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Healthcare: Squaring the Circle

The framework law on the operation of health insurance funds, passed on 11 February, serves as a perfect example of how two, theoretically viable models (single insurer model operating under tight state regulation and a multiple insurer model allowing completely free competition) fall victim to political compromise and are combined into a probably unviable scheme. We know all too well that the current experiment is not without precedent, but it carries unprecedented risks (because it affects everybody living in Hungary) and in terms of consequence, it is equivalent to the sum of educational and pension reform (someone either studies or pays contribution, or receives annuity). This package leaves nothing untouched: flaws in the scheme, risks underlying corporate operation, some Hungarian puszta, not to mention the expected negative effects.

Flaws and risks in the scheme...

There is no competition in health care (either) without a price. Funds cannot compete with each other for contributions, i.e. differentiated contribution payment depending on fund membership is not possible. Although capitation relating to fund members may be differentiated on the basis of age and gender, it is plain to see that risks arising from a health condition cannot be effectively reduced this way. There is no price competition between the service providers, either, because the ten per cent plus/minus variation from the service fees determined by law is insignificant. Based on these two factors, sector participants are unable to effectively apply the most important means of balancing between supply and demand.

Competition between funds (serving the interests of fund members) – announced as the most important objective of health insurance reform – supporting the improvement of the quality of available health services is difficult to imagine between funds with state majority ownership, as this is incompatible with the concept of the state.

The reform also ignored the economic fact that the market of mandatory health services is in all cases characterised by limited supply, i.e. by a shortage economy. “Supply driven demand” means that even though formally the patient is the buyer of the service, the physician determines the service to be provided, providing such service to the patient, that is, he/she is not only the provider but also the buyer of the service (supply and demand is one). This renders supply inflexible and essentially rules out price competition. Such circumstances reveal the symptoms of a shortage economy: dominant position of the seller, continuous exposure of the buyer, waiting in line for the product, appearance of corruption and a rise in product prices (see János Kornai: *A hiány* [Shortage]).

The health care sector is also special in the sense that a substitute product or service offered in a shortage economy is not available for purchase – heart surgery cannot be substituted with a leg cast. The balance between supply and demand is therefore atypical; unsatisfied demand is most common, which generates wait lists and bribes at a higher than average rate.

Economically, logically and on the basis of international experience it is false to conclude that the competing funds provide services of a higher standard to customers than the single insurer model that is mandatory for everyone. In the fund model, the sectoral value chain (citizen-health insurance fund- service provider-citizen) has the result that the citizen at the end of the value chain has no influence over the service provider, because in a scenario determined by a shortage economy, he/she is the exposed customer opposite the seller who is in a dominant position. We would be absolutely mistaken to assume that the citizen in a contractual relationship with a health insurance fund could enforce his/her will. If the member is unsatisfied with the services provided by the fund, he/she has no chance to enforce interests against an owner whose aim is to minimise expenditures (this is how it can realise profit on the basis of constant per capita revenue). The fund member not

wishing to receive a service can express dissatisfaction by switching funds, which is presumably the objective of the given health fund because it can thereby avoid the certain payment of claims, which is definitely higher than capitation received for the fund member.

This law is a framework law, that is, it refers numerous substantial matters under the scope of other legislation, resulting in the instability of the scheme from the very outset and in lacking statutory and institutional guarantees.

The acquisition of minority ownership not linked to market value (bidding) runs contrary to any market logic. This transaction copies the outdated privatisation philosophy of the transition, which is false in the present case, based on the premise that invested professional know-how and not capital is important for the scheme. This obviously raises the suspicion of corruption, even if bidding will be conducted with the best of intentions and under fair conditions and prices.

Considering that anyone with money can take part in the scheme as a minority owner, it is wrong to assume that the investment of private capital will result in the system's efficiency. The legislator expects banks/insurance groups to commit themselves, but they similarly lack service organisation know-how necessary for competently operating health funds, and are not in the position to decide on possibly entering the market. Strategic decisions are taken by the parent company, but commonly not in the middle of the financial year.

By maximising operating costs at 3.5 per cent of capitation and profit drawn as dividend at 2 per cent of capitation, the fund is not motivated to improve the efficiency of organising services (clinical pathways), yet this had been originally the key intention of legislators. Moreover, realised profit can be higher if the fund also relies on other funds (e.g. EU), which significantly weakens the transparency of the scheme.

Taking into account that operating costs and profit drawn as dividend are determined in proportion to capitation, variation from these ratios will be reasonable if the fund also relies on other funds. There is the real threat that owners consider the fund to be a vehicle for converting tender funds and even funds acquired through backroom deals into legal profits. The current bill does not ensure the full transparency of the fund's operation since the regulation of operation is closely linked to operation with capitation.

