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COFFEE AND TEA

SOME COMMENTS ON REFORMING THE SYSTEM OF HEALTH INSURANCE IN HUNGARY

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Transforming the system of health insurance was on the reform agenda of the Hungarian government in 2007. Two alternative approaches were presented: to maintain the old state-owned single-payer scheme, or to introduce a multi-payer scheme based on the competition of private insurance companies. Finally a compromise was accepted. According to the draft legislation several insurance companies would enter, each of them based on a blend of public and private ownership.

The paper presents a critique of this compromise scheme, discussing the advantages and shortcomings of various alternative approaches. It argues against mechanical, universal and too rapid changes, and advocates caution, experimentation and gradual changes.

In spite of the warnings the law on health insurance reform was first accepted by the Hungarian Parliament, and then, a few months later, it was withdrawn.

Keywords: health insurance, post-socialist transition, institutional reform, rapid versus gradual change, Hungary

JEL classification index: G22, H51, I11, P3

INTRODUCTION

The following is an English version of an article of mine that appeared on October 22, 2007 in *Népszabadság,* the largest-circulation daily paper in Hungary. This is a faithful translation of the Hungarian text as it appeared, despite some important developments with the reform of Hungarian health insurance since. I would un-

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derline that I still accept full responsibility for the position I took in the October 22 article – my view is unchanged.

Let me introduce the article with some guidance for foreign readers on events before and after it was published. Similar extra information for foreign readers appears at two other points in the article. These additional passages appear in brackets.

The original Hungarian text, published in a daily newspaper, did not include footnotes and references. All references were added to the present publication.[1]

THE ANTECEDENTS TO THE STUDY AND ITS POLITICAL AND LEGAL BACKGROUND

(Transformation of the health service featured large among the reforms the Hungarian government advertised when it took office in the summer of 2006. One important element in this is the reform of the health insurance system. Several alternative proposals that differed in essential respects were put forward in the debates. Furthermore, the discussions between the two coalition parties – the social democratic Hungarian Socialist Party (MSZMP) and the liberal-inclined Alliance of Free Democrats (SZDSZ) – began with their experts taking sharply different positions. A compromise was reached between them after several months of negotiation. The now common concept was placed on October 11, 2007, on the Health Ministry website for public discussion, to which this article of mine is a contribution.

At the centre of the proposal by the Ministry and the coalition parties stand insurers whose ownership will divide between the state and the private sector, with the state retaining a 51 percent majority. This network of "health care funds" is to be organised on a regional basis, at least initially.

The act that reorganises health insurance was passed by the Hungarian Parliament on December 17. It differs in a few respects from the bill of October 1 on which my article comments. The nature of the amendments bears a resemblance to ideas that I advanced in the article, in agreement with some other participants in the debate. The act now stipulates in detail, for instance, the state supervision of the insurance, and the procedures and principles for insurance premiums and risk adjustment. But the government and parliamentary majority did not alter the former's October 2007 position on the main issues: the distribution of property rights, the sequencing and timetable for introducing the changes, or the matter of

[1] Since *all* references uniformly were added after the publication in a Hungarian newspaper, there is no need to distinguish them with brackets in the journal publication.

rapid or gradualist implementation of the reform. In other words, they did not adopt the main ideas that underlie my article.

The Health Insurance Bill was referred back to Parliament on December 27, 2007 by the president of the republic, with critical observations and a recommendation that it be reconsidered by members. Parliament passed the bill a second time on February 11, 2008 with some amendments. Practical preparations then began for regional decentralisation and partial privatisation.

On March 9, 2008, a referendum was held in which a large majority of voters rejected the previously introduced "visit fee" paid by patients to doctors and the "nursing fee" paid to hospitals, in other words, all forms of co-payment by the patients. The Hungarian Socialist Party interpreted the referendum result to mean that the health-service reform lacked the necessary public support and recommended that the legislation on health-insurance reform be withdrawn. The Alliance of Free Democrats disagreed with this, a factor that contributed to its withdrawal from the government and the break-up of the coalition.

Shortly after that, the now exclusively Hungarian Socialist Party government introduced a motion withdrawing the bill on the decentralisation and partial privatisation of the health-insurance system. This was passed by Parliament by a large majority on May 26, 2008.

Now let us return in time to the fall of 2007. When the following article was published, the proposal twice accepted and then withdrawn was still on the table and being widely debated.)

ADVANTAGES AND DRAWBACKS

There is a debate among the restaurant managers about the beverage to serve at breakfast. One supports coffee, the other tea. After a long argument, they agree to serve a mixture of the two in proportions of 51:49. Henceforth, every breakfast guest will receive the mixed beverage.

The government has often been criticised rightly for not allowing for new legislation to be debated thoroughly before it is introduced. There can be no such reproach with the reform of the health insurance system. The debate has been going on for months, now behind closed doors, and now in public, at meetings, or in the press and on television. Comments have come from health insurance experts, representatives of political parties, physicians, and patients.[2] Only one thing has be-

[2] A general overview of the debate and the conflicting opinions of various experts is provided by the report on a conference initiated by the Ministry of Health to discuss the health insurance reform and convened in the assembly hall of Parliament on January 25–26, 2007. (Hungarian

come clear: the lack of agreement on the situation or what is to be done. There is nothing surprising in that. Two simple forms have been advanced, and christened in the debates in Hungary the "single-insurer" and "multiple-insurer" models. Both have many advantages and many drawbacks, but neither can be said to have an overwhelming advantage over the other. If it were shown convincingly that one model could really outstrip the other, the latter's supporters might concede victory without further ado. But no such advantage has been gained by either side. Earlier government reform programs were criticised for ignoring international experience. That criticism does not apply here either. Both sides in the debate have frequently drawn on foreign examples of favourable experience in one country and unfavourable experience in another to back up their proposals.

