http://www.es.hu/cikk/2008-06-08/banfi-tamas-lukacs-marianna/verseny-a-sorban-allasert-es-a-halapenzert.html

Élet és Irodalom, 6 June 2008

Competition for Waiting in Line and Gratuities?

Accession to the euro zone is both an obligation and an interest; after failing to meet the last unrealistic target date, the government has been hinting at – we thin, correctly – such date. The Maastricht criteria and the possibility of reaching a 0.5 per cent GDP-proportionate budget deficit undertaken under the additional framework of the Stability and Growth Pact imposes strict state finances. According to other European Union fiscal regulations, countries that are no longer subject to an excessive deficit procedure, but have yet to fulfil the medium-term targets, need to reduce their budget deficit by an annual rate of 0.5 percentage points. Deficit reduction is possible through GDP growth or the reduction of the budget's negative balance.

The above introduction serves to support our assumption that health care reform is essential not only because:

1. the financing of unreasonable, wasteful business can harm (assuming constant revenue) other forms of public consumption (education, culture etc.);
2. it has a demoralising effect on all participants of the health economy;
3. the current structure and regulation is inadequate for preventive-curative-rehabilitative work of an expected standard.

The implementation of the convergence programme aimed at budget cuts significantly limits the rise in amounts allocated to the health economy, therefore the operation and activity of the National Health Insurance Fund (hereinafter "OEP") can either limit or support the reform as a whole. The direction mapped for the solution is predetermined by the Government's commitment in this same programme, with the aim of "reducing the GDP-proportionate expenditures of the Health Insurance Fund by 0.9 percentage points between 2006 and 2009."

This article focuses on the alpha and omega of the OEP's operation, the revenue and expenditure sides, which correspond to supply and demand on the health economy market.

A theoretical approach

Any microeconomics textbook lists the criteria of market competition, and the market characteristics of certain sectors of the sharing economy are also well known (E.g. Joseph E. Stiglitz: A kormányzati szektor gazdaságtana (Economics of the Public Sector). KJK., 2000.). Competition is limited on all of these markets, but the degree and nature of the limits are attributable to substantial differences. Assuming that we rigidly adhere to the concept of the market, even though we could reach a mutually acceptable result by using a different category, the market fitted to health care is different than other markets that allow limited competition.

The market of the health economy can be described in distinctive terms. The equilibrium of markets is generally effectively characterised by supply and demand. In the case of the health economy, however, while the meaning of **supply** is relatively straightforward, and can be precisely defined, the concept of **demand** cannot be defined.

Supply (expenditure)

Supply is determined by personnel and equipment capacities, technical equipment, the quantity of single use materials, together with the related unit prices, available at a given geographical location (city, region or country) in a given period (in a fiscal year). We know that the current financing method of the OEP does not follow this practice; general practitioners are financed in proportion to the current revenue side of the OEP on the basis of card money (performance-proportionate remuneration), outpatient care workers according to a point scheme and inpatient care workers on the basis of the homogeneous disease group (HBCS).

Demand (revenue)

In contrast, actual demand at a given place and at a given time cannot be determined, perhaps only potential demand for curative-preventive services. Numerous singular characteristics support the existence of potential demand instead of an actual one. A non-exhaustive list of key characteristics:

1. Growing demand for the cure of birth defects, which can be permanent or temporary, or partial.
2. Aim of increasing the number of years lived in good health (health-profit).
3. General demand for the faster and permanent cure of already curable diseases.
4. There is also similarly general demand for improving curative effectiveness relating to diseases requiring continuous treatment.
5. Similarly general demand for longevity, accompanied by a rise in patient numbers.
6. The increase in the number of accidents resulting from technological development boosts demand for care and rehabilitation, but injury caused to or by other people, stemming from vulnerability or man’s inhumane nature, also requires care.
7. Man’s self-destructive habits (cigarettes, drugs, alcohol) paradoxically require medical care, usually continuous treatment.
8. A person (group of people) wielding political power may kill or attempt to kill out of economic interest, religious fanaticism or brutal inhumanity, but, as a result of this absurd drama, partial success (people disabled by war) against success (death) requires treatment and rehabilitation.
9. Finally, if we regard health care (treatment and prevention) to be not just disease care (treatment), then prevention (primary and secondary prevention) could generate unlimited need, i.e. unlimited demand. Today we still don't call health care institutions (hospitals, clinics, general practitioners) disease care institutions, or the authorities controlling these as a Ministry of Disease or National Sickness Insurance Fund.

Original deficit in health care

It follows from the above that potential demand on the health care market exceeds actual supply everywhere and at all times, resulting in a permanent and fixed state of a deficit. Since potential demand is also impossible to measure, there is no way to “measure” its amount. Moreover, a deficit in this sense, which we will call original deficit, generally blends with other types of deficit commonly affecting the operation of the health economy.

