Health insurance reform in the Netherlands and in Hungary - a comparative analysis

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Introduction

The paper concerns analyzing the similarities and differences between the current reform in the field of health insurance system in Hungary and in the Netherlands. The Hungarian health care system started a far-reaching program of modernization in 2006. One of the cornerstones of the program is the reform of health insurance. This is on the political agenda for 2007 and it is a highly delicate issue. The transition of the healthcare insurance system in the Netherlands recently, attracted the attention of the Hungarian government, since the Dutch model is regarded as a potential blueprint for Hungary[1].

The main aim of this paper is to point out the most important aspects of the reforms relating to efficiency, equity and sustainability. These values might contradict each other or at least trade-offs can emerge between them (Stone, 2002[2]). The paper also takes into consideration the different historical paths of the countries involved as a deterministic variable of the current situation. Moreover, the paper aims to enlighten the most important hindering and supporting features of the reform in Hungary.

The research question of this paper is: **"What lessons might Hungary learn from The Netherlands with respect reforming in the health insurance system?"**

The experience in The Netherlands with the new Health Insurance System, since it was implemented by the Dutch Government in January 1st 2006, may help Hungary to deal with similar problems. These main problems are the followings:

- sharp rise in costs and growing pressure on health budget caused by technological advances; (Weisbrod, 1991)[3]
- aging population;
- illusion of free health care; (Kornai, 1997)[4]
- internal system resistance against reforms;
- lack of transparency and individual responsibility;
- trade-offs, for instance between efficiency and equity.

[1] http://www.minvws.nl/en/nieuwsberichten/z/2007/dutch-healthcare-system-an-example-for-hungary.asp downloaded: 03. 04. 2007.
[2] Stone, D. 2002, "Policy paradox: The art of political decision making" Norton and company, London pp.80-85.
[3] Weisbrod, B.A., 1991. "The health care quadrilemma: an essay on technological change, insurance, quality of care, and cost containment," Journal of Economic Literature, Vol. 29, pp. 523-552.
[4] Kornai, J 1997, The Transition from Socialism, The Reform of the Wefare State and Public Opinion in: American Economic Review Vol. 87, No. 2. 1997.

These problems exist not only in Hungary but also in The Netherlands. However, the severity and level of these problems are diverse in the two countries. The analysis of the problems will be elaborated further on.

The distinction between the health insurance system and the health care system as a whole has to be made. Basically, the paper focuses on the health insurance system further on. However, the health insurance is only a part of the health care system and certain relevant aspects of the health care system as a whole has to be taken into account as well.

The paper will mainly use two approaches to analyze the current situation.

The first approach analyzes both cases from an economic point of view by presenting the design of both systems. The most important financial and economical problems of the current Hungarian Health Care system will be represented. I will draw up a possible model for reforming the Hungarian health insurance system with the help of this economic approach. I will mainly focus on the framing of a new multi-insurance system, since the Hungarian government stated that the Dutch multi-insurance system can be a potential model for Hungary. However, the government takes more options into account. This paper also represents briefly different models of health insurance systems.

The second approach uses a public administration point of view. This approach will be more practical than the former one. In this sense, I will mainly try to start from general and theoretical and go toward practical and concrete. This deductive research method will be observed not only within the chapters but in the paper as a whole as well. However, as Grix (2004) puts the deductive-inductive dichotomy in real-life research is rather doubtful than a clear-cut. Moreover, in the case of Hungarian public administration this dichotomy raises a practical question as well, because the Hungarian governments in power often try to implement foreign models in Hungary due to a special "hold off status" of this Central-European country as the well-known Hungarian scholar Bibó (1948)[5] stated. This means that the models and policy initiatives that are working successfully in other countries often do not work in Hungary due to different social-economic conditions and that Hungary is always (at least) one step behind compare to its Western European counterparts.

The paper is a comparative research; however, due to the fact that the reform and its experiences in the Netherlands are fresh and the reform in Hungary is just in progress, the paper can not be seen as an 'orthodox' comparative research. The paper rather follows the idea of Rose (2005), namely, it tries to answer the question: how countries can learn from each other with respect to successes and failures of policy initiatives. The paper not only

[5] Bibó I. (1948). Eltorzult magyar alkat, zsákutcás magyar történelem. In: Válasz. 289-319.

focuses on the differences but tries to find out the lessons that can be used in Hungary following the Dutch experiences. However, these experiences are a bit too fresh and data are not available yet, I turn my attention to represent the new Dutch model and latest change in the Dutch health insurance system in 2006.

The outline of the paper will be the following. In the first chapter I will represent the theoretical background. The theoretical background of the paper is standing on three pillars. Beside the aforementioned book of Rose (2005), the thesis leans on the paper of Shleifer (1998) with respect to state versus private ownership. Shleifer's paper embodies and strengthens the economic approach of my paper, mainly dealing with questions that are related to economic terms including efficiency, innovation, improving quality and reducing costs. Third, a more public administrative approach by Kornai and Eggleston (2001) is strongly linked to values and trade-offs. Kornai and Eggleston give a suitable framework for constructing a prospective proportion of values with respect to a reformed health care sector in Central Europe. The trade-offs between different values are existing but with the help of the Kornai and Eggleston we can search for an appropriate solution for this problem in the field of health care. The two scholars also take into consideration the hindering conditions that can deter the policy initiative during the implementation phase.

In the second chapter the Dutch model will be described. I will put the Dutch health insurance system into a historical context, however, due to lack of space I will focus on the latest reform implemented in January 1st 2006. The most important features of the Dutch health care system can not be omitted, although, naturally, the health insurance will be analyzed more deeply. I will try to point out the relevant lessons from the Dutch case that can be used by Hungarian scholars or policymakers.

The third chapter will be devoted to the Hungarian reform proposal(s), including the description of the current system and the potential ways for reforming the system. After a short historical overview - what have happened so far – I will analyze the reform proposal of the government both from an economic and a public administration point of view. This chapter will be not only descriptive but also a critical analysis.

The critical analysis will be elaborated in the forth chapter by comparing the two cases. As I have already mentioned this comparison will not be traditional in that sense, that in one country (the Netherlands) a model is already functioning but in the other country (Hungary) the reform proposals are still under negotiations and social debates. Although this time bias will cause some methodological problems, namely, how to compare data, I will try to focus on the theoretical models with respect to the economic part of the paper. On the other

hand I try to use the real life experiences and political processes to analyze the cases from the public administration point of view.

In the conclusion I will emphasize once more what are the most important lessons for Hungary. What are the factors that can hinder the implementation of the new system in Hungary?

1. Theoretical background

In this chapter I will draw up the theoretical background of this paper. As I have already mentioned briefly the paper is mainly based on three theoretical pillars. From these papers the most important is the work of Rose (2005)[6] which gives the essential idea of this paper, namely, how to find useful *'lessons'* in a foreign country that can be adapted in our home national environment. The paper of Shleifer (1998)[7] is also a good starting point, since it gives us the possibility to analyze why *state-ownership* embodies hidden threats and risks. To see the complexity of the practical problem that exists in Hungary, Kornai and Eggleston's (2001)[8] work will be applied.

Furthermore, the definition of health insurance will be formulated and also a possible taxonomy of health insurance will be presented at the end of this chapter.

1.1. Lesson drawing from abroad (first pillar)

How can a country improve the successfulness of its public policies? How can policy makers come up with new programs? Mainly there are two ways, either they use the experiences from the past failures that have happened internally or they can gather information from abroad. Rose analyzes the latter case by coming up the term 'lesson'. According to Rose "a lesson is a distinctive type of program, it draws on foreign experience to propose a program that can deal with a problem confronting national policymakers in their home environment" (p.22.). He also states that a lesson "identifies the laws, appropriations, and personnel and organizational requirements needed for the program to be put into effect" (p.22). These are the most important pre-condition that must be fulfilled before implementing the program itself. On the other hand a lesson can also explain a failure of a program, whether the failure occurred due to "insufficient resources, political opposition, administrative difficulties, an unwillingness of citizens to cooperate or a basic flaw in the logic of the program" (p.24.).

[6] Rose, R. (2005): Learning from comparative public policy **:** a practical guide, London, Routlidge
[7] Shleifer, A. (1998): State versus private ownership, NBER working paper series, ISSN 0898-2937
[8] Kornai J. – Eggleston K.(2001): Choice and solidarity: The Health care sector reform in Eastern Europe and proposals for reform, In: International journal of health care finance and economics; vol. 1 (2001), afl. 1, pag. 59-84.

In the case of the Dutch and the Hungarian reform I have mentioned the time bias between the two reform processes. As Rose states, a lesson is "future-oriented and it *cannot* be evaluated empirically", and, "lesson is a bridge across time and space" (p.24.), hence the application of 'lesson-drawing' is appropriate in our case.

If a foreign lesson has been chosen policymakers must decide to what extent they want to apply that model. The application of a model is rather a public administrative question and has to be analyzed from a public administrative point of view. Rose distinguishes seven possible ways of drawing a lesson (p.81.). The alternatives are:

- *Photocopying*: exact photocopy
- *Copying*: duplicating all major elements
- *Adaptation*: altering some details without removing major elements
- *Hybrid*: combining elements or programs from different countries
- *Synthesis*: combining familiar element of programs with the same objectives
- *Disciplined inspiration*: creating a new program that is not inconsistent with a foreign example
- *Selective imitation*: adopting only attractive parts of other programs while leaving out essential elements

As we can see the lesson drawing goes from a total adaptation of a model (photocopying) to a selective cherry-picking of ideas (selective imitation). In the later phases of the paper I try to find out to what extent the Hungarian policymakers should look at the Dutch reform as a blueprint of the Hungarian health insurance reform. Whether photocopying or only a selective imitation or may be some other aforementioned option would be appropriate it depends on different factors.

For instance, path-dependence (see Pierson 2000[9]) can become a crucial factor during an important political decision process; hence past decisions can highly limits the possibilities of the decision makers in power. Due to this fact most fields of public policy is a 'brown field' area and there is a very small space for brand new initiatives. This is called a 'wicked context' problem by Rose (p.107.) Successfully applying a lesson needs resources, pre-conditions and arrangements. Legal framework, financial support, qualified personnel and new organizational structure are crucial variables of a potentially successful lesson learning (pp.108-110.). Even if these conditions exist there is no guarantee for success since other

[9] Pierson, Paul (2000). "Increasing Returns, Path Dependence, and the Study of Politics." American Political Science Review, June

factors can also influence the reform process such as political support and cultural beliefs (p.113.)

1.2. Cultural beliefs and values (second pillar)

Cultural beliefs and values are crucial declare Kornai and Eggleston (2001) as well. According to them the post-communist heritage in Central-Europe is harmful not just in economic sense but also in mental dimensions. Paternalism deprived the citizens from individual decision taking and from taking responsibilities to themselves. Kornai and Eggleston also underline the problems of the state monopoly and the lack of transparency of the former era. The values and beliefs were extremely influenced during the 'ancien regime' and this fact is cannot be ignored during the implementation of a new health (insurance) reform. However, different values have to be also presented by the new reform. Summarizing their proposals see the table below:

Table 1. [10]

1. **Individual sovereignty**: the transformation must increase the extent of decision taken by individual and reduce the extent of the state.
2. **Solidarity**: help the suffering and the disadvantaged.
3. **Competition**: There should not be a monopoly of state ownership and control. Let competition between different ownership forms and coordination mechanisms.
4. **Incentive**: Forms of ownership and control that encourage efficiency need to emerge.
5**. New role of the state**: The state's main functions should be the followings: to supply legal framework, supervise non-state organizations, and provide last-resort insurance and aid. The state take the responsibility to all citizens obtain basic education and health care.
6. **Transparency**: The linkage between welfare services and the tax burden must become transparent to citizens.
7. **Time need of the program**: Time must be left for the new institutions of the welfare sector to develop and for the citizens to familiarize themselves.
8. **Harmonious development**: Harmonious proportions between growth producing investments in the economy and resources used in the welfare sector have to be managed.
9. **Sustainable financing**: The state budget must be capable of financing the state's obligation persistently.

[10] Source: Kornai and Eggleston, 2001, pp.22-40.

As we can see trade-offs can be easily detected between the different values. For instance the trade-off between the first (individual sovereignty) and the fifth (basic state responsibility) principle is one of the main ambiguities in our case. Enhancing individual responsibility may need a total reconsideration of the role of the state, even more radically than Kornai and Eggleston suggest. As we can see the values involved can be both related to economics (competition, financial sustainability, transparency, incentives) and also to public administration (individual sovereignty, time need of the program to be implemented). All principles are very remarkable, but now I would like to highlight the forth principle, the "Incentive". This leads to the third main theoretical pillar of my thesis, namely to the dissimilarities between state and private ownership compared by Shleifer (1998).