The trouble is that international experience has not been homogeneous[3]. There are as many types of solution as countries, and closer scrutiny of foreign debates on health economics shows supporters and opponents for the prevailing situation in each country.

Consensus cannot be expected as the interests of individuals and groups affected by the reform coincide in some parts and collide in others. The present situation in Hungary also yields winners and losers, with the rewards and losses very unevenly distributed. There is no change that would benefit everybody without exception or in every respect – improving the quality of health-care service, while increasing patients' freedom of choice and reducing the costs of provision (and the contributions to pay for them).

The debates have left no arguments for or against unheard. Since the arguments are familiar, it will suffice to reduce them almost to headings. I will deal for the time being only with the two models prominent in the debates; further solutions are mentioned in a later section. The list has not been compiled with a view to completeness. I have tried initially to pick out the major advantages and drawbacks, and the features advantageous or disadvantageous for certain, so far as I can judge. There will be word later in the analysis of further advantages and drawbacks – real or supposed, and certainly debatable.

Government, Ministry of Health, 2007). The keynote address was delivered by the author (Kornai 2007).

For additional information on the overall debate on health insurance reform in Eastern Europe, see Csillag – Mihályi (2006); Mihályi et al. (2007a); Molnár (2007); Gottret – Schieber (2006); Orosz (2001).

[3] Figueras et al. (2002); Kornai – Eggleston (2001); Roberts – Hsiao – Berman – Reich (2003); Saltman – Figueras (eds) (1997).

The single-insurer model

Advantages: It is easily accounted for: the accounts for all services paid for out of public funds are kept by a single organisation. Relations between the state monopoly insurer and the many hundred or thousand decentralised providers are relatively simple. Administrative costs are relatively low. Political, administrative and financial relations between government and state monopoly insurer are clear. Responsibility for the operation of the insurer lies with the government of the day.

Drawbacks: The state monopoly insurer has no "natural", internally generated incentive to improve its performance in terms of standard of service or economy on costs. Like a state-owned enterprise under a socialist economy, it has to be cajoled into performing better, from outside and in, with administrative instructions, prescriptions and bans, moral imperatives, and in some cases, artificially devised financial rewards and penalties. The inducements to soften the budget constraint and breach financial discipline are extremely strong. No government can stand aside while the state monopoly insurer goes bankrupt. It is obliged to rescue it with extra subsidies time and again.

The multiple-insurer model

For the sake of a clear contrast, let me speak here of a "pure case" in which the competition is exclusively between private insurers.

Advantages: There is a strong "natural", internally generated incentive produced by the profit motive and competition, which give the insurer an interest in improving the quality of provision and reducing costs. The chances of hardening the budget constraint and requiring financial discipline are increased. The government can take a stance of not rescuing an insurer threatened by financial failure.

Drawbacks: Relations between insurers and providers become more cumbersome. Each major provider will have to agree and settle with several insurers, not one. Administrative costs are higher (possibly much higher).

The two lists of advantages and drawbacks draw attention to a characteristic of the public debates so far. Supporters of each scheme praise its advantages to the skies and contrast them with the ghastly drawbacks of the other scheme. Hardly anybody has had the instinct for intellectual fair play to present honestly the drawbacks of the favoured version or the advantages of the rejected one. That approach may do for standard commercial advertising, but it seems to me unacceptable for university professors, research directors, and high-ranking politicians to behave like that on a weighty public issue. The confused public needs objective informa-

tion. Even if some people can be convinced by partial advertising and the excessively lauded proposal is implemented, its drawbacks will still turn out sooner or later. The more its advocates have disguised the drawbacks, the greater the public chagrin will be. The way to convince people of a proposal we wish them to accept is to put the advantages and drawbacks to them in advance. Let those who accept it be prepared to support its drawbacks and all.

PROPOSAL: A "MULTI-SECTOR MODEL"

There is an obvious, well-known solution to the coffee/tea debate. Let both beverages be available and the guests decide which to have. This is called the principle of consumer sovereignty. Not all purchasing decisions can be governed by this principle. Most of the thousands of decision-making problems in health care cannot be so governed at all, or only to a very limited extent. But choosing an insurer can, under appropriate conditions, be placed in the category where consumer sovereignty applies.

The main outlines of my proposal are the following:

The present National Health Insurance Fund (OEP)[4] should be broken into two parts. One part I will call in this article the health care financing authority, the other the state health insurer. Many people have a passion for christening new organisations; let them find more clever names. The only aspect of this line of argument of importance to me is to make plain that one part is a state authority, like the customs office or the consumer-protection body, and the other a company in 100-percent state ownership, like the Hungarian State Railways or the Mint. The authority will be responsible, among other tasks, for distributing the public monies to fund the expenditures on health care.