...in preparation for the market entry of the fund...

To our current knowledge, the purchase of funds by bidding (more precisely, by single round bidding) will take place in June. Members will not be recruited in the initial year because of a time shortage (and what happened to competition?), while the setup of the IT system and the service network needs to be resolved by the launch on 1 February 2009. Those who have taken part in such a task know that execution is impossible without mistakes. In only 7-8 months, the local service providers need to be organised for each fund, with the implementation of a system that can flawlessly communicate with the National Risk Pooling Fund (OKA) and the APEH, and with the service providers on a daily basis, and of a customer service. Again with reference to the Patika Fund, despite serving 100,000 customers at 4,000 locations at the present time, the implementation of the system lasted one year together with a test operation.

The operation of the fund would be significantly more transparent – and more stable – with respect to the exercise of shareholder rights if, upon the foundation of the fund, the various rights (sale of shares, appointment of officers, drawing of dividend, raising of capital) would be attached to the types of shares regulated by the Companies Act, preventing operation from falling victim to unpredictable backroom deals.

The founding of public and not private limited companies would fulfil the principle of transparent funds, not to mention the fact that privatisation through the stock exchange would be least open to objection.

It is striking that the law forgot to regulate the actuary. Although the fund may not apply risk selection, the members do have risks.

No one projected the scenario in which nobody buys a given county, and it is surrounded only by funds operating with minority owners. In such a case, the law prescribes amalgamation into the neighbouring fund. For a financial investor it is a primary school (or kindergarten colouring book) exercise to surround a given county, especially if oligopolistic agreements are concluded in the background.

...and in corporate operations

The situation is not much better with regard to risks underlying corporate operation. Perhaps the biggest concern is the grave violation of the funds' freedom to conduct business. The OKA is planned to become the successor organisation to the OEP, which, as a national data centre, would manage information on everything. Central records based on the data provision of funds is not unknown in a private pension fund scheme, but beyond keeping records on the individual members of the given funds, the OKA also exercises oversight of the fund's finances. For example, it does not physically transfer the capitation to the funds, but determines the balance of capitation and fund expenditures at the end of the month – if there is a surplus, it makes it available to the fund, and in the event of a deficit, it orders the fund to top it up. Thus, funds will not be in the position, either, to invest temporarily unused capitation to serve the interests of members. Moreover, the service providers submit supporting documents serving the settlement of services directly to the OKA and not to the health funds.

The subjective factors underlying capitation calculation (quote from the act: "calculation adjusted to the needs of fund members") open doors to backroom deals, which harms the fairness of competition. Moreover, a possible surplus within the OKA is easy prey for the budget, as capitation is determined on the basis of figures for the previous year.

The minority owner is expected to provide knowledge capital, but neither the general assembly (49 per cent), nor the board of directors (six members, the chairman appointed by the majority owner) has a substantial say in the operation of the fund.

Key decisions relating to the fund are passed and modified by a simple majority (statutes). This may be ideal for a limited liability company, but very unusual for a company limited by shares, where a 75 per cent proportion of votes has been common practice for centuries concerning key matters of a company (e.g. resolution of cessation, capital raise).

A six-member (!) board of directors is mandatory for funds operating with a minority owner. Again, such practice is in stark contrast to company law, but it seems quite straightforward that the opinion of the three members representing the minority owner will differ from the opinion of the three members representing the majority owner. The provision stipulating the casting vote of the chairman wouldn't be out of place in an operetta. For connoisseurs, the question remains open as to whether a six-member board is required if the fund does not operate with a minority owner, i.e. it is fully owned by the state, or the provisions of the Companies Act can be applied (odd number of members) in such case?

The possibility of disabling the given company executive delegated by the minority owner from supporting state objectives with day-to-day decision-making renders the entire scheme vulnerable and may even result in the impairment of the company. As an additional risk, the professional know-how of the minority owner may fail to produce more efficient health care services, and the state majority owner cannot go public by admitting any shortcomings because it would suggest that people do not receive reliable care.

We are not wary of risks because we're Hungarians...

The name "one insurer, several funds" is misleading because the fund scheme means something else anywhere around the world compared to what the Hungarian fund signifies. The fund scheme is recognised by the laws of several countries (USA, England: Mutual Fund, France: Mutalité,

Germany: Krankenkasse), with voluntary and private funds also operating in Hungary. As a common feature of funds operating around the world, the fund is owned by members. The fund member exercises ownership rights based on his/her assets accumulated in the fund in relation to funds collecting contributions, and on the basis of membership in relation to service providing funds. Obviously the Hungarian fund does not fulfil the above criteria because Hungarian funds are actually profit-generating, privately or state-owned companies limited by shares.