1.3. State versus private ownership (third pillar)

Shliefer (1998) turns our attention towards the threats of state ownership, although he also admits the existence of market failures. He summarizes the most important problems what - even a benevolent government leaded - country might face. Due to lack of 'perfect contracting' "government cannot fully anticipate, describe, stipulate, regulate and enforce exactly what it wants" (p.137.). Although, 'imperfect contracting' conditions alone would not been a state failure, since this is also the case in the private sector as well. The difference lies in the ownership; hence the ownership gives "the owner control and bargaining power in situations where contracts do not specify what has to be done". While focusing on both cost-efficiency and service quality; there are two types of investment incentive: either reducing cost or innovate. According to Shleifer government ownership is likely to be superior in some cases. These cases are when (p.140.):

- there is a high possibility for cost reductions that lead to significant deterioration of non-contractible quality
- innovation is (relatively) unimportant
- competition is weak and consumer choice is ineffective
- reputation mechanisms are weak

On the other hand private ownership performs better than state-owned property if:

- there is a low possibility for cost reductions that lead to significant deterioration of non-contractible quality
- innovation is important

- competition is strong and consumer choice effective
- reputation mechanisms are strong

Incentives with respect to private ownership are more adequate to fulfill consumers' needs. Profit-orientation and hard budget constraint lead to more prudent financial actions and higher cost-consciousness.

In the following chapters of the thesis I will analyze whether these factors really exists or not in the field of health insurance.

Summarizing this chapter of my paper so far, I have presented the three theoretical pillars of my thesis. These pillars were once again:

- How to draw a lesson from a foreign case (Rose, 2005)
- Cultural beliefs and values (Kornai and Eggleston, 2001)
- State versus private ownership (Shleifer, 1998)

I also tried to present how these pillars can linked with the two applied approaches (economics and public administration). While the book of Rose will strengthen mainly the public administration aspect, the paper of Shliefer will back up the economic point of view of the thesis. Kornai and Eggleston's work can be linked to both approaches.

1.4. Definition of health insurance systems

In this section I will define the term health insurance system.

A health insurance system is a "system for the advance financing of medical expenses through contributions or taxes paid into a common fund to pay for all or part of health services specified in an insurance policy or law. The key elements are advance payment of premiums or taxes, pooling of funds, and eligibility for benefits on the basis of contributions or employment without an income or assets test. (…) Private health insurance is organized and administered by an insurance company or other private agency; public health insurance is run by the government."[11] As the definition declares there are various forms of health insurance system depending on the difference of the financial forms and ownership or number of insurance companies involved for instance.

Major differences can be distinguished between a single-payer health care system and a multiple-payer health care system. In a single-payer health care a single government entity

[11] Britannica Concise Encyclopedia, downloaded from: http://www.answers.com/topic/health-insurance 10.05.2007.

pays for all health care costs, usually from taxes and the usually for the entire population. On the other hand the multiple-payer health care system has several (either private or state-owned but rather private) organizations that collect and pool revenues and purchases health services for specific segments of the population[12].

In the next part I will describe a possible taxonomy of the health insurance system.

1.5. Health insurance taxonomy

Four main criteria for classifying health insurance models can be distinguished according to an OECD study[13] (p.2.):

- Sources of financing (i)
- Level of compulsion of the scheme (ii)
- Group or individual schemes (iii)
- Method of premium calculation in health insurance (iv)

According to the study if we look at the sources of financing (i) on one hand **public health insurance** embraces

- *tax-based* public health insurance;
- and *social security* schemes.

On the other hand **private health insurance** systems are financed through private premiums, including:

- private mandatory health insurance;
- private employment group health insurance;
- private community-rated health insurance;
- private risk-rated health insurance.

With respect to level of compulsion on participation (ii) to the system the study determines four different types of possibility:

- Mandatory participation in a single insurance scheme;
- Mandatory participation in a health insurance scheme, but a given freedom to choose between alternative carriers or schemes;

[12] Anderson G.F. and Hussey P.: Health, Nutrition and Population (HNP) Discussion Paper Special Issues with Single-payer Health Insurance Systems, 2004.
[13] Proposals for a taxonomy of health insurance, OECD Study on Private Health Insurance, June 2004

- Involvement by the conditions of employment;
- Involvement completely voluntary.

Insurers can calculate premiums (iv) in three ways mainly. These premiums are the:

- Income-related premiums;
- Community rated premiums;
- Risk-related premiums

This taxonomy will be a great help later on to define and to compare the different kind of health insurance systems in both countries.

2. Description of the Dutch Health Insurance System

In this chapter the Dutch health care system will be described. The focus will be on the reform implemented in the Netherlands 1st of January 2006. Hence, the pre-reform situation and the post-reform status of the Dutch insurance system will be presented both from an economic and a public administration point of view. However, for the better understanding of evolution of the current reform a short historical overview is inevitable to be portrayed. In addition, relevant Dutch morbidity and mortality data will be represented as indicators of the Dutch health care systems.

2.1. Short historical overview of the evolution of the Dutch health care system[14]

The Netherlands has an extended tradition of health care including voluntary organizations at local and regional level. Churches, monasteries, guilds were the early predecessors of modern hospitals. These organizations had roots that date back to the Middle Ages. The medieval guilds offered their members financial support in the event of sickness, accident or death. Local communities, monasteries, convents and churches offered shelter to the elderly, homeless and others who could not look after themselves. They played an enormous role both in health care and in social care as well at the same time.

The great majority of the hospitals and other institutions in the Netherlands have been owned or run by not-for-profit private organizations. This tradition of private ownership has not been overturned, as it was in the former Soviet block in Central-Europe including Hungary, through the nationalization of health care in the middle of the XX.th century.

As each country has its own history which to a certain extent has an influence on policy making in the present, the Netherlands also has three main cultural and historical factors that has an influence on policy making. These factors are the followings:

- the predominantly private nature of the supply;
- the mix of public and private finance;
- the Dutch consultative procedure.

As I have already highlighted the private sector played and is still playing a crucial role in the health care and also in health insurance. The government only started to become more involved in health insurance on a major scale around the Second World War. The government

[14] Health Insurance in the Netherlands, Ministry of Health Welfare and Sports, 2004.

created the Health Insurance Decree in 1941 which has been followed by the Health Insurance Act (Zfv[15]) in 1964. Under German influence this Health Insurance Decree was the first legislation when the health "insurance market was divided into three sub-markets: (1) a compulsory social health insurance scheme for employed people (and their families), (2) a voluntary social health insurance for self-employed people and (3) private health insurance for the rest of the population" (p.9.)[16].

The Exceptional Medical Expenses Act[17] (AWBZ) has been enacted in 1968. The act provides help "for the considerable financial consequences serious long-term sicknesses or disorders, in particular the cost of caring for disabled people with severe congenital physical or mental disorders and psychiatric patients requiring long-term nursing and care"[18] (p. 16.) The insurance with respect to AWBZ is statutory, all residents who fulfill the criteria written in the legislation is automatically insured and accordingly obliged to pay the statutory contribution. Several modifications and amendment were taken place during the years. From 2000 the AWBZ has become voluntary. In this chapter I will further elaborate the role of AWBZ in the Dutch insurance system.

The Health Insurance Act (Zfw) fully came into power in 1966. Zfw covers acute/general medical care insurance. Like in the case of AWBZ, Zfw is also statutory and all people who meet certain criteria will be automatically insured and obliged to pay a given contribution. There is an opt-out alternative, if somebody refuses to pay a contribution he or she can pay an additional tax instead, although doesn't get care for this.

Beside AWBZ and Zfw other supplementary insurances were available for contracting. For instance, some 93 percent of those who insured under Zfw funds in 1999 and 2000 participated in supplementary insurance[19]. For supplementary insurance there were no obligations.

This complex three compartments system of the health care (AWBZ, Zfv, and other forms of insurances that are not in the first two compartments) has been changed after several years of negotiations in 2006. The new Dutch health care system will be presented later on in this chapter.

[15] Ziekenfondswet, Zfv
[16] Busse, R.; Doljsak, M.; Exter, A.; Helmans, H. (2004): Health Care Systems in transition, Netherlands
[17] Algemene Wet Bijzondere Ziektekosten, AWBZ
[18] Health Insurance in the Netherlands, Ministry of Health Welfare and Sports, 2004.
[19] Reinhard Busse, 'The Netherlands', in Anna Dixon and Elias Mossialos, *Health Care Systems in Eight Countries: Trends and Challenges,* London, 2002. p.62.

2.2. Statistical overlook of the most important Dutch mortality and morbidity rates

In this part I will briefly illustrate the most important data on mortality and morbidity rates in the Netherlands. These figures will represent the current health status of the Dutch citizens.

The Netherlands disposes of quite reasonable figures with respect to health status. Life expectancy both related to females and males were 81.4 years and 76.9 years respectively in 2004[20]. Although, these figures are not the best in Europe (Nordic countries have even better mortality rates) but compare to the new member states the Netherlands still has a big advantage.

Infant mortality is 0.41%[21] which is just slightly better than the OECD average (0.43% without Mexico and Turkey). However, the Netherlands already had relatively good infant mortality rates a few decades ago. (Only Iceland and Sweden had better figures than the Netherlands in 1960, for instance.)

If we look at the diseases of the respiratory system, the Netherlands produces surprisingly bad figures. 59.7[22] death cases per 100,000 inhabitants is the worst (!) statistics among available OECD data in 2003. The figure related to diseases of the respiratory system of women is also the worst (44.4 death cases per 100,000 inhabitants), even worse than the figures of the Central-European countries.

The diseases of the respiratory system can be originated in the significant usage of different kind of tobaccos. The 32%[23] of the total population is a daily smoker. This also puts the Netherlands into an 'exclusive' position in an international comparison.

Summarizing this part we can conclude that the citizens of the Netherlands have relatively good health conditions. Only Nordic countries have better figures with respect to life expectancy. However, if we look at the morbidity data we can say that in some field the

[20] OECD Health Data 2006
http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html
[21] OECD Health Data 2006
http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html
[22] OECD Health Data 2006
http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html
[23] OECD Health Data 2006
http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html

Netherlands has some lags. For instance, diseases related to the failure of the respiratory system remains a big, probably one of the biggest problem in the country.

2.3. The structure of the Dutch Health Insurance System before the reform

In this part I will describe the Dutch health insurance system before the reform. The old system based on three compartments. These compartments will be described and also analyzed from an economic and also from a public administration point of view.

As I have already mentioned the former Dutch health insurance system can be divided into three compartments. These compartments are:

- the AWBZ
- the Zfw, WTZ, Civil servant scheme and Private insurance
- other Supplementary private insurance

2.3.1. The first compartment, the AWBZ.

The AWBZ was created in order to allow all Dutch citizens to possess health insurance against severe health risks. AWBZ is a national insurance, which means that all inhabitants of the Netherlands participate compulsorily. Everyone who is legally residing in the Netherlands and also non-residents who are employed - and therefore liable for payroll tax - in the Netherlands are insured.

AWBZ is based upon the idea of solidarity and risk-sharing at a national level with respect to serious medical risks. Individuals may not bear these uninsurable risks such as for handicapped people but the national community can. The AWBZ is funded by income-related contributions, general taxation and other social insurance contributions. It means that the value of 'solidarity' also takes place in the funding as well. There are no co-payments for long-term or chronic care except for certain hotel-type expenses for better care. The government sets the premium level annually. In 2000, it was 10.25 per cent of the first taxable income bracket of €22000[24]. These premiums are levied in the same way as income tax. The government pays on behalf of the unemployed and those without independent taxable income. Residents in paid employment have their contributions levied at source by their employers, who pay the money to the tax authorities. Residents who are not in paid employment but are

[24]Towards a sound system of medical insurance? Consumer driven healthcare reform in the Netherlands: The relaxation of supplyside restrictions and greater role of market forces. (2002)

liable to pay income tax and social insurance contributions receive tax assessments and they pay their contributions directly to the tax authorities. Insured persons below age 15 and those older than 15 without their own taxable income do not owe any premiums[25].

Six different kinds of entitlements have been defined in terms of functions under AWBZ. These entitlements are the followings:

- Personal care
- Nursing
- Supportive guidance
- Activating guidance
- Treatment
- Accommodation

In practice, functionally defined care is provided in the form of 'products'. A product can consist of one or more functionally defined forms of care. These products can be carried out for the entitled patients.

Looking at the funding of the AWBZ and the taxonomy of health insurance (see part 1.5.) at the same time, we can conclude that AWBZ is

(i) with respect to resources: a public based sources, mainly tax-based

(ii) with respect to participation: mandatory

(iii) group or individual schemes: national risk community

(iv) with respect of calculating premiums: income-calculated and community-calculated (no premium below age 15 and those older than 15 without their own taxable income)

Summarizing the first compartment we can say that this was a national health insurance scheme for exceptional medical expenses. Obligatory for the entire population and strongly regulated by the government via premium setting and controlled by other laws and mechnisms such as quality control.

2.3.2. The second compartment

The second compartment consist of four sections: Zfw, Civil servants scheme, Private insurance, WTZ. This compartment mainly covers acute and general medical care insurance.

According to Ministry's data approximately 64 per cent of the population was covered with Social Insurance (Zfw). This proportion (two thirds of the population) remained stable

[25] http://www.minvws.nl/en/themes/exceptional-medical-expenses-act/

during the years. Zfw coverage was mandatory for residents earning less than a certain income threshold, which has been set at €32600 in 2004. Zfw also covered residents over-65 with an annual pension less than a certain threshold; partner and children of the insured; the unemployed and self-employed with low earnings.