Every Hungarian citizen has to join the health insurance system. Everybody has to pay the contributions, except people for whom the state pays the contributions on certain grounds. Contributions paid by individuals (or by the state on behalf of individuals) are augmented by the contributions paid by employees. Everybody who becomes a member of the insurance system in this way gains an entitlement to basic health care. This is expressed in terms of finance techniques by the fact that all those entitled receive a health-care voucher or quota per capita. Using an initial rough approach, the total of contributions paid can be said to be

[4] It is a state-owned, state-managed single payer that funds the expenditures of the health care providers out of the compulsory employer and employee contributions and the other contributions made by the central budget.

divided by the number of insured to give the average value of the voucher in HUF. In practice, this is not the procedure – the voucher has to have a differentiated value. For instance, the elderly, the chronically ill, and some others receive a voucher of a higher value. The risk of likely health-care spending is not evenly distributed, with the deviations clearly relating statistically to age, chronic illness, occupation, and other circumstances. Equalisation of these differences is reflected approximately in the differentiation in the value of the vouchers. (This is known technically as a system of risk-adjusted capitation payment.) Of course there will be a spread in the real health-cost costs for individuals who statistically represent the same risk (and possess vouchers of equal value). The evening out of these individual risks takes place within the insurer (as with other types of insurance).

Initially, everyone is insured with the state insurer, where every voucher appears in the first instant. And it can stay there if the insured so wishes.

But the health-care market must be open to private insurers, if the requisite conditions are met. If a private insurer entering the market can attract clients by offering more advantageous conditions, the way must be left free for it to do so. In that case, the clients take their vouchers with them. After the transfer, their vouchers will be cashed with the health-care authority by the private insurer, not the state insurer. In return, the private insurer will be responsible for funding the basic health care of these insured. Those participating in the insurance system may also take out additional supplementary insurance to fund further provisions beyond the basic care. Paying the contributions, which act as the source of funding for the basic care, is compulsory, but clients may decide for themselves whether to take out supplementary insurance and take on the additional expenditure involved. (The idea actually being put forward seeks, incomprehensibly, to prevent the existing 51:49 insurers from offering their clients supplementary insurance.)

I have called the recommended form "multi-sector" because it has the state sector and the private sector existing side by side with equal rights: the state insurer and as many private insurers as are willing and able to operate in this sphere. The idea is not new or original. I am not looking for praise as an innovator. It is known in the literature and it has been mentioned in the debates in Hungary. I myself have presented it before in greater detail, orally and in writing. But it has not received enough attention, and so I would like to bring it up again, in the critical period before the legislation on insurance reform is passed.

My proposals lie close to the position taken by the party of Alliance of Free Democrats (SZDSZ) in the spring of 2007, when the idea of coexisting state and private insurers was adopted. My proposals do not conflict with the SZDSZ position at that time, but I feel it is especially important at this stage in the debates to draw attention to the part that refers to the starting position. Everybody starts auto-

matically as a client of the state insurer, even if its monopoly ceases and private insurers may win its clients away. My proposal is diametrically opposite to the proposal currently being put forward, in which everybody would start, willy-nilly, by being assigned to the 51:49 public-private body.

THE MINIMUM CONDITIONS FOR THE INTRODUCTION

The new system must not be introduced before some conditions are in place that allow it to operate properly. I do not mean that nothing should happen until *all* the conditions for full development are met to complete perfection. It is not a matter of firing a starting pistol and having a variety of rival private insurers all rush onto the market and start competing to sign up clients. I am advancing a more moderate proposal. What are the *minimum* conditions to fulfil before the *first* private insurers begin operation? Later, these conditions can be steadily improved and a good many more insurers can be expected to be keen to enter the market. Let me list the conditions, if not in order of importance. The *four conditions* listed together constitute the requirements for private insurance to commence.

1. Any possibility that the insurer may discriminate against some group of clients has to be excluded (Daniels 1998; Newhouse 2002; Kornai – Eggleston 2001). Such discrimination must be prohibited by law and the prohibition re-emphasised time and again, when private insurers receive licenses to enter the market. But the instincts are known precisely from the theoretical literature and from experience under the socialist economy: an administrative or legislative ban is not enough. The right financial incentive has to be given if insurers are not to be wary of signing up costlier clients. For instance, the likely health care costs of an older person will be many times those of a younger person. The value of the former client's voucher has to be set to cover the statistical average of the extra cost. This is not a difficult matter of principle, but only of practical arithmetic. For it is possible to set voucher values that will have insurers falling over each other to sign up as many older clients as possible.

Initially, the differentiation of voucher values cannot be expected to be calibrated to match the risks perfectly. We have to start as best we can, calculating the proportions between the values of vouchers assigned to various groups and equalising the risks, and then correcting them repeatedly. The process for it must be made clear, along with the institutional frames for it – what committee is responsible for drawing up the initial guidelines and calculation documents for equalising the risks and later making continual corrections to them. (The scheme now published refers briefly to a "Fees Committee". This strangely named body may be intended to perform the difficult and responsible task just outlined. It

would be reassuring to know a lot more about who will be deciding about the equalisation of risks and how they will go about it.)

2. It has to be stated clearly what the insured is entitled to under the basic insurance scheme. What comes in exchange for the voucher, whether it is handed over to the state insurer or to one of the private insurers? What is due? Replies like "all medical science is capable at its present stage of development" or "all that the official protocols prescribe" are meaningless.

The starting point is obviously the status quo. Whatever has been financed so far by the national health insurance will be part of the future basic insurance package as well. But there are many open questions along the borders between "entitled" and "not entitled", for which the medical profession and those familiar with the funding possibilities must provide answers and present their positions. The debate over insurance has continued for months, but the key question has hardly been mentioned. I get the impression the matter is being obscured deliberately to leave more room for manoeuvre. Yet this could become a veritable minefield, with hundreds and hundreds of bitter complaints of a private insurer refusing to finance some provision or other, though the patient was entitled to it. (I have to note here that such complaints could arise with 51:49 insurers, and with the state insurer, if the latter retains its monopoly. For the time being, the patients themselves do not know if they can bring up such cases at all.)