As a further major risk to the operation of funds, the state – even if a majority owner – is not permitted to top up the possible operating deficit of funds operating in the form of a company limited by shares because that is incompatible with the laws of the European Union. The example of the Netherlands is worth noting, where the debt accumulated by privately owned health insurers amounted to a substantial percentage of the GDP – this is presumably why the Dutch insurance companies in Hungary are keeping their distance from the future Hungarian health insurance market. It is also necessary to raise the following question: In contrast with the laws of the EU, how long is it possible to grant a business tax or corporate tax exemption for funds? We, Hungarian citizens, would be worst off if the EU does in fact introduce a VAT payment obligation in relation to insurance. After some mental arithmetic, the taxes will increase the current contribution rates by 15-20 per cent.

Patients are exposed everywhere around the world. The Hungarian patient carries the additional burden of a poor financial culture and of a buyer's attitude conditioned in the shortage economy. The visionaries projecting competition between the health insurance funds were probably oblivious of the Hungarian population's poor financial culture (e.g. choice of banks, borrowing, insurance exposure, switching between private pension funds). Clearly they did not assume that the average Hungarian is better in choosing a health insurance fund than a physician or pharmacist, otherwise they would not have set the objective of boosting future competition between the service providers, with the support of the funds...

Beyond the fact that the hastily passed law – lacking any prior public debate or professional consensus – is unprecedented in the history of a democratic state, its implementation is also uncertain without an appropriate base. The obvious faults of the scheme (all details of such reform cannot be worked out in two months) will be regularly corrected, which demands continuous adjustment by its participants, accompanied by an almost certain loss of public confidence. The biggest problem, however, is the risk of the reversal of the fund scheme, which would eliminate any manoeuvring room in the next 4-6 years for genuine, necessary reform.

Hungary will one day have to confront the EU, which will have gotten fed up with our continuous excuses and book-keeping tricks (see private pension fund reserve). EU politicians may even tolerate the tax exemption of Hungarian health funds in the short term, who are well aware that the common finances falls short of tax revenue. They will probably also overlook the fact that Hungarian legal regulations relating to mandatory health insurance will be regularly amended, after all, this area will be the last to be regulated by common EU directives in the future. With such behaviour, Hungary will obtain permanent membership only in the standing area of the European club of leather armchairs.

...and because we'll stay Hungarians

Last but not least, let us assess the expected negative effects in the operation of funds.

Instead of solidarity, the mandatory health insurance scheme in Hungary will be dominated by market mechanisms, which is clearly incompatible with the directives of the European Union relating to health systems (Council Conclusions on Common values and principles in European Union Health Systems (2006/C 146/01): universality, access to good quality care, equity, and solidarity).

Competition assumed between service providers will not lead to attrition on part of the worst performing medical workers. On the contrary: The best staff of public service providers will seek

careers elsewhere, resulting in the deterioration of the standard of health services provided within the framework of mandatory insurance. In this regard, Hungary should also take into account that on the basis of the free movement of labour in the European, Hungarian medical workers may choose employment under the most optimal working conditions, which are not necessarily in Hungary.

Operating costs arising within the system represent real profit for minority owners with a bank/insurance company background. The funds are expected to launch operation with maximum operating costs (3.5 per cent), thereby significantly increasing the current 2 per cent rate of the OEP and reducing amounts available for care. We may assume that mandatory health insurance – together with mandatory motor vehicle insurance – will be the other large sector that realises guaranteed revenue at an enormous cost.

The operation of profit-oriented funds in a health care system characterised by limited supply (shortage economy) leads to longer wait lists because the easiest way for funds to turn a profit – with inflexible revenue mechanisms – is by cutting expenditures. If we want to avoid the wait lists, there is the good old Hungarian invention of gratuities, which will raise corruption to ever higher levels.

The range of services guaranteed by the law may also very likely narrow, as this seems the only option for funds to avoid deficits, and we know that consolidation by the state is not possible. Citizens will experience these developments in the form of services of deteriorating standards, which is in sharp contrast with the original objective of the law.

It is a paradox that the narrowing range of services benefits minority owners. The law allows the fund to act as the insurance agent of the minority owner, which offers an outstanding opportunity to sell products developed for services excluded from the package of mandatory services. This is how the state can reduce the basic package practically “without risk”. In fact, this would also serve the interests of the minority owner, and I am not referring to commission paid on sold insurance.

Furthermore, it should not come as a surprise that the newly established health funds will ultimately launch operation sometime in 2009 (any delays could well end by that time), with or without a minority owner. This fact only seemingly stands in contradiction with the above observations; instead of the beneficial effect of competition and the market, the solid tradition of backroom deals continues to shape Hungarian health care.

This is how we, Hungarians, once again showed the rest of Europe how to square the circle.

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