The premiums that were mainly income-based set annually by the government. Employees paid 1.25 per cent and employers paid 6.75 per cent in 2000. Financial resources were managed by the College Voor Zorgversekeringen[26] (CVZ). Considering a complex risk-adjustment method, the CVZ paid allocated budgets to the insurance funds from its General Treasury. The funds were only given 90 *per cent* of their costs – providing an incentive towards efficiency. The remaining income required was made up by charging all members of the fund a flat-rate 'per-capita premium'- regardless of risk. Due to the fact that funds could charge different amount this was a clear incentive to keep this premium as low as possible in order to attract as many customers as possible. The average flat-rate was €188 per annum in 2000[27].

The patients had a freedom of choice from several non-profit insurance funds. The insurers had an obligation to accept all suitable applicants. All insurers had to provide a given standard of health insurance policy including a package of medical care benefits. This customers' freedom of choice from several insurance fund packages indeed was already a significant value of the former Dutch health insurance system (see Kornai-Eggleston first principle, *individual sovereignty*)

Talking about values, at the supply side patients also had a choice of provider as well. However, the supply side of health care itself has been regulated centrally. All providers must have applied for permission to provide health care services. Every provider must have contracted every insurer. The government had the potential to determine the charges of the care, and maximums were being set annually. The GPs got an annual fixed amount after every insured person.

The Civil Servant Scheme was a compulsory civil service package which was very similar to Zfw but with a broader range of services, dental care for instance.

The private substitutive insurance was purchased voluntarily by 31 percent of the population in the 2nd compartment cover. These insured people generally paid for medical treatment on a fee-for-service basis and received a rebate from sickness funds. This

[26] College Voor Zorgversekeringen, in English: Health Care Insurance Board
[27]Towards a sound system of medical insurance? Consumer driven healthcare reform in the Netherlands: The relaxation of supply side restrictions and greater role of market forces. (2002)

phenomenon raised the cost-awareness of the citizens. Moreover, this method made the system more transparent in that sense that people could recognize how much did different services cost. Private insurance premiums were risk-related and insurers did not have the obligation to contract with everybody.

The WTZ scheme enabled people with high risk (elderly for instance) who were excluded from the Zfw system, and also refused private substitutive insurance to take part in the system. These clients received a 'standard policy' with regulated premiums and benefits determined by the central government.

2.3.3. The third compartment

The 3rd compartment provided supplementary private insurance including medical services that were not covered neither by Zfw, nor by AWBZ. These services could be plastic surgery, higher level dental care, alternatives medicine treatments for instance. The data regarding private insurance was not always available due to business secret. However, as I already mentioned (p. 12) approximately 93 percent of the people who were insured under Zfw funds took out supplementary insurance in 1999 to 2000. The government played only a regulator role in this compartment. The role of the government was very small and the private ownership and private incentives were very strong, however only 3 percent of the total health expenditure were accounted with respect to this 3rd compartment[28].

These supplementary insurances were based on a contract negotiated between the insurer and the insured. The insurer accepted to bear the risk meanwhile the client paid a premium. The amount of the premium was highly related to the health status, health history etc. of the insured. All conditions, circumstances were free to negotiate between the parties and no government influence was present. Hence, insurers were not obliged to sign contract with every potential client. Only one exception existed, namely the Wtz[29] that declares that an insurer can not refuse to insure someone who satisfies given conditions and who wishes to buy a "standard package policy".

According to the taxonomy of health insurance (see part 1.5. again) these supplementary insurances were

(i) with respect to resources: private based sources

(ii) with respect to participation: voluntary

[28] Towards a sound system of medical insurance? Consumer driven healthcare reform in the Netherlands: The relaxation of supply side restrictions and greater role of market forces. (2002)
[29] Wtz: Medical Insurance Access Act , enacted in 1988

(iii) group or individual schemes: individual

(iv) with respect of calculating premiums: risk-related premiums

It means that with respect to the 3rd compartment the idea of *competition* was the main "coordinating mechanism" (Kornai-Eggleston p.28.). This means that the insurance companies were competing for clients by lowering premiums and offering better services than their rivals. Both parties, insurers and clients took part in the system voluntarily which means that if they had participated they would have had the incentives for participation. On one hand the profit incentive, on the other hand the demand for better health services. The contracts were based on individual premiums which were determined by individual risks. This meant discriminatory pricing from the insurers' side; hence insurance companies could obtain the whole consumer surplus and raised their profit. However due to competition and voluntary participation clients also benefited from this supplementary market, since they had the opportunity to buy better health services if they were willing to and were able to afford it.

Summarizing the former system of the Dutch health insurance we can say that it was a very complex and compound system. Three compartments with different organizational structures, objectives, values which ended up in an overcomplicated system of health insurance. The first compartment (AWBZ) was representing an insurance scheme for long-term health risks by assuring that every resident in the Netherlands had a health insurance. The value of solidarity was predominating in this compartment over other values like economic efficiency for instance. Approximately 38% of the health care expenditures could be link to AWBZ.

The second compartment was already complex in itself. The Zfw, the WTZ, the Civil servant scheme and the Private insurance covered the 59% of the health care expenditures. This compartment covered acute care via income-related premium and an additional flat-rate premium. This scheme was also centrally controlled and regulated. However, the substitutive private insurance in the 2nd compartment also existed which increased the citizens freedom of choice between insurers.

The third compartment, the supplementary private insurance, completely represented the idea of individual responsibility. The role of the state was the lowest in this compartment. Market mechanisms coordinated this sector meanwhile the government was only responsible for the control of the quality of the services.

2.4. What were the most important problems and failures of the former system? Why was the reform inevitable?

The functioning of the former system was quite reasonable. Both solidarity and efficiency showed up to a certain extent. On one hand solidarity could be mainly linked to AWBZ and Zfw, on the other hand efficiency appeared with respect to the contracts of supplementary private insurances. However, the system was complex and became too complicated as well.

As several SER[30] report had stated[31], numerous problems could be observed with respect of the former Dutch health insurance system. These problems were the followings:

- The system had too many aims at the same time (health care, income redistribution, welfare policy, long-term care, housing, home care).
- Complicated system involved complicated and inefficient bureaucracy and red tape.
- Freedom of choice was limited.
- This lack of choice influenced (decreased) the quality of services because health care providers did not have the incentive to improve their services.
- The system was divisive and inequalities were also presented in the Netherlands.
- Unfair premium and income effect appeared.
- Increasing costs were aggravated by inefficiency.
- No actor who had the incentive to restrict cost

First of all the former system indeed tried to take into account several aims. Income redistribution should not be the primary goal of a health insurance system. However, considering the differences between income groups by income-related premiums does not indicate significant income redistribution. This is more like a sign that the given health insurance system is solidarity sensitive and tries to avoid regressive contributions. This premium setting up also had an effect on the welfare policy as well.

Inequalities also affected the system. Different income groups were treated differently and some of these groups were obliged to take part in given sector(s) of the health insurance. For instance, residents earning below a given threshold had to be covered by the Zfw. This meant that the system was divisive and citizens were not treated equally by the law but

[30] SER, Sociaal-Economische Raad, In English: Social and Economic Council
[31] SER, Towards a sound system of medical insurance (2001)

discriminated by the classification of income groups. These inequalities were also perceptible at the health care providers during the treatment which was totally unacceptable.

The freedom of choice was limited. Although patients were able to choose between insurance companies but due to uniform supply patients' choice couldn't be efficient. Furthermore, this uniform supply hindered the providers to become more and more innovative. Only the market of supplementary private insurances enabled the clients to choose freely from different proposals of the insurance companies. However, in this market the insurers had the opportunity to turn down the request of the patient for contracting. Insurers were allowed cherry-picking and ignored 'risky' patients with simply not contracting with them.

On one hand the role of the state was very decisive and influential. Due to the complexity of the funding, government was involved in the money flow several times. These governmental financial involvements included: setting up premiums (both flat-rate and income-related) and other contributions (such as taxes), care subsidies and tax rebates etc. Pricing, capacity and supply planning was also highly influential part of the government role with respect to health care provision. Although, the private sector already played a huge role in the health sector the government arranged almost everything. This meant an overregulated health insurance sector with lots of directives and rules that made the system inflexible. For instance, it was very hard to change insurer due to compulsory participation in a public law scheme or because of mandatory collective contracts.

On the other hand private ownership and the private actors were already very significant as well. Most physicians were working as private entrepreneurs and hospitals were mainly private, non-profit foundations. Besides the different kind of health insurance schemes with different premium structures, an unregulated competitive market for private insurance existed. Due to the fact that this market was unregulated several negative effects emerged, such as cherry-picking from patients, excluding risky clients etc. However, the only incentive to promote cost-awareness and efficiency emerged with respect to these private insurances. Thus, the final evaluation of this unregulated private health insurance scheme is ambiguous. The advantages of private ownership (as Shliefer stated) had been manifested, the incentive to take costs more seriously and try to offer better services were also presented.

Summarizing this part we can conclude that the previous health insurance system was operable. However, the complexity and the extensity of the system called for changes. Changes were needed not just because of complexity but due to inequalities and the lack of freedom as well. Moreover, due to complexity bureaucracy grew too big which raised cost

that were already far too high. These costs with respect to total health care expenses were increased by the fact that there were no actors who had incentives to limit health care outlays.

2.5. The new health insurance system in the Netherlands since 2006

In this part I describe the structure of the new health insurance system. I will highlight the most important changes from both economic and public administration point of view. Due to the fact that the new system was only implemented in 2006 I have to deal with the lack of data. Thus, I will rather focus on the structure of the system and the expectations beforehand of the reform.

2.5.1. Prelude of the reform

Before implementing the reform on the 1st January 2006 the reform procedure towards a more market-oriented health insurance begun in 1986 by setting up the Dekker-committee. The two key elements of the proposed system were compulsory health insurance for the whole population and regulated competition. These reforms can be characterized as "a transition from government regulated cartels to government competition among insurers as well as among providers care"[32]. In the early 90's the reform continued with the Simons plan that had almost the same aims like the Dekker-committee had proposed, namely a combination of national health insurance and regulated competition. Since 1989 a step-by-step implementations of the reforms can be observed. This step-by-step process has paved the road to the implementation of the new health insurance system.

But what is the reason for the slowness of the reform process? According to a report[33] four major factors can be distinguished as a possible reform hindering reason.

First, powerful interest groups who are able to evolve influential lobby activity can hinder the process by protesting against changing. The most important stakeholders in our cases are the organizations of physicians, health insurers, health care providers, employers, employees and patients. For instance every stakeholder group opposed the Simons plan because of different reasons[34]. The government must have the support of the majority of the

[32] van de Ven, W.P.M.M. and Schut, F.T.: The first decade of market oriented health care reforms in the Netherlands, p.2.
[33] Busse, R.; Doljsak, M.; Exter, A.; Helmans, H. (2004): Health Care Systems in transition, Netherlands
[34] e.g.: "Employers opposed the Simons Plan because they were afraid that the government would pay more attention to compulsory health insurance with a broad benefits package (which would increase total health care costs because of moral hazard) than to cost containment and improving efficiency." or „Insurers opposed the

main stakeholder groups otherwise it's hard to implement the changes. Especially in such a country like the Netherlands where there is a long tradition of consensus building and the power of the central government is limited due to high level of decentralization and several power-sharing mechanisms.

Second, political support is also vital for such big changes that have effect on the whole society. Without minimum political support a new government might turn back the entire reform process[35]. In the Dutch case the two key elements complement each other in that sense that a compulsory health insurance that covers the whole population is attractive for the political left-wing, and regulated competition is attractive for the political right-wing. However, both sides have to give up a part of their conceptions and ideas in order to reach political consensus.

Third, there was no quick need for the reform. As I have already stated the former system was operable and more or less sustainable as well. However, the system was suffering from several aforementioned failures and problems. This step-by-step reform process and this slow preparation for the most important change that was implemented in 2006 were suitable. There were no need for constrained reform and there were no pressure on the policy makers coming from given stakeholders.

The forth problem was the implementation of the reform proposals. The public administration was not prepared for such huge changes. Discrepancy and inconsistency arose with respect to old and new regulations. EU regulations just made the legal background even more complicated. Other Dutch regulations also had to become consistent with the new health care reform, such as anti-trust policy in the health care or regulation that prevents cream skimming in a competitive health insurance market.

However, after more than a decade of negotiations and discussions and step-by-step law adjustments the new health insurance system has been implemented in January 2006.

2.5.2. The most important features of the new health insurance system

The new health insurance system that was implemented in January 2006 was a logical link in the reform processes that had begun with the setting up of the Dekker-committee. The main aim of the whole reform process was to transform the Dutch system from a supply-

Simons Plan because they strongly opposed a system of risk-adjusted premium subsidies from the Central Fund and other government regulation that reduces their entrepreneurial freedom." (p. 123.)

[35] Like we can see in Slovakia, where the new Fico government has the intention to turn back the health insurance reform what was implemented just one year ago in 2006.

driven model to a demand-driven model. As a SER report[36] puts: "[SER]…advises gradually replacing the present system of supply, price and budget management [with] a demand-driven, competitive, open market system". And furthermore "Consumer and patient demand for care must be the basic principle underlying all policy. Insured parties should (…) be given a real choice when it comes to selecting a health care insurer, a policy and a care provider" This concept as a whole is perfectly in line with Kornai-Eggleston's recommendation, more precisely with their first principle (individual sovereignty).