3. There can be no competition in health care, including health insurance, without transparent qualitative monitoring and comparison. Clients can only decide blindly whether to leave insurer B and join insurer C, if they have no idea of the possible advantages and drawbacks of changing. And behind the choice of insurer lies a more important dilemma: which doctor and which hospital will see a patient switching from insurer B to insurer C? In any case, how can one know which is the better doctor or better hospital? One acquaintance died in one hospital and another was cured in a second – does that confirm that the second has the edge? Or will the choice be guided by a neighbour criticising one hospital and expressing satisfaction with another?

Buyers of cars, hi-fi equipment or washing machines have objective, circumspect comparisons to rely on. Credit-rating institutions grade those applying for loans. There are specialist international institutions making comparative analyses to grade the world's universities. Yet qualitative assessment of health care provisions is hardly in its infancy. One of the gravest shortcomings of the insurance debate has been this problem has hardly been raised. It is extremely difficult to evaluate the quality of health care provisions. Furthermore, the handling, comparative assessment and publication of data obtained under such an analysis raise several problems of personal rights. But the existence of difficulties does not mean the

task is not impossible. In listing the minimum conditions, let me emphasise two inescapable tasks:

– The legal conditions need clarifying about what results of qualitative assessment and comparison can be published. It must be established what the existing legal regulations allow and what legal regulations must be changed to ensure transparency.
– Within the legal frames at any time, a start must be made with comparative assessment of the quality of health care provisions. That calls for an apparatus for qualitative control and comparative assessment. This organisation will certainly develop further in the future. Competition itself will require and demand that objective comparisons be made.

4. It is necessary to organise an institution or network of institutions to which patients can turn with complaints or claims they may have against their insurer. Consideration and action cannot be delayed in some cases, for instance if the insurer refuses to fund an intervention or drug to which the patient is entitled in the patient's own, or his or her doctor's opinion, and delay in reaching a decision could cause irrevocable harm. It must be clear what the procedure will be in such cases, who is entitled to intervene and with what powers. It must be decided who takes responsibility and pays the financial consequences. I have not examined closely the province and practice of the insurance supervisory body already established. Problems 3 (qualitative monitoring and evaluation) and 4 (rapid complaints procedure) may have been solved in part, without the public learning enough about it. Alternatively, further legislation and institutional organisation may still be required. Whatever the case, everybody must be given clear information about the rapid emergency procedure for appealing against an insurer's decision. That is one of the minimum conditions.

I would add one general remark to the four conditions. I have presented them as minimum conditions for introducing the "multi-sector" form that I am recommending. But in fact, the four conditions must also be met if the government goes for its latest, 51:49 scheme, or if the funding of basic care is given exclusively to private insurers. In fact, conditions 2, 3 and 4 must apply even if the state monopoly remains. Only condition 1, averting discrimination would be automatically satisfied by preserving state monopoly. (In fact, even in that case I would not exclude the possibility that some providers will use secret, tricky ways to rid themselves of awkward patients for whom the National Health Insurance Fund pays too low a capitation.)

The four conditions can be found in the proposals, but with the exception of condition 1, it is not stated clearly enough in the document that these are indispensable conditions for the introduction. Unfortunately, attention throughout the debates was focused only on condition 1 (averting discrimination). The others

were almost entirely ignored by health care politicians in public debates, in the press, on the radio and on television. Perhaps they were swept under the carpet because no side in the debate could use them to its own advantage.

PATHS TO SUBSEQUENT DEVELOPMENT: COMBINED FORMS

So far I have outlined the first two stages in instituting a "multi-sector model". The first is for everyone to be a client of the state insurance company. The second is that those who choose to move to a private insurer may do so, taking with them their voucher for basic care. In describing these conditions, I assumed there was a sharp dividing line between the provision sphere and the financing and insuring sphere. But there are no grounds for assuming that this dividing line will remain for evermore.

There are forms that combine insurance activity with other certain provision services. An insurer may have its own system of primary-care and specialist physicians, or even its own specialist clinics or hospitals. There existed such combined organisations in Hungary before the capitalist economy was dismantled. Hungarian State Railways, for instance, had its own insurance company, clinic, and hospital. There was a separate insurer for journalists, with its own primary-care and specialist physicians. Such combined forms operate effectively in many foreign countries.

This so-called Health Maintenance Organisation is the version found most commonly in the United States. Let there be no misunderstanding: I am not recommending its introduction. I am no fan of "introducing" various forms from above. I am a sincere believer in decentralisation, the "unseen hand", and spontaneous initiative, not of reorganisation by central directive. Leave scope for initiative. If an insurer or a big employer or an association or union comes up with the idea of introducing a form that combines insurance with certain provisions, let us not impede it. Let us specify the conditions under which it may be permitted to operate. Let us create the legal frames that protect the interests of patient, doctor and state equally in the combined forms, just as these interests need protecting where insurance and provision are kept strictly separate.

Why should the transformation of health insurance proceed in step, like the changing of the guard? Why should the picture not be many-colored, so that it emerges after a while which initiative really works? Institutional development is an evolutionary process. An institution is not planned by a genius in advance, in every detail. If an institution, form of organisation or method of operation is viable, it will survive its early perils, while the unviable ones wither and die.