Such other type of deficit depends on the relative disadvantage of the given country. What does this mean? Ties between countries pursuing independent fiscal policies – attributable mainly to the free flow of capital and labour – have deepened to such an extent that individual needs, hence their potential demand are adjusted to the actual choices of more developed countries, and ultimately to those of the most developed countries. Such type of deficit on the health care market is the consequence of relative underdevelopment, which will cease once relative underdevelopment is fixed. Alternatively, this type of deficit can be reduced if more public finances are allocated to health services at the expense of other public consumption, or individuals receiving health services spend a higher proportion of their personal income on the purchase of health services.

A simple concrete example from another sector offers a straightforward explanation. Let us take a "fictional" example based on the public transportation of Budapest. Some say that the city's public transportation is acceptable and good, while others argue that it is not. The capital's public transportation company (BKV) is unprofitable each year, which means that in addition to collecting ticket revenue, it requires budget financing each year. BKV claims that ticket prices are low, while passengers say that they are high relative to their wages. Public transportation in Berlin is wonderful – at least in comparison to Budapest. Upon pressure by the financing local government, BKV is forced to reduce losses either through ticket price increases and/or the cancellation or reduction of services. Both an increase of ticket prices and the cancellation or reduction of services may trigger opposition by Budapest passengers. What is the truth? The table below indicates some figures:

	Budapest		Berlin
	HUF	euro	euro
Single ticket	280	1.10	2.10
Day-pass	1,150	5.90	6.10
Monthly pass	8,250	32.30	72.00
Average wage		831.00	3,510.00
GDP/capita	8,900		28,200

The situation is clear and straightforward. The price of the single ticket costs almost twice as much in Berlin, and the monthly pass costs more than double the fare there in comparison to Budapest. The price of the monthly pass equals 3.9% of the average wage in Budapest and only 2.0% in Berlin. The significantly higher ticket price accounts for a much lower proportion of the average wage in Berlin than in Budapest, which is attributable to the threefold difference between the per capita GDPs in the countries.

Until the deficit remains an inevitable element of the health care market, not least because of the above two reasons, there will be no market prices or profits, potential profits determined by the quantity and quality parameters of services. Were we to divide the health care market into (2, 22 or any number of) market segments, the deficit remains in all market segments; competition emerges only when waiting in line (wait lists) and for paying additional fees (gratuities).

Prices and profit in health care are a question of regulation, which can be resolved and implemented, but a list of assumed advantages should be drawn up in advance. There is one such advantage. If there is a private investor who wishes to become a 49 per cent minority

owner in awareness of relevant regulation, private funds are then available to replace unlikely state funds for the development of health care services. The only question remaining is the price of a development surplus, that is, the amount of directly identifiable and unidentifiable (partly unquantifiable) costs.

Viable path: Maximisation of demand (revenue) with rationalisation of expenditure (supply)

What is the solution? Health care reform is essentially a professional issue to be resolved not be economists, but through the "labour" of physicians. The financing of the health economy, however, is an economic and social policy issue, which can and should not be resolved without knowledge and consideration of the whole of public finances. Even so, it is good news that Hungary has won some time; on the basis of published preliminary data, the OEP budget closed with a moderate surplus in 2007.

A solid OEP, operating within strict budgetary limits, is the most viable means of **maximising revenues**. In other words, the fund should be strictly capped from above, i.e. expenditures should not exceed revenues, because funds are not available for financing extra expenditures due to commitments undertaken in the convergence programme. This is easiest to achieve if in addition to employees, other members of the population (under the age of 18, pensioners, the unemployed, dependants) would pay a higher fixed amount of health contribution to the OEP. An increase of the ratio of the fixed, tax-type amount of citizens' mandatory contribution within the OEP fund is justified by the fact that Hungary has a high rate of concealed wages, i.e. contribution payments relating to wages have not covered public burdens for years.

Simple mental arithmetic produces the sum of 12,000 HUF/capita/month, which would cover the complete revenues of the OEP for the year 2008 (the fund is planning to collect HUF 1,437.9 billion), making reliance on other funds unnecessary. The state's power to assume the payment of the fixed amount on behalf of a designated group is reasonable and should be upheld (the current sum is HUF 4,350/month based on living conditions and age groups regulated by law). The annual indexing of the fixed amount and its method should be regulated in advance (inflation-proportionate OEP expenditures are continuously increasing!). For example, an annual increase of HUF 300 is required until the annual consumer price index exceeds 5% (obviously, both figures can be modified).

The wage-proportionate contribution obligation paid for employees would remain in place alongside the fixed amount of health contribution, but it could be less than the current percentage rate on the basis of the surplus fixed revenues of the OEP. It is open to debate whether the employer and/or employee should pay such contribution. The answer also depends on whether grossing up is implemented in personal income tax within the framework of future tax reform.