I will briefly summarize what are the most important changes and what are the key elements of the new system[37].

1. A new standard insurance for all.
2. Citizens can change insurer every year.
3. Insurers compete for contracting with the insured.
4. Insurers and clients stipulate care suppliers to provide better quality.
5. Compensation on people with lower income.

The insurance system has become simpler. The previous compulsory health insurance for acute care for incomes below a certain level and the voluntary private insurance for acute care for incomes above that level were merged into a new, mandatory and privately administered basic health insurance for curative care.

The citizens can change insurer very year and insurers must accept all applicants regardless of their health history, age, individual health risk. All patients must pay a given amount of fixed (nominal) rate premium. It was predicted that it would be approximately an average of €1050 in 2006. It covers approximately the half of the cost of health care services. (One of the effects of this compulsory flat-rate premium is that people realize that health care is not free and it makes them more cost-conscious.) The remaining part of the costs is mainly covered by income-related contributions of employees paid by employers. The contribution from this income-related premium was 6.5% in 2006.

Insurers compete among each other through their standard premiums. They can not discriminate among patient. Price discrimination is absolutely forbidden, insurers have to offer the same package on the same price for every consumer regardless of their health status, age, gender or any other factor.

Insurers are no longer obliged to contract with every supplier. This way health care providers have the incentive to perform better and to be more efficient (either reduce cost or improve quality). Health care providers are mainly privately owned organizations and it

[36] SER, 2001
[37] New health care system in the Netherlands, 2006, Ministry of Health, Welfare and Sports

means that the competition among them makes more sense than a competition among mainly state owned-hospitals (like in the Hungarian case).

People earning lower income has the opportunity to apply for care allowance. Everyone pays according to their ability to pay. This safety net represents the solidarity among income groups and makes the system affordable for everyone to take part in. More than 5 millions citizens get this care allowance which is a significant part of the Dutch society. Naturally, the care allowance differs for everybody according to their income.

2.5.3. The financial framework of the system

Although I have already mentioned some information about the financing structure of the system, in this part I elaborate on this framework.

Fixed (nominal) premium (45% of the expenses)

Almost half of the expenses of the health care system are paid from the fixed (nominal) premium. This premium is the same for every citizen: an average of approximately €1050[38]. The patient pays this premium directly to the health insurer who offers various types of policies and sets its own premiums.

Income-related contribution (50%)

Citizens must pay a contribution of 6,5 percent from their income. The contribution is levied up to the first €30,000 and hence amounts to a maximum of approximately €2000 per year. In fact, employers pay this contribution because they have to reimburse this contribution to their employees. Pensioners and self-employed citizens pay 4,4 percent. The total revenue from this contribution is taken into a Health Care Insurance Fund.

State contribution (5%)

The government pays a contribution to the Health Insurance Fund to cover the financing of the nominal premium of the citizens under the age of 18.

Care allowance

As I have already mentioned care allowance is available for citizens who have lower income. The state maintains this social net to make the new health insurance system affordable for everyone.

Payment of the bills and reimbursement

[38] In 2006 it was precisely 1038 euros according to former Minister of Health , Welfare, Sport Mr. Hoogervorst Source: Health reform in the Netherlands: a model for Hungary?, - presentatiton, presented in Budapest, 29.01.2007.

Citizens can mainly choose between two options. They can either choose a policy based on cost reimbursement or a policy with previously contracted care. In both cases the citizen has to pay the bill directly to the care provider and the insurer will reimburse the expenses. In the first case the level of cost reimbursement is can not be limited by insurer companies (otherwise the incentive for insurers to become efficient would be lost) however, they do not have to reimburse costs above what is reasonable in the Dutch market of health care (in order to ensure that they do not run excessive financial risks). In the second case the financial flow is very similar; the difference is that the citizen chooses a previously contracted care. However, citizens still have the opportunity to opt for a non-contracted care as well in the second case.

Equalization of payment

In order to avoid scream skimming on the part of insurers a risk equalization system is needed. Otherwise insurers would try to avoid financial risk by contracting with as many citizens with low risk as possible. An effective system of risk equalization would protect insurers from suffering financial losses due to an unequal distribution of the insurance risks. Even if an insurance company only has patients with potentially high health and financial risks due to this system of risk equalization it doesn't suffer financial losses. The insurers must compete against each other on other fields; such as premium and package setting, contracting with providers.

No-claim reimbursement

Insured are entitled to a no-claim reimbursement from the insurer company. These adults insured have some part of their fixed premium reimbursed if they use less than €255 in care during one year. The government took this measure in order to prevent the overuse of (secondary) care (visits to GPs are not included). In the first year when it was introduced (2005) almost 4 million individuals had part of their fixed premium reimbursed.

2.5.4. New state role and new ownership structure

In this part I will discuss the changing role of the government and the new ownership structures that changes the incentive in the health care system.

The role of the state greatly changed with the implementation of the reform. Even before the reform the state did not managed everything alone within the health care system since the private actors played a crucial role already. Now, the government acts on a smaller scale however, it is still responsible for the accessibility, affordability and quality of the care. In order to maintain affordability and accessibility government pays contribution to the Health

Insurance Fund (see page 24) and pays care allowances to certain entitled citizens (see page 24).

One of the most important roles of the government is to build up a legal framework to support private actors. The government only regulates the market but tries to get not to be involved directly in the provision and insurance for instance. Private actors have growing influence on the entire health market. Both insurers and health care providers are private actors and this is the first step to build up a managed competition (see Enthoven[39]) in health care.

Private ownership with respect to the insurers is important because:

(i) Profit-oriented insurer companies compete with each other (lower premiums offered to consumers, higher quality services and cost-effective contracts with providers) for higher profit. This competition is good for the consumers since it probably lowers the premiums in the long run[40].

(ii) As Shliefer (see part 1.3.) stated private ownership is superior if consumer choice is effective. In this system consumers can shift insurer every year. In 2006, around 30 private insurance companies were in the market and almost 3 million people (around 18 percent of the citizens) switched to another company.

(iii) Reputation mechanism (see part 1.3. again) is also crucial in this market. However, this factor will affect the market in the long run (or at least after 1 or 2 years) after citizens can get acquainted with the insurer companies.

Private ownership with respect to providers is also important because:

(i) Providers compete with each other in order to attract insurers. Insurers are no longer obliged to contract with every provider. This forces the providers to become more efficient (cut costs or/and raise quality).

(ii) New benchmarking schemes and performance-oriented costing systems (such as DTC[41]) will support the aforementioned concept.

(iii) A real competition among providers can emerge since private providers can distinguish themselves from each other by customizing their services by themselves. It can link to one of the concepts of Shliefer, namely, where innovation is important private ownership is probably superior.

[39] Enthoven A. C. (1988): Theory and practice of managed competition in health care finance, Amsterdam
[40] Already in 2006, the fixed premium on average was €1038, lower than it had been expected.
[41] DTC: Diagnosis/treatment combinations

2.5.5. Summary of the reform

Summarizing the reform implemented in 2006 we can conclude that the Dutch reform process is highly based on social discussion and negotiation. The final phase of the reform has been supported by a step-by-step evolution of a new health care system, starting with the report of the Dekker-committee. The 'slowly ness' of this whole reform procedure made it possible for the stakeholders to adapt or even to request for changes and it also made possible for the legislature and decision makers to correct the potential mistakes in the system.

The final phase of the reform procedure, the implementation of the new health insurance system, is the cornerstone of the reform. It embodies all the expectations of the policy makers. These expectations are to set up a system that is more efficient than the previous one but it also remains a solid social institution at the same time. Efficiency and solidarity should be equally important values and both have to be equally promoted by the new health insurance system.

Efficiency emerges from the competition among private insurers on one hand, and also competition among privately owned care providers. The insurers will compete against each other by offering better conditions to the insured (lower premiums, contract with suppliers providing better care). The care providers also have to compete against each other since insurer companies are no longer obliged to contract with every provider. Hence, providers must deliver better and better services in order to attract the attention of insurers. These providers not only have to deliver better services but they have to become as efficient as they can due to their solid budget constraint.

Citizens are better off in the new system since they have greater freedom of choice. Apart from choosing the insurer they can choose the level of nominal premium, the type of policy (care in kind or reimburse the costs), the level of voluntary excess (from zero to €500), the option to take out supplementary insurance.

Apart from competition and efficiency; solidarity is also ensured in the system. Through care allowance everybody has the opportunity to take part in the system. This care allowance depends on the income of the insurer, since this allowance has to be line with one of the main policy concept, namely that everybody should contribute to the costs of the health care depending on his/her financial abilities. This safety net emphasizes the solidarity between different income groups.

In the long term the new system is expected to guarantee better quality, greater cost-awareness, and more demand-oriented health care thanks to the competition for consumers.

3. Description of the Hungarian health insurance system

In this chapter the Hungarian health insurance system will be discussed. During the critical picturing of the Hungarian case the two main approaches (economic and public administration) that have been already mentioned in the introduction will be applied simultaneously. First, the past of the Hungarian system will be described by a short historical summary. Then the most important attributes and problems of the current health insurance system will be summarized. Finally, I will bring out potential options, scenarios that might solve the problems, or at least they might bring closer to a better financial framework with respect to the health care system.

3.1. Historical overview of the Hungarian health insurance system[42]

Hungary, just like the Netherlands, has a long tradition of social insurance and health insurance. It even goes back to the XIIth century when first sickfunds were formed to help sick miners by sharing the risk with the help of the so-called 'fellow-minerboxes'.

The first act on mandatory sickness insurance for Hungarian workers was introduced in 1891 following the introduction of Germany's sickness insurance system implemented by Chancellor Bismarck. The Act XIV. regulated the sickness-, and accident insurance providing sick-allowance and other allowances such as funeral aid and aid for parents of newly born babies. The natural provisions included free medical care and free medication. However, the biggest fault of this system was that the workers' insurance became very fragmented and this caused distortions and affected negatively the workers themselves.

In the interwar period the Hungarian health and social insurance system was working quite well compared to other Central and Eastern European countries. Not only the service provisions but the proportion of insured people had also been extended. The German (Bismarckian) model had a great influence on the Hungarian social insurance from the very beginning till 1945.

After the WWII. the social insurance scheme was nationalized and the state took the responsibility to guarantee the social security. In 1975 the Act II. regulated both health and pension insurance systems. By the end of this decade the whole society was covered. The communist ideology highly emphasized the value of solidarity and equality. The access to health care – at least theoretically - was general, equal and free of charge for every citizen.

[42] Gaál P. (2004): Health Care Systems in Transitions, European Observatory on Health Systems and Policies pp. 5-7.

But in practice it was the other way around. In this sub-chapter instead of analyzing deeply the malfunction of the health care system in the communist regime I would only highlight the fact that to access good health care provisions patients had to have back-stair influence or pay twice for the service: pay social security contribution first and then pay for the doctors (high level of corruption). The distortions of the communist health policy will be elaborated further on.

At the beginning of the transition, in 1989, the health insurance fund and the pension insurance fund were separated. After the separation the funds were supervised by the main stakeholder group (patients) via special municipality control. This kind of a self-governing control shifted to a central government control in 1998. First, the health fund was supervised by the Prime Minister's Office (1998), and then by the Ministry of Finance (1999), finally the task was taken over by the Ministry of Health in 2001. This supervision included and still includes the control over the total budget of the health insurance fund. Moreover, the supervision covers the quality management control over health care providers as well.

3.2. The most important features and problems of the current Hungarian health insurance system

In this part I will briefly describe the present of the Hungarian Health Insurance System. With a critical approach I will point out why the reform is inevitable in the current situation. First, relevant statistical data will be presented with respect to the health condition of the Hungarian citizens, and with respect to the financial and economic condition of the Hungarian health care sector. As a state monopolist and the most important player in the current Hungarian health insurance sector, the solitary insurer National Health Insurance Fund will be described critically, mainly focused on the weaknesses and opportunities.

3.2.1. Brief statistical overlook of current health data in Hungary and current data on the Hungarian health financial system

Hungary is often referred in the EU as a country where people have the worst life expectancy. Indeed, according to the OECD figures[43], the data for females and males were the lowest (respectively 76.9 and 68.6 years, in 2004.), except for the three Baltic countries. These figures are even more warning with respect to middle age men.

[43] OECD Health Data 2006
http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html

Infant mortality (0,66% in 2004) is still worse than the European Union average (0,47% in 2000) although the Hungarian figures have been improved spectacularly in the last decades. Mortality conditions have been improved only with respect to citizens under 30 years old.

In an international comparison we can see that the chance of survival in a mammary cancer case for women or in a colon cancer for men is lower than in other European countries (except some post-soviet state)[44].

The number of lost life years is very high both for men and women (11825 years and 5280 years for 100 000 people respectively).

After figures related to mortality data with respect to morbidity will be described.

The most significant disease can be associated with problems of the circulatory system. More than 15% of the inpatient care cases and also, more than the half of the deceases can be linked to this type of disease! Undoubtedly, high blood pressure can be declared as a people disease in Hungary, since the probability of high blood pressure among men and women above 19 years is 19,3% and 24,6% respectively[45].