The variety of the picture must include variety of forms of ownership. I find it grotesque to stipulate 51:49 as the public/private ownership proportions, and likewise grotesque to rule out the privatisation of hospitals. For my part, I would not say no in advance to 100 percent state or municipal ownership, or to 100 percent for-profit ownership, or to non-state, non-profit ownership by a foundation, or to public/private ownership in any proportions. Nobody has the prophetic skill to say beforehand when and where any of those forms of ownership will prove best. Those who want to plan property relations with arithmetical precision have learnt little from the failure of socialist central planning.

This brings us to the issue of involving private capital in health care development. One argument the advocates of a multi-insurer model put forward in the debate was that marketisation of the insurance would draw in private capital that would be ready to fund sizeable investment projects. I fear that the argument lumps the capital requirements of insurance and of health care provision together. Insurance activity could certainly do with modernisation as well. Think only of how rudimentary today's paper national insurance cards are. It would be well worth spending some tens of billion HUF on developing the system of computerised records. But even if the long-overdue modernisation is carried out to the highest standard by the private insurers entering the market, the volume of that inward capital investment would still be dwarfed by the appetite for capital of the health care provisions themselves, which has a different order of magnitude and would call for several hundred billion.

Private capital will only be invested in the latter (i) if the insurance reform permits combined forms to be used, i.e. the insurer itself can transform the new clinic or hospital. Or (ii) if there is a hearty welcome instead of the present aversion and hesitation shown to investors in the provision sphere, not just insurance. A relatively firm legal and regulatory environment will have to be provided, with opportunities for concluding longer-term contracts, so that investors are willing to put their money into the branch.

We have arrived here at one of the main problems with the reform. It should not be a question of comparing two simple formulae – "one or several" – but of weighing two general forms of existence. One is well known from the socialist system: public ownership, centralisation, monopoly enterprises and other organisations, uniformity, rigid institutional forms, no freedom of exit or entry, but one unviable organisation forever.

The other form is a lively market economy: several ownership forms coexisting and combining, various degrees and ways of centralisation and decentralisation, competition, variety, enterprise, flexible institutional forms, and dynamic

entry and exit. The main problem with the proposal advanced now is that it seeks to use bureaucratic centralism and rigid prescriptions to impose the second form of existence on society. That cannot be done.

HARDNESS OR SOFTNESS OF THE BUDGET CONSTRAINT[5]

The debate was unduly focused on the issue of ownership. Supporters of the multi-insurer model give the impression that the presence of private capital will ensure financial discipline automatically. Fans of the single-insurer model argue that it is easier to keep tight control on a single fund than on several.

Unfortunately the situation is more complex than that. We have just witnessed in the credit system, the most intrinsic realm of private capital, how irresponsibly excessive expansion has occurred, "bubbles" have arisen, in some areas of commerce, and as they burst, they may push the whole world into general recession. Even the most conservative heads of central banks cannot refrain from throwing lifebelts to the endangered banks and other financial institutions, in an attempt to avert macroeconomic catastrophes. Everybody knows this causes bad blood and encourages irresponsibility, in other words, it softens the budget constraint, yet people do it just the same.

It is hard, very hard indeed to enforce financial discipline in health care. *Everybody* has an incentive to overspend. Patients hope for swifter, surer recovery, doctors for a facilitated cure, and pharmaceutical factories and appliance makers for higher volume and profits. No politician can expect to gain popularity or votes by opposing an increase in health care spending. The state insurer is reluctant to say no, which will only infuriate the medical profession and the patients. Let me add that private insurers do not gladly deny funding either, which is unpleasant to do, liable to scare away clients, and give a firm a bad name in the press. Instead they prefer to put pressure on policy-makers to increase the state contribution (in my example, to increase the value of the voucher). In addition they may raise the insurance contributions and pass the extra costs onto the insured. Even if the insurance contributions are regulated by the state, the insurers can force increases by pleading a rise in costs.

The underlying problem in health care – whatever the form of insurance, the means of funding, or the ownership relations – is who will say no. Who has a responsibility to say no? Who has an incentive to say no?

[5] The concept of the hard and soft budget constraint is explained in Kornai – Maskin – Roland (2003). There is a growing literature on the soft budget constraint in the health sector. (See, e.g. Duggan 2000; Hagen – Tjerbo 2008.)

The question can be put emphatically, but has no simple or sharp answer. All that can be done is to give all the actors in the drama at least some degree of incentive to control costs and economise. This purpose is served by the co-payment for visiting the physician and for hospital care, and a stricter system of accounting by doctors' offices and hospitals. Although the appearance of private insurers would not solve the basic "saying-no" problem, it would add another strong and important player to those with at least a partial incentive to control costs. This function, however, would be weakened by stipulating ownership proportions of 51:49, which would almost impose state paternalism and a soft budget constraint.

Hardening or softening the budget constraint under any system in any country is very largely in the hands of the government of the day and ultimately the political forces that support it. The present government has intervened strongly on costs, with spectacular results. For the first time in many years, the deficit on the National Health Insurance Fund has given way to a surplus, available for spending on health care development. But there has been a high political price to pay, as it is hard to imagine less popular government behaviour. There is no guarantee that this or another government, in another situation, will not start to soften the budget constraint again and it will be able to do so even with a higher degree of health care decentralisation on the provision and insurance sides.

