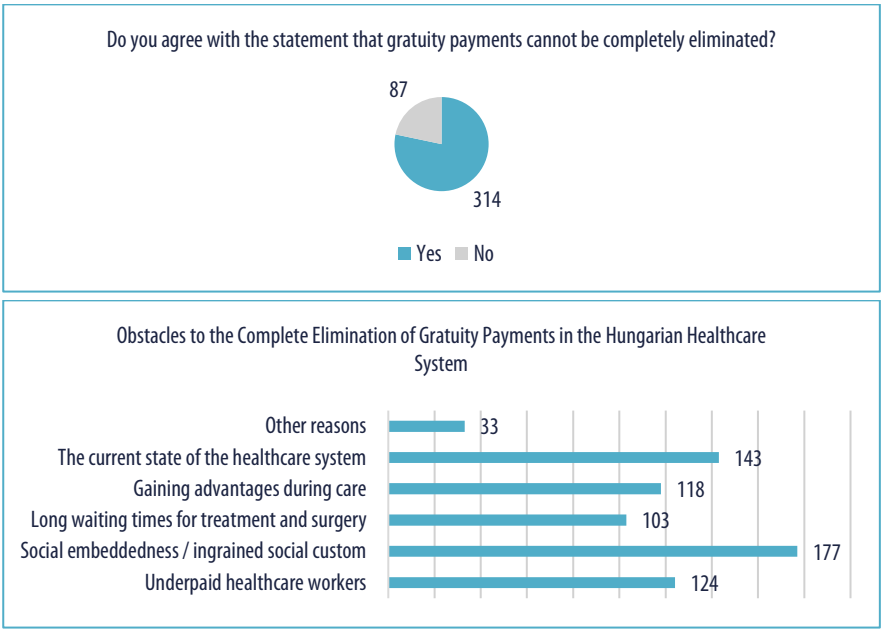


8. Conclusion

The reform that entered into force on 1 January 2021 clearly identified the elimination of parasolvency as a central policy objective. The legislative strategy combined three elements: the separation of public and private healthcare activity, wage increases for physicians, and the criminalisation of informal payments. Whether these measures will be sufficient to eliminate the practice in the longer term, however, remains uncertain.

The survey findings suggest considerable public scepticism. A substantial majority of respondents considered it unlikely that parasolvency could be fully eliminated from Hungarian healthcare, notwithstanding criminalisation. The most frequently identified obstacle was the deep social embeddedness of the practice. Informal payment appears to have become more than an occasional individual act; it has long functioned as a socially learned pattern of behaviour. In this respect, the findings are consistent with earlier sociological observations that the meaning of parasolvency gradually shifted from the expression of gratitude to a form of social compulsion and perceived necessity.

Figure 6: Perceived Obstacles to the Elimination of Gratuity Payments



The survey also suggests that criminalisation, while important, may address only part of the problem (see Figure 6). Wage reform may reduce the willingness of healthcare providers to accept informal payments, but it does not necessarily eliminate the patient-side motivations that sustain the practice. Many patients do not appear to view informal payment primarily as a means of securing an

unlawful advantage, but rather as a way of ensuring that they receive adequate care of a quality to which they believe they are already entitled. This perception is closely linked to broader concerns about the condition of the healthcare system, including staff shortages, uneven quality of care, and limited trust in the effective functioning of publicly funded services. From that perspective, the long-term success of criminalisation may depend not only on enforcement, but also on wider structural improvements in the healthcare system.

Comparative experience may offer some orientation, although direct institutional transplantation is unlikely to be feasible. The British and German systems suggest that informal payments are less likely to flourish where entitlement is clear, financing is transparent, and the boundary between public and private care is consistently maintained. These examples should be treated with caution, given the significant historical and institutional differences between those systems and Hungarian healthcare. Even so, the underlying principles of predictability, equal access, and institutional trust may still be relevant in thinking about future reform.

From a legislative perspective, several clarifications may be worth considering. The current Hungarian framework appears to raise interpretive difficulties regarding the relationship between the Criminal Code and the Health Act, including the practical addressees of the relevant norms and the precise role of the sector-specific definition of "unlawful advantage." Greater doctrinal clarity might improve both legal certainty and compliance. Similar concerns arise in relation to the statutory exception for low-value gifts in kind, which may be difficult to apply in practice, and to the question whether the rules on unlimited mitigation available under the general bribery provision extend fully to the healthcare-specific privileged form. These are not merely technical issues: they bear directly on foreseeability, consistency, and the practical intelligibility of the prohibition.

Taken together, the available material does not support a simple answer to the question whether informal payments can be eliminated entirely. A cautious conclusion would be that criminalisation is capable of narrowing the space for parasolvency and may contribute to a gradual change in professional and social expectations. At the same time, legal prohibition alone is unlikely to produce a complete and lasting solution if broader structural causes remain unaddressed. The future of the Hungarian regulation may therefore depend on whether anti-corruption enforcement is accompanied by improvements in healthcare financing, access, quality, and public trust.

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