Oncological sicknesses, have been already mentioned partially, are the second most significant type of disease. 65000 (0, 65% of the overall population!) new cases are revealed year by year. While women are highly insecure between the age of 19 and 54 (especially breast, lung, colon disease arise) men are mostly insecure above the age of 55 (mainly because of lung cancer)[46].

High level of alcoholism produces a great number of chronic liver sickness rates. Not only the mortality rate due to liver problems is high but also the occurrence probability is also very high of this type of disease.

After these figures we can conclude that the Hungarian citizens have comparatively and relatively worse health condition than their other European counterpart. However, these shocking data are also the consequence of several - mainly sociological – factors; the mal-functioning of the health care system can not be ignored.

3.2.2. National Health Insurance Fund[47] (NHIF further on)

[44] Green book on Hungarian Health Care
[45] Green book on Hungarian Health Care
[46] Green book on Hungarian Health Care
[47] In Hungarian: Országos Egészségügyi Pénztár, OEP

The central state-owned body of the Hungarian health insurance is the National Health Insurance Fund. The NHIF (more precisely its predecessor in title) joined the International Social Security Association in 1963. From then on the NHIF actively participates in international events organized by the ISSA and also maintain valuable bilateral relationships with other national organizations as well.

The NHIF as the Managing Authority of the Health Insurance Fund began to function in 1994. As I have already mentioned the centralization with respect of the supervision of the fund started in 1998 due to the "weakness of the self-governing bodies" (Dózsa-Dérer-Takács-Bognár 2006. p.6.). The weakness of other stakeholder groups such as unions and the troubles of delegation system ended up in a "total government and fiscal centralization" (p. 7.).

If we look at the income side of the Health Insurance Fund the NHIF does not possess too much information about its own resources. Due to lack of individual accounts, NHIF has no idea about the in-payments of neither individuals nor companies. This is very problematic because this situation is far away from transparency which should be a core value of an ideal-typical state of world. On the other hand the NHIF can almost totally (90% according to Dózsa et al.) define and follow who and when uses the different services of the health care system. The levy of health insurance contribution is not the responsibility of the NHIF but the task of the National Tax Office which makes it harder for NHIF to follow the cash flow and to match the incomes and expenses (both for individuals and for companies) to each other.

Looking at the balance of the Health Fund we can see that year by year the shortage were about 300-400 bn Hungarian Forint (1€ ≈ 250HUF). This shortage was not because of real processes but because of lack of autonomy and managing skills in the top level of the organization. This shortage was decreased in 2006 by the government with a modification. From now on the state guarantee will be normative after the individuals who do not pay contribution. This seems to be only a technical cost diminution, since the state was already the ultimate sponsor of the health fund, but at least, this modification turns the attention to problems such as transparency, lack of individual health accounts, cost sensitivity and free riding.

As the only insurer in the Hungarian "market" the NHIF faces some traditional problems of a monopoly. These economical failures in this health care context are the followings:

- lack of incentives to innovate and to develop internal management techniques

- lack of competition among insurer companies
- inefficiency
- lack of competition among health care providers to better contracts with insurer(s) also causes inefficient allocation of resources

At the mean time as a state-owned company it also faces some problems of state ownerships as well. According to Shliefer there is "rather a narrow set of circumstances in which government ownership is likely to be superior" (p.139.). These situations are once more:

- Opportunities for cost reductions are significant (with respect to non-contractible deterioration of quality)
- Innovation is relatively unimportant
- Competition is weak and consumer choice is ineffective
- Reputational mechanisms are weak.

In the case of the Hungarian NHIF, Dózsa et al. states that in the current situation the state-owned NHIF can not fulfill the role of a real insurer company. This makes the whole system even more inefficient. If we look at the Graph 2 .the NHIF must move right on the axis, while it is standing at the Finance house status now.

Graph 2.[48]

Cachier → Finance house → Purchaser → Insurer

Lack of innovation and internal management problems can be detected in the functioning of NHIF. Developing strategic management and enhancing flexibility would not only increase the profitability of NFIH but also strengthen its reputation, and the acceptance of this single state-owned insurance company among citizens.

Due to informational asymmetries – with respect to health risks for instance- consumer choice is rather ineffective in the health care sector. According to an OECD work paper[49] made by A. Goglio "a wider implementation of managed care over the long term does not necessarily mean the publicly financed single-purchaser system should be abandoned. [A single purchaser might] "use its monopsonistic power to closely monitor service provision and, based on comparisons, pressure caregivers into following best practices". It means that it lowers consumers' transaction costs (seeking cost) by eliminating

[48] Dózsa-Dérer-Takács-Bognár p.12.
[49] In search of efficiency: improving health care in Hungary, Economics Department Working Papers No. 446., OECD

the possibility of choice, although, numerous scholars (Mihályi, Bokros) would say that this is a disadvantage of the single-purchaser system since citizens should have the right to choose between insurance companies.

3.3. Structure of Hungarian health care

Due to the extreme complexity of the Hungarian health care system I will not describe every aspect and organizational details of it. However, for the better understanding of the role of NHIF within the health insurance system; the whole health care system has to be presented briefly. As you can see in Table 3. the structure of the Hungarian health care is indeed complex.

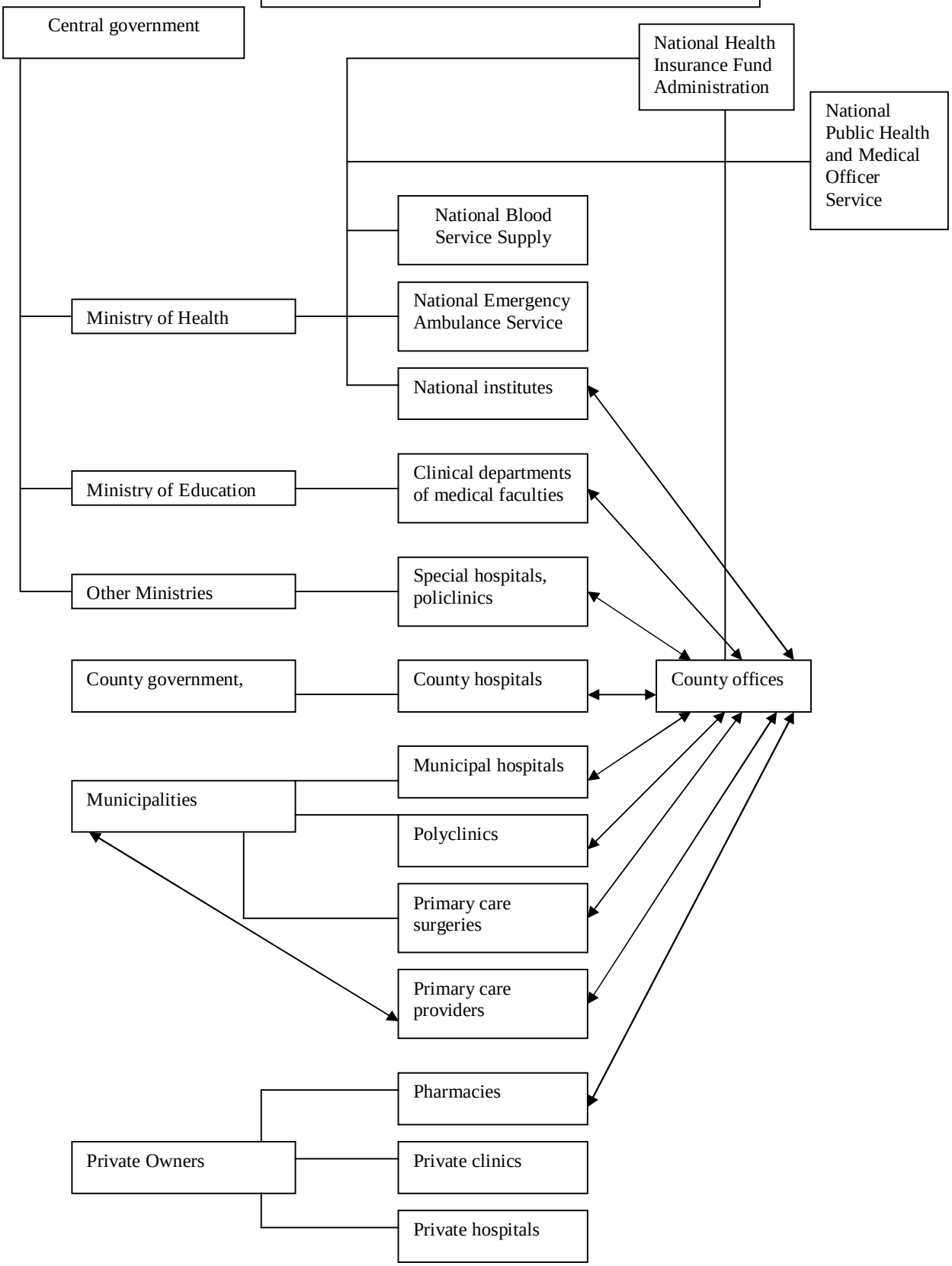
The central government even after more than seventeen years after the transition still plays a crucial part in the health care system. Via ministries (mostly via the Ministry of Health) the government has direct influence on the daily functioning of the National Emergency Ambulance Service, National Blood Supply Service, Special hospitals, Policlinics, Clinical Departments of Medical faculties and others National Institutes related to health care. As we can see in the current situation the central government is definitely a cohesive player of the system. As I have already mentioned indirectly the central government determines the annual budget of the NHIF and also the annual rate of premiums as well.

However, the provider side of the structure (hospitals, policlinics, pharmacies) shows a great diversity. The hospital can be a property of a ministry, a region, a municipality or it can be even a private hospital. This fragmented structure of the providers one might think can lead to competition but on the contrary it leads to parallel allocation chains and wasting of resources. The cornerstone of the problem is that the NFIH does not act like a real insurer. This fact influences the hospitals, hence they do not compete to reduce cost or improve quality. The state as a last resort helped the hospitals to overcome their enormous debt that has emerged.

The financial loss of hospitals can be explained by the statement from a report that says: “Problems in hospital care are amplified by weak progress in preventing uneconomic access to hospital services, so that hospital care remains overly dominant in the system.” And, “patients have relatively easy access to hospital consultations”[50] (p. 10.)

[50] In search of efficiency: improving health care in Hungary, Economics Department Working Papers No. 446., OECD

Table 3.
Structure of Health Care in Hungary



Hierarchical relationship ———
Contractual relationship ←——→
Source: Gaál, P. (2004): Health Care Systems in Transition: Hungary

3.4. Proposals and plans – searching for a solution

In this part I will describe the potential proposals and plans that can be applied by the government to mitigate the extern and intern pressure on the health care system. The government seems to be highly committed to the reform since several measures have been already taken. The only, but probably the most important, question is still there, whether the multi-payer system or the single-payer system (see page 9.) would serve the interests of the most important stakeholders.

3.4.1. What have been already done?[51]

After the new government had been formed in April 2006, the reform procedure in the health care system unexpectedly was given a huge impulse. Five major health acts were passed during the autumn 2006 Session of the Hungarian Parliament[52] in spite of the hectic political debates. All of them were signed by the President therefore they all entered into force.

The first important step was the re-regulating of the **drug market**. The new measures provoked resistance and opposition from several sides. "From 2007, pharmaceutical producers and importers are obliged to offer price cuts in contracts with the Health Insurance Fund. In case of over-selling producers will have to share the costs of this overrun." (Mihályi et al p.4.) Thus, physicians and GPs have the incentive to prescribe inexpensive medicines in order not to surpass the figures determines by the Fund's budget. No free prescription will be available anymore; the patients have to pay a minimum HUF300/box, even if the medicine is 100% subsidized. The market will be liberalized in two ways. First, the preventing rules of opening new pharmacies will be abolished and second, non-prescription drugs are allowed to be sold outside of the pharmacies.

The other dominant measure was the restructuring of the **hospital network**. The hospital network has a structural problem; the hospitals are either too huge or too small. There

[51] Mihályi et al. (2007): The 2007-2009 Reform of the Hungarian Health Insurance System
[52] The Hungarian Parliament has only one chamber with 386 representatives.

exists also a financial problem, namely that the hospitals have to face a growing operational cost (10% estimation) and a decreasing income from NHIF. Without the reframing all hospitals would go bankrupt according to the report made by Mihályi et al. Number of acute beds were reduced by 26% (from 60 thousand to 44 thousand) and the number of chronic beds were increased by 36% (from 20 thousand to 27 thousand). The act introduces new definition of different hospitals. Although, the hospitals are mainly in central state ownership; municipalities, medical universities, churches also possess hospitals, and from now on, around 40 hospitals will be seeded and will get a special, privileged status. The new regulation allows the Ministry of Health to determine the size of *every* hospital (detailed down to the level of departments)! However, the seven Regional Health Councils[53] can reallocate the numbers of beds in their regions among the hospitals.