CONSTRAINTS ON COMPETITION

Economics has shown the advantages of competition convincingly and in detail. But those who go beyond the first chapter in their reading on competition and read the second will learn of the theory and practice of constrained, non-perfect competition. There are many forms of this, depending on how many players appear on the two sides of a transaction, the buying and the selling sides.

There are not just two extreme cases – "perfect competition", with a high number of sellers competing for the buyers' favours, and monopoly in a strict sense, with buyers at the mercy of a single seller – there are also intermediate cases, involving various degrees of defencelessness and superiority. Unfortunately the debates have not analysed deeply the market structure that will emerge from the changes. Those proposing a multi-insurer model have done a disservice to their cause by stopping at the end of the first chapter on microeconomics to laud the advantages of ("perfect") competition, and suppressing the second chapter, on the problems caused by the constraints on competition. Let us look first at the demand/buying side, at insurers as main buyers of health care provisions. There is no question of the government's new concept involving a large number of actors; perhaps ten or twelve can be expected. The market form due to appear is what

economists call oligopoly. Oligopolists may easily arrive at a situation where they can abuse their superiority. Nor is this about a few giants who have won themselves a position of power through real competition and market performance, only about winners of a bureaucratic competitive process. Every hair on the head of the economist Hayek, the great apostle of the market, would stand on end if he could read on the Internet, somewhere above the clouds, the ideas advanced for making the selection. With Hayek (and all true believers in a true market), competition carries out natural selection in a spontaneous way. He scornfully dismisses "constructivism", schemes devised in advance, any artificial, contrived form of selection. What we have here is a "constructivist" master plan indeed! We are told in advance how the national market will be divided into regions, and where each insurer may and may not operate. It is largely laid down that there will be quasi-monopoly in each geographical zone.

Let us now turn to the other side, the supply/providing side of the market structure. It follows from the nature of health care that this under any circumstances will fall far short of "perfect competition". For one thing, the geographical distance between patient and doctor is not immaterial. Convenience alone dictates that patients will be keen to travel far for a small problem, while a major one may need urgent treatment. This makes a degree of geographically determined quasi-monopoly inevitable. This is compounded by the high degree of medical specialisation and by the high cost of technical advances. It is sensible to concentrate the best specialists in a problem and the expensive equipment. So one provider obtains a near or total monopoly position in the performance of some task or other.

These, I repeat, are general features of the health care sector. But in Hungary, the competition has been still more constrained by two more circumstances. One is the anti-market, anti-private capital, anti-business school of opinion, which places political, legal, and economic obstacles to the foundation of the new provider organisations. There can only be true competition where there is freedom of entry – that is a well-known axiom of economics. Obviously, freedom of entry here would not mean freedom for any quack doctor or self-appointed healer to provide health care. Freedom in this context means that if all professional requirements are met fully, there will be no obstacle for new firms, private investments, or use of the various forms of ownership.

The second problem has a more recent origin: it is connected with the episode in the transformation of health care intended to eliminate spare capacity. This article is not designed to assess comprehensively all changes in the health care system in the last year and a half, only to cover the insurance reform. But that too calls for a short detour into the capacity-reducing actions of the last few months. There is no denying there was much hospital capacity that was unjustifiable on any mana-

gerial or medical grounds and a way had to be found to eliminate it. Yet the search for professionally well grounded, balanced solutions has been made almost impossible by the haste and the political power struggles accompanying it.

Let us stay with the subject mentioned before, restrictions on competition. The action seems to have gone too far in many places. Concentration, almost inescapable for the professional reasons cited already, has strengthened further. Even more hospitals, clinics, diagnostic institutions, and laboratories have attained a monopolistic or near-monopolistic position. It is well known from competition theory that surplus capacity is a relative concept. There is competition for guests among hotels and restaurants precisely because they have spare seats or tables. Buyers under the socialist shortage economy were at the mercy of sellers because there were more guests than rooms or tables.

Let us now return to the transformation of insurance. On the one hand there is an artificially created oligopolistic configuration: a small number of buyers. On the other (due to breakneck reduction and concentration of capacity) there is a monopolistic or near-monopolistic seller in many cases. All the textbooks state that this is one of the least advantageous market configurations. It creates an unstable situation, leaves scope for abuses, breeds blackmail and corruption, and almost cries out for constant intervention and introduction of extra-competitive methods.

The phenomenon cannot be avoided entirely or everywhere. There must be sober preparation for the contingency of such a detrimental seller/buyer configuration, lest it come to the public as a nasty surprise. Advocates of competition weaken their own credibility by stating its advantages without mentioning its serious problems. In fact it emerges from what has been said that on the selling/providing side, the reformers themselves have been compounding the inevitable problems caused by restricted competition.

THE PATIENT'S RIGHT OF CHOICE

Advocates of the multi-insurer model underline that it increases individual choice. The single-insurer regime allows no opting out, but dissatisfied clients in the multi-insurer scheme have a right to leave one insurer for another. This really is an inestimable advantage, but it must not be presented one-sidedly, in isolation from the complex process of choice, without raising client expectations that cannot be met. One great feature of present government thinking is regional decentralisation of the insurance sphere. The insured party will wake up one morning to find themselves clients of a regional insurance institution, the one that won in the region where they reside (not by real competition, but after a bureaucratic process

of competitive bidding). Clients do have the right to transfer to another insurer and to that extent the insurance institution concerned does not enjoy a territorial monopoly in the strict sense, but the situation is very close to being a true monopoly.