Once the revenue side of the restructured OEP becomes stable (all parties involved duly fulfil their contribution and tax payment obligations by a fixed date, in respect of all periods), moving forward with health insurance reform can be considered. Within a few years, the creation of private health funds operating according to the principle of insurance would be possible, where members would be offered a choice of curative and complementary services in parallel with continued payment of the fixed contribution to the OEP. The range of services covered by insurance policies concluded with commercial insurance companies, allowing the termination of the wage-proportionate contribution payment obligation of the policy holder vis-à-vis the OEP, is yet to be determined. If the decrease in payments resulting from a

decline in demand for OEP services and the loss of wage-proportionate contribution payments is proportionate, the policy holder may also receive services financed by the OEP, regulated by law in advance, without placing an unreasonable burden on the OEP fund. (Such duality exists today: In addition to paying OEP contributions, the employer may also buy separate health services for employees, which carries the possibility of a private health fund in respect of workplace (group) risk management.)

This means that the OEP would continue to be financed by the entire population, but the wage-proportionate payment – at the discretion of the employee – could be either paid to a private health fund or to the OEP. This would not lead to a "poor and rich" insurance fund because the entire population would also make OEP payments. The voluntary health fund, providing a savings plan (Anglo-American equivalent: MSA or medical savings account), would complement the services provided by the two institutions.

Under **commercial sickness insurance**, a product is essentially offered – subject to a prior assessment of risks – only for unforeseeable events. By using a concrete example for illustration purposes, a customer who was told by doctors that he needs hip implant surgery in one year, for example, is not desirable for an insurance company. A customer is desirable, however, if implant surgery is unforeseeable (due to an accident or the deterioration of his health condition). Unforeseeable changes to a person's health condition (i.e. unidentified sickness during risk assessment) constitutes an unforeseeable risk, that is, a risk for which the insurer can develop products. The imagination of product developers and the risk tolerance of the insurance company determines whether it chooses to offer a sickness insurance product to complement possibly every service financed by the OEP.

The **voluntary health fund** manages the individual accounts of members relating to personal and employer's payments made on behalf of members, interest on accumulating money, and the fees of received services. It provides services only through contracted service providers. The member knows that the amounts paid to the health fund may only be spent on his/her own and the family's health. Accordingly, the member may spend on health services allowed by law for up to amounts paid by him/her.

It also follows from the nature of the health fund and sickness insurance that one can buy services / products not financed or only partly financed by the OEP from both institutions. The individual can freely decide whether to finance amounts not financed by the OEP either with his/her savings, i.e. through the voluntary health fund, or on the basis of the insurance policy concluded according to a preliminary risk assessment, which does not exclude a given service provider from providing the relevant service.

The **rationalisation of supply (operation of the OEP and financing of expenditures)** requires changes on several levels. Focal points:

1. The OEP should be freed from social-welfare duties not closely linked to health care (e.g. financing of retirement benefits under retirement age (the disabled) or expenditures related to child parenting through the fund).
2. The state is presumably partly fulfilling social duties by making payments of non-means-tested sick pay, which amounted to HUF 107.6 billion in 2007, equalling 6.4% of the OEP's total expenditures. We are all familiar with cases of people evading unemployment by seeking sick pay, but we are yet to hear about cases in which the strict OEP inspector screens the free-riders and sends them back to work.
3. The public employee status of health care workers does not allow the differentiation of workers based on their duties and performance.

4. A key issue is control of health care institutions by the OEP. Beyond the control of service providers by the ÁNTSZ (National Public Health and Medical Officer Service) relating to the fulfilment of professional-personnel requirements of provided services, control by the OEP – in its capacity of insurer – is also essential. It is possible that the number of physician-patient meetings, multiple times higher than the European average and considered to be a starting point of reform, is excessively high without effective control.
5. The local governments, as owners, are faced with remedying a deficiency that is at least as important, with the need to start carrying out checks of what is actually going on in the hospitals and medical practices they own. It's time to disperse rumours about the 30-40% (!) ratio of private patients in institutions exclusively owned by local governments and financed by the OEP, who pay the fees of treatment not to the owner local government/state body.
6. Long-term care – introduced as the fifth branch of social insurance in more developed European countries – does not even appear on a conceptual level in Hungary. A separate institutional form has not evolved – voluntary health funds could carry out this function as well.

Epilogue

It seems that the WHO devised a perpetual rule. Our individual health condition is not only determined, to a lesser extent (20%), by the current condition of the health care system, and, to a greater extent (80%), by living conditions, it seems that this rule can also be applied to the health care system itself. The performance of the Hungarian health care system is to a greater extent determined by the country's economic potential and social prospects than by its functioning as a subsidiary system of public finances. This holds true even if the WHO's finding – in harmony with the Pareto principle – seems to be slowly changing. A publication of the EU (The Contribution of Health to the Economy in the European Union, 2007) observes that "healthcare interventions have had a substantial effect on the decline in mortality, especially over the past 30 years".

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