The **Health Insurance Authority**[54] (HIA) as a new body has been set up from the 1st January 2007. The tasks of the authority are the followings so far:

- to monitor the contracts between providers and insurers
- to monitor price developments
- to assess the quality of hospitals using quality indicators
- to 'send' patients to another hospital if patients complain against the unfairly treatment in a given hospital

The foundation of the HIA is a precondition of the planned health insurance reform since after the implementation of the reform (if the multi-payer system will be the chosen one) the list of tasks of the authority will be extended by the followings:

- HIA will award the licenses to the health insurance companies to enter the market
- HIA will control and check all the complaints with respect to price subsidy decision of the insurance company

In order to abolish or at least to mitigate the illusion of free health care **co-payment** entered into force with respect to each visit (both GP and hospital) in February 2007. The symbolic amount of the co-payment is HUF300/visit probably has to be risen in the future due to economic raisons[55]. This **visit fee** was totally unknown in the history of Hungarian health care so far.

[53] In Hungarian: Regionális Egészségügyi Tanács (RET)
[54] In Hungarian: Egészségbiztosítási Felügyelet
[55] The simple fact that a machine dealing with the visit fee costs more than HUF3million drives us to the solution that either this fee was introduced only because of psychical raisons (as I mentioned before) or the fee has to be risen otherwise even the operating and administrative costs (as a transaction costs) will be higher than the revenue from the visit fee.

A new regulation of the **waiting lists** has been applied since April 2007. Two main lists will exist now on, a central one for implementations and another one maintained by all hospitals on there own. As I have mentioned the HIA will have the power to intervene in those cases when patients have reasonable problems with the lists.

The **basic benefit package** is more tightly defined from April 2007. Certain dangerous activities, given types of sports (bungee jumping and mountain climbing for instance) are out of the package and not covered any more.

The **referrals** will be monitored and controlled more severely. If a patient goes to the provider without referral from the GP the treatment has to be fully paid by the patient. This measure strengthens the idea that the GPs have to be the gatekeepers of the system.

Chambers including doctors, nurses and pharmacists had obligatory membership until 2007 respectively. This compulsory membership was abolished in all fields. This measurement was highly opposed by these vocational organizations. From a public administration point of view this can be a great threat for the implementation of the whole reform procedure. If many professional organizations will resist against the changes the reform can not be fully successful.

Summarizing these changes we can conclude that the reform of the Hungarian health care system has been speeded up after the new government had been formed in April 2006. These reform measures took into consideration the principles of Kornai-Eggleston. One of the most important principle that can be highly underlined in the Hungarian reform case is the sustainable financing (9. principle). The whole health care sector suffers from lack of financial resources. Reorganizing the hospital network (which still remains mainly in state-ownership); re-regulating the drug market; implementing the visiting fee; tightening the basic benefit package; more severe monitoring of referral routes are measurements that were taken in order to mitigate the financial pressure on the central health budget.

The reform of the health insurance system will be a milestone in the reform process. Like in the Netherlands; the restructuring of the insurance system will be the final step of the whole reform process. Without that step the successfulness of whole reform procedure would become doubtful. All the measurements will be useless and ineffective if nothing happens with respect to the insurance.

However, the structure and the legal framework of the new Hungarian health insurance system are still unknown and doubtful. Several options exist, there is no consensus between scholars; and furthermore there is no consensus between political parties at all. The only thing that everybody agrees on that something has to be changed because the current situation does

not functioning well. Due to the fact that the state still has too much of influence on the whole sector (even in the provision) and market mechanism are not working at all (no real competition among providers, no competition for insured at all, consumers can not choose from insurer companies etc.)

3.4.2. A potential model – Competing insurances

As I already mentioned several alternatives exist with respect to how the health insurance system might be reconstructed. One of the alternatives is the model worked out by Peter Mihályi[56] and al. (2007). This model embodies elements from the Dutch and Slovak insurance models. Nevertheless, it takes into account German and Czech reform plan as well. According to Mihályi deep and major reform measures has to be implemented as soon as possible "in order to minimize the potential reversal after the 2010 general elections"[57] (p 19.).

According to the proposal four main elements represent the current situation. These are:

(i) Significant redistribution among social groups (rich-poor, male-female, young-old, urban-rural) → Solidarity

(ii) Participation and contribution is defined by law → Virtually 100% coverage

(iii) Soft budgetary constraint. Revenues do not cover expenses.

(iv) Medical care is financed by taxation, payroll contributions and illegal payments.

Among these elements the latter two have to be changed and the first two must be maintained further on. In order to achieve this several government measurements have to be taken (pp.19-22):

- Government must attempt to make the transition from the old system to the new system relatively smoothly and safely.
- Managed competition has to be set up; with the participation of for-profit private health insurance companies operating within the mandatory range of 0,1 - 2 millions members.[58]

[56] Chairman of the Health Care Working Group within the Public Reform Committee of the Prime Minister

[57] The threat of a potential reversal is real. As I have already mentioned in Slovakia the Fico government announced that severe adjustment on the health insurance system is needed. (Even the total turnaround of the system can not be excluded.)
In Hungary, the major health advisors and politicians of the main current opposition party (Fidesz) announced that they will turn back the reform procedure if they gain power.

[58] According to calculations this 0,1-2 million consumers range would be the most suitable. Under that range it's hard to operate country-wide effectively. Above this range the given company would be a threat for the competition.

- Strict regulatory supervision is needed. Mainly carried out by the newly set up organization; the Health Insurance Authority (HIA).
- Connections between health contribution payments and eligibility have to be more transparent.
- Reconsidering the role of the state by decreasing the importance of the Ministry of Health.
- Private insurance companies have to operate prudently with respect to their financial operation. There will be no state guarantee for companies.
- Insurance companies can not distinguish between consumers. The amount of premium for the same package has to be the same for everybody. Cream-skimming will be strictly forbidden. A risk-equalization fund will redistribute the contributions among insurers.
- Consumers can change insurer every year.
- After a 3-5 year transition period clients of the insurance companies can choose among different policies and different packages.

As we can see, many elements are in line with the Dutch model; these similarities will be analyzed in chapter 4.

The core idea behind this new Hungarian model is the separation of medical packages into three tiers. The Pillar 1. will rely on tax financing and mainly public care, preventive care, blood collection etc. will be financed by it. This means that this pillar will avoid profit considerations and that the nationwide risk pool will remain. The risk pool will be also maintained with respect to the most expensive and individual treatment (Pillar 3.) The Pillar 2. will embody everything which is not covered by Pillar 1. and 3. This will be the component when for-profit private health insurances take part. Table 4. provides an overview of the scheme.

Table 4. Pillars of health care packages[59]

Level (Pillar)	Shares in costs	Content	Insurance fee	Responsible institution
Pillar 3	15-20%	Catastrophic illness involving very high costs. Long term care	Proportional payroll taxes	NHIF
Pillar 2	60-65%	Basis or routine care. Everything which is left out from Pillar 1 and 3.	For a long transitional period payroll taxes, then flat premium	Mandatory, private health insurance companies (max.8-10)
Pillar 1	20%	Surely: Preventive care, public	None	Ministry of

[59] Source: Mihályi and al. (2007) p.

		care, blood collection, school health, emergency ambulance Perhaps: sickness payments, financial support in pregnancy and child birth etc.		Health

As we can see from the Table the NHIF will still operate in the future, however, its new role is under intense political and professional discussion. According to this given proposal the NHIF would be responsible for managing the Pillar 3. Furthermore, NHIF might become the managing authority of risk equalization fund with respect to Pillar 2. But it would give a special *'primus inter pares'* status to NHIF among insurance companies. It would probably distort competition, no matter how good the legal framework will be. NHIF will be a competitor and a regulator (or at least a managing authority) at the same time. This is not in line with the main concept of this reform working group. Hence, they also take into account a radical option which indicates that after a predetermined deadline (12 or 18 months perhaps) the remaining NHIF members will be transferred to a private insurance company according to some kind of random algorithm.

Indeed, one of the biggest questions of the reform is what will happen with NHIF in the future. This is not only an organizational issue; although with a properly operating NHIF Hungary might not need a health insurance reform at all[60]; but also an issue that raises plenty of questions and challenges. How can the new system maintain solidarity? All the citizens will be treated equally no matter with respect to their financial status? Will be this new model applicable in Hungary?

In the following chapter, mainly applying Rose's book I will highlight the lessons that Hungary might learn from the Netherlands.

[60] see Dózsa-Dérer-Takács-Bognár

4. 'Lesson-drawing'

In the previous chapters I have described the Dutch reform process by mainly focusing on the last reform phase; namely the introduction of the new health insurance system. I have also described the Hungarian reform case including a potential solution for the current challenge. In this chapter applying Rose concept I will draw potential lessons for Hungary which might be useful and applicable derived from the Dutch experience.

Rose states that a lesson "combines knowledge about what is happening in another country today with a specific proposal actions that a government here might take to improve public policy in the future" (p.24.). In our case I derive lessons from the Netherlands where the final phase of the reform was implemented in 2006. These lessons might be applied in the near future in Hungary where the reform has been already started as well by implementing several measures in the health care system (see page 38-41.).

Concrete governmental measures have high importance since we have to distinguish between lessons and recommendation. As Rose illustrates a recommendation is "no more than a prescription about what ought to be done" (p.25.) A lesson needs more detailed description of practical measurements and detailed plan how a program should be realized. As we could see in the previous chapters the practical measurements are given in the Dutch case and so far several measures – in some aspects very similar to Dutch measures - were already taken by Hungarian decision makers as well. The final question is what kind of further lessons might be adapted by the Hungarian government?

4.1. "Where to look for lessons"[61] – is the Netherlands a good place for Hungary looking for lessons?

In this sub-chapter I will summarize why the Netherlands is a good place for Hungary to search for lessons.

Both countries are relatively small and both are part of the European Union[62]. Both have many similarities in the past with respect to their health care and health insurance systems. Beside the role of the private (guilds) and religious actors (churches, monasteries) in the middle age, the most important parallel element is that the German Bismarckian system had a great influence on both schemes. This means that in the past century we can find

[61] Rose p.41.
[62] The Netherlands was among the founders of the EC, Hungary joined the EU in 2004.

similarities with respect to the financing (payroll taxes levied on employers and on employees) and to the values (social solidarity) as well.

However, a huge difference can not be avoided while comparing the past of the two countries. After the WWII. the Netherlands became an independent country meanwhile Hungary started to suffer under communist dictatorship. In Hungary the enormous social-economic changes in the late 40'ies radically transformed the ownership proportion, to be more precise the entire health care system was nationalized for instance. The intensity of dictatorship has changed over the decades but the most important thing from our point of view is that private initials and private ownership were repressed during the former era which ended in 1990.

The communist era significantly modified the values of the society. The current Hungarian society is more collectivist than its Dutch counterpart[63]. Using Kornai and Eggleston words we can say that - at least in health care - Hungarian citizens appraise solidarity and they disagree on the reconsideration of the role of the state. Of course in this phenomenon we also have to take into account that citizens are usually afraid of new policy initials and in this case they got used to paternalism during the previous decades.

After regarding the facts I can affirm what I have stated in the introduction, namely that both countries face rather similar problems. Aging population (growing average life expectancy observed in time series), technological advances, cost-unconsciousness, lack of transparency, growing costs exist in both cases. Also the complexness of the former Dutch system and the complexness of the current Hungarian system[64] seem to be parallel with each other. However, in the Netherlands the main aim beside other sub-goals of the reform was to strengthen individual sovereignty and make the system more transparent and simpler. On the other hand in Hungary the main aim of the transformation – among other important aims - is to maintain financial sustainability. We can see that goals also overlap each other in the two countries; however the stress is on different aspects of the reforms.

Summarizing this sub-chapter we can conclude that regarding the fact that every country is different from each other the Netherlands and Hungary had and still have numerous similar features. These similarities not only concern the common problems but also the similar historical past (Bismarckian system) and similar goals as well. It means that the

[63] According to a representative poll carried out in April 2007 91% of the population would agree on maintaining the state-owned insurance company (NHIF) And only 6% would agree on total liberalization. http://www.median.hu/object.cace512d-7fff-4167-b077-0e40bc838726.ivy. downloaded in: 10.06.2007.

[64] According to the same poll only 32% of the citizens think that they can more or less (29%) or totally (3%) understand what are the differences between the current and the proposed systems. http://www.median.hu/object.cace512d-7fff-4167-b077-0e40bc838726.ivy

Netherlands is a good territory where Hungarian policymakers can search for potential lessons. Moreover, as Rose states "today Central and East European countries are free to look for lessons where they wish. They usually turn their backs on their Russian neighbor and look to governments in the European Union…" (p. 51.)

4.2. State versus private ownership – main difference and main question

One of the causes why Hungary and other Central European countries are looking for lessons in Western Europe is that after the transition back to democracy and market economy these Central European countries should find examples where private ownership and market mechanism are already working reasonably well.