This sense of monopoly is reinforced by a territorial duty to provide. Those familiar with the Internet may soon gather the required information and not shrink from using it to maintain contact with an insurer in another region, but many Hungarians are not so agile. They are not too conversant with modern IT and may not even have access to a computer. They will therefore (rightly or wrongly) feel tied to the insurer responsible for their region.

Another side to patients' right of choice is choice of provider. It will depend on the detailed terms of the insurance contract how freely clients can choose a primary-care or specialist physician, a clinic, or a hospital. International practice is for each insurer to have an own approved network, even if it has no physicians, clinics or hospitals of its own. So clients can choose among the doctors who feature on their insurer's register. It will depend on the insurer and type of contract whether a chosen primary-care physician refers patients to a consultant or hospital, or whether they can choose for themselves – i.e. whether clients choosing an insurer are choosing a network and scope and limitations of choice ("patient paths") as well. The big decisions (such as who insures the patient) will be freer, but freedom in many important detailed decisions may be reduced, especially in a country like Hungary, where referral processes have not always been open and official, but conducted on the side as well. So the commercialisation of insurance may actually reduce freedom to choose doctors, by comparison with actual practice at present. The market must be opened to private insurers, but they must be obliged to declare openly and transparently to potential clients the rights and limitations of choice entailed and the whole system of referrals. The contract between insurer and insured should state clearly the rights and obligations of both sides.

This in any case should also be made clearer today, under the single-insurer system. For neither doctors nor patients are fully familiar with the twists and turns of the "patient paths" under the present referral system. Where the consequences are uncertain, who has the right to decide?

UNCERTAIN CONSEQUENCES: WHO HAS THE DECISION RIGHTS?

Having tried to outline the changes I recommend, the conditions for introduction and the scope for further development, let me return to the starting point, to contrast my proposals with those of the coalition parties and health care administra-

tion, and with some views expressed publicly in recent months.[6] It may well be wondered what grounds some experts and health care politicians have for their utter self-confidence. Can the liberal economists championing competition between exclusively private insurers be dead certain this will bring all the advantages they describe and none of the drawbacks and dangers they ignore? How can left- and right-wing advocates of a single-insurer system be certain that retaining and patching up the status quo is the desirable option? Why to them is any criticism of the state monopoly like water off a duck's back? And as for the amalgam of the two types of position, the strange 51:49 mixture, is that certain to bring an essential improvement over the present situation?

The stress in the questions is on "certainty", the arrogant self-confidence over a decision-making problem where the results of the choice lack certainty. Perhaps some messianic sense of vocation has been bestowed on these people, so that they and only they know just what is good for people and they have a right to impose on people the scheme they think best, whether people like it or not. It seems grotesque that this "imposition of bliss" is accepted and proclaimed by people who call themselves liberal. To caricature one viewpoint, they say they are believers in the market, free choice, and individual sovereignty: like it or not, accept this.

Equally grotesque in my eyes are self-styled right-wingers and conservatives seeking to conserve the centralisation, bureaucratic control, state monopoly, and opposition to the market and capital imposed by the communist regime and supported by the old-style social democrats.

It is hard indeed to explain to a foreign political scientist what liberalism and conservatism mean in the context of the debates here on health care reform.

My position starts out from the limitations of our knowledge. We do not know with enough certainty what effects one scheme or other would have here and now, in Hungary. Some say the decision in that situation has to be passed to the citizens. "Let the people decide," let there be a referendum on this, as on so many other questions. That, in my view, is just demagogic bluff. It emerged from the debates what an intricate, ramified problem this is. The people do not make a genuine choice by putting a cross in a box. Whether an individual votes yes or no in a referendum, he or she does not bear the consequences. The decision must be given to people to allow a real choice. If they like, people can stay in the state insurance framework. If they like, they can leave that framework, and taking with them the entitlements gained by paying contributions, join a private insurer. This choice seems a hard one to make, especially to start with. It is hard to see what advantages and drawbacks are entailed in joining some insurer or other. Some limitations and

[6] There is a wide and very instructive literature on the political aspects of market-oriented reforms. See e.g. McMillan (2004); Reich (2002).

distortions of information can be expected. Let us hope that citizens will receive a lot of help in making their decisions, from experts, the academic world, unions, the press, and the electronic media. But the limitations of information do not justify withholding from citizens their right to decide.

I condemn the practice of scorning those who fear change. Everybody has a right to stick to the accustomed things they know well. It is not right to deny them the use of the previous institutional form if they wish to do so. But I also condemn the threats made by those who would deprive of the new forms those who have chosen or been forced back onto the earlier forms. It can be brought up against my line of argument that my emphasis on consumer sovereignty reduces the role of representative democracy and legislation. In my view, it is not the task of Parliament to take decisions out of the hands of consumers in cases when individuals are capable of making them. There are enough tasks here for the legislature and the executive, the government, without that: regulating and monitoring the market, and providing legal frames for its operation. Furthermore, there has to be strong redistribution to apply the principle of solidarity. The state has to fund out of the contributions of wealthier people (well above their own health care costs) the basic health provisions of poorer people.

I see no contradiction between the central idea in my proposal – making individuals responsible for choosing between the forms – and recognition of the role of the state. On the contrary, I have tried to point out government tasks that have not received enough attention in the public debates so far.