As I have already mentioned in the previous sub-chapter the Netherlands and Hungary have numerous similarities. However, this difference with respect to the current ownership status is a crucial factor from our point of view. On one hand the health insurance system in the Netherlands is mainly driven by market forces now. Providers are mostly in private ownership and also the insurance market is determined by private actors. Although, significant state control has been remain in order to maintain a stable framework for the managed competition. On the other hand state-ownership is still much more decisive in Hungary. Decisive, since there is only one state-owned insurer in the market; however it does not really acts like an ideal-typical insurer. Up to now this state-owned insurer - the NHIF - hasn't played a crucial role in choosing the suitable providers. Why? One reason is that the vast majority of providers are also run (indirectly via municipalities and regions; for instance) by the state. This means that providers are not competing against each other by providing better care but competing against each other to obtain higher financial support from the government. Once a hospital signed a contract with the NHIF the hospital is no longer has the incentive to increase the quality of its care. Moreover, according to a new regulation the Ministry of Health is allowed to determine the size of *every* (state-owned) hospital (detailed down to the level of departments in these hospitals). This regulation surely hinders the competition among providers hence they can't possess freely with their resources.

Analyzing the two cases from Shleifer framework's point of view (see part 1.3.) we can derive to remarkable conclusions. Innovation is really important in health care. Although, innovation can be linked typically to the pharmaceutical segment of the health care but also providers (hospitals, clinics) can make improvements and, for instance, technical innovations and investments to improve the quality of their services. In Hungary hospitals were lack of

this innovative approach so far mainly due to lack of financial support. As I have shown in chapter 3 the government can not raise the financial support for hospitals any more, and until now NHIF had a very slight possibility – except for some minor quality benchmarks - to measure and to sanction bad-performing providers (until the end of 2006 the NHIF was obliged to contract with every provider).

Improving quality at hospitals and enhancing competition among these providers is hardly achievable unless the ownership conditions are not going to change. With respect to competition we can say that because of there is only one single state-owned insurer in the Hungarian market there is no competition for clients at all. In contrast in the Netherlands private profit-oriented insurance companies are competing for clients by offering better services and setting up lower premiums than their rivals. However, the empirical data are too fresh for depth analysis we can say that there are some promising facts[65]. Although, critical voices say that this was only a special year, the introduction year of the new system, hence insurance companies had the incentive to attract as much patient as they can in the beginning of the 'race'. It can be regarded as a special strategic behavior by the insurance companies; we can even say that the first year was the year of 'predatory pricing' (see Cabral and Luis M.B.[66]) Insurance companies might expect that consumers are not as flexible to change insurer every year, therefore consumers will stay at the same company even if that given company raises the premium for instance. In economic terms, assuming that the consumer is rational, if the transaction cost (in our case it can be the searching cost for another companies for instance) of one given consumer is higher than its expected profit gain (e.g. lower annual premium) by changing insurer in this case this consumer will not change insurer. That's why it's really important to ensure that performances of insurer companies have to be more comparable and that comparison has to be accessible and inexpensive or free for every consumer. With such a benchmarking and performance measuring integrated system informational asymmetry and transaction costs can be mitigated, hence as Shliefer states consumer choice will be more effective.

Consumer choice was indeed effective in the first year of the Dutch reform since almost every fifth citizen (18%) changed insurer which number also exceeded the expectations. In Hungary the Health Care Ministry expects 20-25% of the citizens to switch to private insurers in case of the state-owned company will be maintained. On one hand,

[65] The nominal premium paid by Dutch citizens in 2006 was lower than it had been expected. The expectation was around €1050-1100 but the real figure was lower, precisely €1038.
[66] Cabral, Luis M. B., Introduction to Industrial Organizations, Massachussets Institute of Technology Press, 2000, p. 269.

regarding the fact that individual health care expenses represent relatively high proportion of the total expenses of an individual every citizen has to be more cost-conscious. This means that Kornai-Eggleston principle, individual sovereignty, will be strengthened. On the other hand I have already mentioned that effective consumer choice is hindered by informational asymmetry for instance. The citizens also have to gather information about the new system and according to surveys the majority of them don't know what the main differences are between the old and the proposed system (see page 42.).

4.3. Cultural beliefs and values matter

In this sub-chapter I will emphasize the main differences (and similarities) between the two countries with respect to cultural beliefs and values. Like in the previous chapter the differences between the two countries with respect to slightly different cultural beliefs and values are originated in the history of the two countries.

The Netherlands has a long tradition of consultative procedure and has been regarded as one of the symbolic country of well-functioning neo-corporatism states. Stakeholders' interests and opinions, even if they are negative or seem to be destructive for the first sight, are usually taken into account or at least should be taken into account by the government (Olson, Mancur[67]). Radical changes in public policy are unlike to happen, since the government has to consult main stakeholder before taking crucial measures. These stakeholders often have the intention to maintain the current 'status quo'. For instance, from the political side the modification of the Constitution is impossible without political consensus[68]. This makes the procedure lengthy but at the end the final policy proposal gets the sufficient political and professional support from politicians and from other stakeholders as well. As we could see in the Dutch case the reform started in 1988 by setting up the Dekker-committee and lasted for almost two decades to reach the final phase of the reform in 2006.

In Hungary four decades of communist dictatorship not only changed the ownership conditions but also had a huge influence on common values and beliefs as well. Instead of consultative procedure and corporatism severe central state control dominated. This major difference still exists since the paternalistic controlling mechanism survived in the cultural heritage of the communist era. Both the central government and private actors have been got

[67] Olson, Mancur: Logic of Collective Action: Public Goods and the Theory of Groups, (Harvard Economic Studies), Cambridge, 1965.
[68] In the Netherlands changing the constitution needs political consensus, since the amendment made by a parliament has to be confirmed by the next generally elected parliament as well.

used to paternalism during the decades. This Marxist attitude (in that sense, that everything can be improved and that the remedy is known but only 'we' - the current central government - know the remedy) can be observed in the policy making process (e.g.: The working paper of the main promoter of the reform has the title "What is right has to be done". This title does not leave any space for negotiations or not even for social discussion. It also suggests that the remedy for problems is known but it does not have alternatives. However, policy making is also about considering alternatives and choosing from potential alternatives.

Other examples from the reform proposal made by Mihályi and al. (2007) also support my former statement about this attitude: the "The reform measures should be deep and all-embracing in order to minimize the chances of a reversal after the 2010 general elections." (p. 19.) This statement can be defined that political consensus is not needed for the implementation of the reform. According to this attitude not political and professional consensus but path dependency and time might solve this problem.

"The existing institutions and the medical profession working in Hungary don't like reforms. They are inherently conservative, like everywhere else. But they are willing to go along and make the necessary adjustments, if the rules of the game are changed in a constitutional manner." (p. 18.) Obviously every stakeholder is more or less to a certain extent would like to maintain the status quo. But according to this statement there is no need for consensus building among stakeholders, since the central government has the power to change rules and make new regulations. These regulation and laws are essential variables of a reform procedure (Rose p.22.) however if there is not enough support on the part of the crucial stakeholders the success of the entire reform will be jeopardized.

This governmental philosophy also indicates that the Hungarian government ignores Kornai and Eggleston's seventh principle, *time need of the program*, already in the drafting phase of the reform. There is no need for lengthy discussions about the potential alternatives since the benevolent and omnipotent state already knows which way is the best, furthermore the central government knows that this is the only way.

I don't suggest that the Hungarian government should devote two decades for examining the situation or negotiating with stakeholders who will stick to their opinion and defend their interests toughly. But this paternalistic and authoritative approach might cause political instability[69] and also might cause lack of support from the citizens toward the reform.

[69] See the Slovakian example in page 22.

If we analyze the other values listed by Kornai and Eggleston after looking at the cases we can say that both reform procedures are in line with the scholars' attitude. As I have already mentioned the stress is on different principles in the two cases. In the Dutch case these were the improvement of individual sovereignty (larger scale for choosing), enhancing transparency, promoting competition (among providers and among insurers) and defining a new role of the state (steering instead of rowing[70]). In the Hungarian case the reform procedure should primarily avoid financial unsustainability but also it has to improve individual sovereignty, enhance transparency, promote competition and define a new role for the state.

While lesson-drawing these similarities have to be seriously taken into account later on. These values are not only important because they have great important with respect to policy making (Stone, 1998) but values are backed up by concrete measurements that can help the given country to achieve its final goals. During the case descriptions (chapter 2 and 3) I have aimed to link these concrete measurements to values and beliefs already.

4.4. Lesson drawing – a proposal

In this sub-chapter I will aim to come up with potential proposals, lessons that are drawn from the Dutch model and from its experiences. With the help of Rose's framework I will attempt to determine to what extent the Dutch reform measures should be adopted by the Hungarian government.

Following Rose's framework we have to decide between the alternative ways of lesson drawing (see page 6.) After considering and comparing the two models we can see that although there are several similarities between the countries, however due to crucial social-economic and also political differences the *"photocopying"* of the Dutch model would be inappropriate. These main differences such as

- the ownership conditions of the providers (mainly private in the Netherlands and mainly state-owned in Hungary);
- different historical past from 1945 till 1990 (long and uninterrupted tradition of private ownership and market economy in the Netherlands and decades of paternalism and strict central state-controlled economy in Hungary);

[70] Osborne, D., Gaebler T.(1993): Reinventing government: how the entrepreneurial spirit is transforming the public sector, New York, Plume

- different values (with respect to governance: corporatism in the Netherlands and 'etatism' in Hungary; with respect to citizens' attitude more individualistic in the Netherlands and more collectivist in Hungary)

make photocopying the Dutch model extremely dangerous for Hungary. Considering the current ownership condition of the hospitals it is not clear how these hospitals can compete against each other. If the management of these hospitals can not decide autonomously about the use of their resources but fundamentally influenced by the central government (determining the number of acute beds for instance) how can real competition emerge?

The huge difference with respect to historical past is also crucial. On one hand Hungary is having only a single insurer – the NHIF - in the health insurance system for several decades now. This organization is state-owned and is bleeding from several wounds (lack of financial resources, inefficient distribution of these resources within the health care system, high operational cost and red tape.) However, this organizational structure of the NHIF is operable and the experience (informational database, provision organizing and planning etc.) of the NHIF is priceless. This means that the total elimination of the NHIF from the system would be a great loss. However the reconsideration of the role of the NHIF is a vital element of the reform process. The most suitable function for the NHIF would be to live on and the NHIF would be the key element to maintain solidarity in the system. As I have already mentioned the survivorship of NHIF might provoke problems.

This new NHIF can become the insurer of the poor. Due to the aforementioned attitude of the Hungarian citizens (accepting paternalism), especially lower class people can remain contracted with NHIF. Although, if a risk adjustment system is implemented (similar to the Dutch one, namely, having regarded to age, sex, health history and health status) this won't be a problem at all.

The photocopying of the system would be also inappropriate from a public administrational point of view. As I have shown (chapter 2.) the Dutch reform procedure evolved slowly step by step. In contrast the Hungarian reform procedure is radical and in my opinion too fast. Since even the state-owned organizations (hospitals managed by the Regional Health Councils etc.) can not follow the central reform rush by adopting the new regulations. But what is this rush? This rush can be associated with rather political than economical reasons. One raison might be that due to the effect of political cycles in a democracy the government wants to do the harmful transformation at the beginning of its mandate as soon as possible to avoid political defeat at the end of the political cycle. A second raison can be that according to the theory of path dependency (Pearson, 2000) even if the

current government fail at the next general elections the reform procedure might be irreversible by that time.

Instead of this political-driven reform rush the government – just like in the Netherlands – should devote more energy and time (see Kornai and Eggleston) for negotiation with stakeholders. This would lead to a bigger support from professional organizations (hospitals, chambers etc.) that can back up the whole reform process. Even if the government has to take into account proposals of the stakeholders and has to make adjustments the new system to come will be more stable. This is vital since without this political and professional consensus the new system will be therefore so unbalanced that even the new players of the market - the private insurers - will be insecure.

Private insurers need calculable and stable market conditions since they plan for the long run. In this sense political instability can hinder private actors to join the market. So far in the Hungarian reform process the insurers are abide their time and waiting for the government for the final proposal.

But if photocopying is inappropriate than which alternative would be the most suitable for Hungary? Considering the differences and similarities between the two jurisdictions I would recommend the '*hybrid'* solution. As Rose states "[hybrid way of lesson drawing is]…combining elements of programs with the same objective in different jurisdictions." (p. 81.) Considering the current Hungarian health care system (one insurer, state-owned providers etc.) this solution wouldn't be that radical than '*photocopying'* would be. Photocopying would lead to such enormous changes in the system that the consequences (adaptation problems in the public administration, large proportion of the society is not prepared for radical changes due to lack of information and lack of financial sources etc.) can not be forecasted or foreseen. Though, several features of the Dutch model are worth to take into consideration during making the last phase of the reform in Hungary.

What are these features? The most important features that seriously have to be taken into account are the following:

1. Solidarity has to be maintained;
2. Competition should be strengthened with the participation of private insurers;
3. Insurance market should be transformed from supply-driven 'market' into a consumer driven real market by covering the residual demand coming from the citizens;
4. More transparent way of handling individual health account is needed;

5. Time need of the program is important (negotiations and discussions with the stakeholders are unavoidable for instance);
6. Role of the state has to be reconsidered (more steering and less rowing);
7. Checks and balances (guarantees and obligations) have to be built in the new system.

These features are only recommendations and not lessons yet. Drawing lessons need concrete policy measurements that are adapted from abroad. After considering the aforementioned recommendations the following policy measurements might be suitable in the current Hungarian situation. (These concrete measures can be linked to the recommendations respectively.)

1. *Solidarity has to be maintained*

The NHIF shouldn't be abolished. The NHIF should provide last-resort insurance and aid for those people who can not afford to take part in the new system and without this possibility they would be out of contract. From the Dutch system the adaptation of the *care allowance* would be very important with respect to solidarity. Due to income differences this care allowance would affect proportionally more citizens in Hungary than in the Netherlands.

The other important measure is to set up guarantee that make impossible cherry-picking impossible for insurers. These regulations have to be very similar to the Dutch method, namely, a risk adjustment fund has to be set up. (This risk adjustment fund may function under the management of the NHIF. However, in this case the role and the range of action and liability of the NHIF have to be defined precisely. Although the NHIF remain a special insurer but the on one hand it can not have a primus inter pares status among insurers otherwise it would harm competition. On the other hand NHIF has to act like a profit and market oriented insurer and can not become the 'insurer of the poor' otherwise it may cause discriminatory treatment in hospitals - as we could see in the former Dutch system.)

2. *Competition should be strengthened with the participation of private insurers*

Private insurers should also participate in the new health insurance system in order to increase competition. The only state-owned insurer currently makes it impossible for citizens to choose between health packages. First of all the competition between insurers would indicate higher variety of choice for citizens. Second, it would enhance quality improvement with respect to providers.

In contrast with the proposal of Mihalyi (2007) I would recommend that the entry constraint should not be linked to the number of patients[71]. The entry conditions should be more in line with the Dutch practice; sufficient capital potential, prudent financial management and fulfilling the legal and ethical requirements should be more important. Otherwise due to unnecessary entry constraint the competition would be harmed.

Due to political instability[72] private insurers are hesitating and unsure about their participation in the new system. Unless, they won't receive the final legal arrangement from the government they can not decide about their business plans. This is important since the government wants to implement the new insurance system from 1 January 2008 and if the draft version is always changing even the insurers will be unprepared for the new system not only the citizens. As Rose states that a successful reform needs "laws, appropriations, personnel and organizational structures to be put into effect"[73].

Other vital segment of the appearance of private insurers is that they have to be strictly supervised. This task will be linked to the Hungarian Health Insurance Authority (see page 37.). This supervision will be one of the key elements of the new system since it may guarantee not only the clearness of the competition but it also safeguards patients' rights for instance.

3. *Insurance market should be transformed from a supply-driven 'market' into a consumer driven real market by covering the residual demand coming from the citizens*

Like the reform in the Netherlands the Hungarian reform process also aims the transformation from a supply-driven market to a consumer driven market. The difference is that in Hungary there is no real market since there is only one insurer and the citizens can not choose between insurers and between reform packages. The new private insurers will determine health packages and this will allow the patient to choose between the alternatives. If the market works efficiently (patients are rational, information is free and not distorted) the patients will show their real health risk via their choosing. On one hand patients who think about themselves as a 'risky' patient will choose a package that provides more or/and better coverage. On the other hand patients who think that they are not threatened seriously by diseases will choose only a basic package.

The concrete measurement with respect to health packages might be that a basic package should be provided by the NHIF for those people who can not afford to contract with the private insurers. Together with the care allowance this former measurement probably

[71] Minimum of 100.000 citizens.
[72] The opposition is trying to hinder several aspect of the reform process including the entrance of private insurers to the market.
[73] Rose (p. 22.)

guarantees that only a small proportion[74] of the society will be out of the new system. This guarantee from NHIF is indeed a trade-off between equity and efficiency because it strengthens equity by guaranteeing rights for the poor and lessens efficiency by distorting competition.

4. *More transparent way of handling individual health account is needed*

Encouraging transparency is a clear aim in both countries. Kornai and Eggleston also underline the importance of transparency since bigger transparency strengthens cost-awareness, eliminates the illusion of free health care and finally it makes easier for citizens to decide between alternatives.

The lesson drawing in this point is clear. First of all, individual health accounts have to be implemented. In this scheme all stakeholders can follow the cash flow. From the Dutch practice the *no-claim reimbursement* should be also adapted in Hungary in those cases when patients use less then a certain amount in care during one year. This would prevent overuse of care and would make patients more aware of costs.

5. *Time need of the program is important (negotiations and discussions with the stakeholders are unavoidable for instance)*

The reform process has taken almost two decades in the Netherlands. It began with the work of the Dekker-committee in 1988 than finally ended with the implementation of the new health insurance system in 2006. Unlike in the Netherlands, the reform process is going really fast in Hungary. The first measures were taken in 2006 and according to the government the new health insurance system will be implemented in 2008. On one hand this can be a sign that the Hungarian policy makers have already searched for and also have learned from foreign experiences and now they know what to do. But on the other hand the reform process is accelerated due to political reasons. In my opinion the latter might be the true reason (see page 49).

New programs and new structures are not always welcomed by all of the stakeholders. Like in the Netherlands fierce political debates have been taken place in Hungary as well. However, due to a lower level of corporatism compare to the Netherlands the Hungarian government has devoted less energy and time for negotiations and for convincing the stakeholders about the necessity and the suitability of the reform. Unfortunately political backstage consensuses have more importance than professional and rational reasoning during the fine-tuning of the reform. As I have already mentioned without the majority of the different stakeholders (hospitals, insurers, patient) the successfulness of the reform process as

[74] nobody in theory

a whole will become in danger. Without this support the political stability of the reform might be also lost in no time since a new government might turn back the reform process.

The concrete measures that have to be taken are the following. All major stakeholder groups have to articulate their opinion on the reform and the reform proposal. These opinions to a certain extent have to be seriously taken into account by the government. The concrete organizations that should be involved are the Hungarian Chamber of Doctors, Regional Health Council and Hungarian Pharmaceutical Chamber. Remember, the mandatory membership in the chambers has been abolished in April 2007 (see page 38.) This governmental measure lessened the potential and the legitimacy of the chambers right before the negotiations and discussions over the reform.

Finally, I would recommend that more time is needed since a fast solution might be harmful and also unstable in the long run.

6. *Role of the state has to be reconsidered (more steering and less rowing)*

Following the Reagan and Thacher administrations' practice Western-European countries started to reconsider the role of the state. Most of them decided to shift from 'rowing to steering'. The higher costs indicate that the state has to reconsider its role in the health care as well. In both countries the state tasks are changing. They have to give more and more space for private actors in order to maintain financial sustainability. New private actors can bring new incentives into the system such as hard budget constraint, profit-orientation (cost reducing). These incentives might turn the health care into a more effective system from a financial point of view.

As Shleifer states private ownership is more suitable if innovation is important, consumer choice is effective and reputation mechanisms are strong. In health care innovation is indeed important. Assuming that the market functions perfectly (no asymmetric information, consumers behave rationally, there are no transaction costs etc.) consumer choice is effective. However, in practice the market does not function always perfectly since these aforementioned factors exist in real life. The task of the state is to reduce the effect of these factors.

The concrete measures that have to be taken are the following. The performance of the insurer companies have to be comparable. Integrated benchmarking and performance measurement systems have to be set up in order to inform citizens about the activity of the insurers. This way the problem of asymmetric information and transaction cost can be cured to a certain extent. The state has to set up the rules for the competitors and than supervise the

competition. In my opinion unlike the Netherlands, as a last resort the Hungarian state has to maintain a state-owned insurer to guarantee the solidarity in the system.

7. *Guarantees and obligation have to be built in the new system*

In order to defend the rights of the costumers guarantees and obligations have to be built in the new system. These rules can be 'photocopied' from the Dutch model since the aim of these guarantees are exactly the same in both countries. These aims prevent insurers to cherry-pick and to discriminate among patients. Every patient has to be accepted by the insurers. A scheme that determines health risk for every citizen has to be adapted. This scheme might take into account the age, gender, health history of the patients.

Like in the Netherlands a risk adjustment fund has to be set up. This fund might be managed by the state-owned NHIF.

Summarizing this chapter we can say that the Netherlands is a good place for Hungary to look for lessons in the field of health care. However, due to noteworthy differences - such as ownership conditions – the lesson drawing is not an easy task. I have showed that *'photocopying'* wouldn't be the most suitable solution for the current problem. Photocopying would mean a radical change in the Hungarian health sector and this would lead to unforeseen consequences. The health insurance reform and the health care reform should be in line with together but due to (political) time pressure huge distortions would happen if the Dutch model would be entirely photocopied[75]. The Hungarian reform process should be more coherent and more considerate. Like in the Netherlands the policy making method should be based on more cooperative and corporatist way of negotiations. Hungarian policy makers should not only focus on 'what' but also on 'how'.

Answering the 'what' question I have drawn up eight lessons. After drawing up recommendations I linked concrete policy measures to these recommendations in order to give a possible answer to the challenges that faces the Hungarian health sector. Some of these policy measures can be adapted from the Dutch practice some of them are different from it.

[75] On one hand shifting from an only state-owned insurer to a system where mostly private-owned insurers function. And on the other hand hospitals are still state-owned which probably hinders competition.

Conclusion

This paper aims to draw up lessons for Hungary taking the Dutch health insurance reform process as a blueprint.

In order to achieve my final goal I mainly used three theoretical papers. First, Rose's paper gave the framework of lesson drawing. Second, Shliefer's paper distinguished the important differences of private and state-ownerships. Third, Kornai and Eggleston's paper focused on values and beliefs that influence the successfulness of a given policy.

I mainly used two approaches. These approaches, the economic and the public administration approaches, were not contradictory with each other but rather complementary. The two approaches were applied parallel during the analysis and the lesson drawing.

First, I described the Dutch reform procedure. I mainly focused on the latest changes implemented in 2006. Beside the description of the financial structure of the new health insurance system I also devoted a reasonable attention to portray socio-economic and political segments that has influenced the reform process. Values and beliefs that have vital effect on the political decision making also have been illustrated.

In the following chapter I have presented the current status of the Hungarian health care system. After presenting the latest measures implemented by the government I have critically analyzed a potential policy proposal written by Mihalyi et al.

While describing the Dutch and the Hungarian systems I aimed to present both of them from the same point of view. After presenting the two cases separately I have compared them. During the comparative analysis I have discovered numerous similarities but also noteworthy differences as well. These comparative facts made it possible to draw lessons for Hungary from the Dutch case.

As I have already mentioned the similarities between the countries such as dealing with the same problems (aging population, illusion of free health care, growing technological costs, free riding etc.) and also trying to reach the same goals (improve efficiency meanwhile maintaining solidarity, enhance transparency, increase individual sovereignty and cost-awareness etc.) made the Netherlands a good ground for searching for lessons that can be implemented in Hungary later on.

However, vital differences make it impossible to 'photocopy' the Dutch model. Using Rose's terminology hybrid adaptation would be a better choice in my opinion. Differences can be observed with respect to secondary providers (hospitals are mainly private in the Netherlands and mainly state-owned in Hungary), values (corporatism in the Dutch policy

making method, paternalism in Hungary), historical past (uninterrupted market-oriented capitalism in the Netherlands and decades of severe central planning communist regime) for instance. This means that photocopying would be a too radical change and it would lead to unforeseen consequences. Transforming only the insurer market would not lead to better health care. All-comprehensive and fundamental changes are needed with respect to the entire field of health care.

The next recommendations and steps for Hungary have been summed up in the last chapter. Taking the Dutch reform as a potential model first I have written recommendations. Then I linked concrete measures to the recommendations mainly using the Dutch model. These recommendations can be summarized in seven points. Once more these recommendations are the following:

- Solidarity has to be maintained;
- Competition should be strengthened with the participation of private insurers;
- Insurance market should be transformed from supply-driven 'market' into a consumer driven real market by covering the residual demand coming from the citizens;
- More transparent way of handling individual health account is needed;
- Time need of the program is important (negotiations and discussions with the stakeholders are unavoidable for instance);
- Role of the state has to be reconsidered (more steering and less rowing);
- Guarantees and obligations have to be built in the new system.

The seven recommendations have to be complemented with concrete policy measures. These measures might be the followings:

- Private insurers have to be involved in the new system but at the same time NHIF shouldn't be abolished.
- Care allowance has to be adapted in order to maintain full coverage.
- Risk adjustment fund has to be set up in order to hinder cherry-picking.
- Framework of the competition should be clear and unambiguous to every stakeholder however, setting up unnecessary constraints for insurers (e.g. maximum or minimum number of patients) have to be avoided.
- Supervision of competition has to be carried out by the Hungarian Health Insurance Authority later on.
- Individual health accounts have to be implemented in order to strengthen transparency.

- More time is needed for the reform process, negotiations and discussions with the stakeholder groups are unavoidable while configuring a stable and socially accepted new system.
- Integrated benchmarking and performance measurement systems have to be set up in order to lessen the effect of asymmetric information and decrease transaction costs.
- Consumers should be allowed to change insurer every year.
- Guarantees and obligations have to be set up in order to avoid scream-skimming by the insurers. Moreover, all patients have to be accepted by insurers.

No matter what will be the final decision of the government some of these lessons taken from the Netherlands can be practically used in Hungary in the near future. However, I have shown that the photocopying of the Dutch model might be risky. Instead of total photocopying the Hungarian decision makers might adapt certain lessons from the Dutch model.

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