LEGAL SECURITY AND FLEXIBILITY

I have heard advocates of radical reforms say more than once, "We have to cement the changes, lest they are reversed later after a political change." I also fear this danger, and my sense of it has been increased by repeated threats of reversal. Nonetheless, I cannot accept the metaphor of "cementing in". Leave cementing to the building industry. It is not permissible to bind the bricks of social changes together with material that is rigid and can only be broken again with a chisel.

The desirable attributes for the institution created by the reform are not rigidity or ultra-stability, but flexibility, transparency, and "convertibility". Let me again cite the uncertainty about the consequences. If we knew precisely what all the effects of the forms to be created would be, we could think about creating an immutable structure for them. But we do not and cannot know that. Some innovation or other may prove itself, but it may equally fail to fulfil the hopes placed in it. Instead of seeing the latter as a shameful failure, let us calmly correct it, or reject it and try something else.

Laws need to be respected, but if new institutions are being created with the force of law, let the law not be too rigid about details; let it leave scope for transformation, innovation, and experiment with the institutions. One dreadful example of the opposite in the health care sector is the legislation on hospital capacities, mentioned earlier.[7] Every dispassionate expert recognises that there is a lot of spare capacity in the Hungarian health service and the drastic cut was justified. But there is no justification for having Parliament decide every detail. The Ph.D. dissertation I wrote for the Hungarian Academy of Sciences exactly half a century ago bore the title "Overcentralisation in Economic Administration" (Kornai 1959). I wrote pages on the baneful effects of bureaucratic centralisation, from disregard for local knowledge to production of faulty incentives. But not even in the 1950s was it prescribed centrally how many beds there should be in each hospital department.

The administration intends to present a bill on reform of health insurance. I sincerely hope it will not "cement in" the 51:49 scheme. Let the law provide a chance for state-owned insurance to continue and other forms of ownership to appear as well, under appropriate conditions. The rest will be decided in real life.

AN UNACCEPTABLE PRINCIPLE: "THE WORSE IT IS THE BETTER"

The debate may drag on for a while, but it has to be settled somehow in the end. I very much hope there will be a favourable conclusion and that Parliament will pass good legislation. It may, but it is not certain. But even if the new laws, regulations, and institutions are not good, or not good enough, it will still be the civic duty of every staff member in health care to make the system work as well as possible. That is what professional honesty dictates and the unwritten directives of human honesty call for. To conclude that "the worse it is the better because then at least it will turn out that the thing won't work that way" is to my mind a shameful view. I use hard words here to express how deeply I condemn those motivated by this idea in their words and deeds. Sometimes incitement to withhold payment of taxes, compulsory dues, or contributions is graced with the title of a call to "civil disobedience".

Such people have no idea what Martin Luther King, for instance, called civil disobedience. King and associates braved the law on behalf of basic human rights.

[7] The Hungarian Parliament legislated on December 22, 2006 to reorganise the state hospital structure. The act prescribed the closure of some hospitals, reorganisation of others, closure of some departments within hospitals affected and cuts in bed numbers in other departments. It also merged several hitherto separate hospitals.

He urged people of colour to ride the buses reserved for whites, but he did not will them not to pay the fare or to vandalise the equipment. He encouraged a black female student to enter the university where she had won a place, even if the racists stood in her path, but he did not prompt the teaching staff not to complete their tasks. And they broke the law knowing they would be jailed for it, not reckoning they could sound off about breaking it without harming a hair of their own heads. Legislation by Parliament is part of the democratic process. A piece of legislation may only be good in part. From that point on, doctors and patients, government administrators, and supporters of the government and opposition alike have to work to ensure that the good sides of the law apply as far as possible and the bad sides apply as little as possible.

PERSONAL REMARKS

I am often asked if those concerned heard what I had to say before bringing in some regulation or other, and if they had listened, whether they had accepted what I recommended. In the past, I would often give a straight no to both questions. In this case, with the health care reform, I must give a more detailed reply. I wrote a book with co-author Karen Eggleston on health care reform, and a new, expanded edition appeared in Hungarian in 2004.

I was asked for my opinion on health care reform when the 2006 government program was being compiled. I had a chance then to express my views to high-ranking decision-makers, verbally and in writing. I was invited to a two-day debate on the reform of health insurance, held in the Parliament building, where the Health Minister invited me to deliver the opening lecture, which then appeared in full in the daily press. Laying aside my usual aversion to appearing on the screen, I also put my views on television. So to some up my reply to the first question: yes, I was heard.

As to whether people listened, they *half-did and half-did not*. The changes in many important matters did go in the direction that I was recommending, with the agreement of others. But my advice was not taken on other important matters. I will not give a full report here on where my recommendations were followed and where they were not. Let us remain with the subject of this article, health insurance. Readers may compare the text of my lecture in the Parliament building with the concept that has now been published as a compromise. From the latter I dissociate myself clearly.

The basis for this article is the same as the one my lecture in the Parliament building contained; at most I have tried to give some new arguments to support it and to criticise the viewpoint I recommend rejecting.

I am convinced that the view expressed in this article could be a starting point for a healthy compromise. Perhaps it will be listened to in the end, although it is also possible that people will pass it by again and do something different. I promise that even in the latter case I will not become an opponent working against the plan chosen. Anyone who undertakes to advise people active in politics must do so without illusions, whether the advice is accepted or not. For my part, I feel obliged to retain the modesty that I expect of other participants in the debate. What if they are right not to have taken my advice? What if I am wrong and they are right?

I heartily desire to see the reform of health care move forward successfully.

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