

Equity and health care reforms in Hungary: comments on the government's reform proposal

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I. Introduction

Health care reforms are difficult not just in Hungary, but all over the world. The reason for this is not simply technical: the well known peculiarities of health care that make commonly used resource allocation and distribution mechanisms to produce unwanted outcomes. It is as much political: the members of human communities often have confronting views about the good society, and within that the good health care system and disagreement over values is also a source of heated health care reform debates. Furthermore, politics influences the feasibility of reform plans: individuals and groups try to further their interests regardless of whether or not these are in line with the normatively defined values of the community as a whole. To be successful, policy makers should take into account the normative political (moralphilosophical), the feasibility as well as the professional/technical aspects of health care reform. To be constructive, policy analysts should clarify all these aspects of a reform proposal. In this paper, I try to do exactly this on the basis of the problem-based policy making framework which has been developed over the course of the past 10 years in the health policy workshop of the Health Services Management Training Centre.

II. First Principle: Value-driven Policy Making – The Normative Politics of health care reform

Too often, decision makers focus on specific ideas or models, which they would like to introduce. We can hear statements like “the problem in Hungary is that we do not have competition in the health insurance system”. The problem with this type of “problems” is that they concentrate on the therapy without properly diagnosing the disease. Diagnosing a disease, however, requires first the identification of symptoms and signs, the areas, where the human body or mind malfunctions compared to a healthy individual. But how do we know if a health system is healthy or ill? The answer to this question is not as unequivocal as in the case of patients. Unlike medical problems, the definition of health system problems depend on such an ideal state, which can be very different for different human communities depending on their vision of how the “good society” should look like. What is a fair or just distribution of health or health care, for instance, depends on the moralphilosophical standpoint and individual or a society adopts. An equitable system for a libertarian is not the one which minimizes the disparities of health status or access to health care among the members of the society or different groups of people within a society, but the one which provides the choice of individuals to spend as much on health care from their income as they wish. For a utilitarian, who would like to maximize aggregate gain, how much health care one has access to does not matter until health care is consumed by those, who get the highest net benefit. Thus, the same state of affairs in a health care system can be problematic from one

point of view, while welcomed by another. Therefore the first prerequisite of a meaningful problem definition is to clarify the normative politics of the reform.

II.1. Accessible, high quality and sustainable healthcare and long-term care: How should we handle the trade offs?

The framework for the health policy objectives of the Hungarian governments' reform proposal is the European Union common objectives of accessible, high-quality and sustainable healthcare and long-term care. It is important to realize, that these objectives represent a mixture of moralphilosophies, and the multiple objectives can and often do get into conflict with each other. For instance measures, which are planned to improve the financial sustainability of the system by containing health expenditures can hurt quality and accessibility, which often require increased spending. It is important to note that from the point of view of policy making and policy analysis not multiple objectives per se are problematic, but the lack of clear priorities between objectives when these objectives come into conflict and we are forced to make a trade off. Without clear priorities it is not possible to evaluate the appropriateness of reform measures unless a strategy is dominant, i.e. better (or at least the same) for all objectives.

II.2. A more precise definition of equity: Further complications for policy making

Further complications may arise from the imprecise definition of objectives. Although, equal access for equal needs, and the reduction of disparities in health and access to care is a more precise definition of the equity objective, they do not provide sufficient guidance for what is considered desirable, what is considered problematic and what the restrictions on reducing inequalities are. A policy which would exclude the treatment of certain diseases from public financing may not be considered inequitable horizontally, and if care is denied for rich and poor alike may not even increase disparities in health status among rich and poor. It certainly will increase disparities in health status of these patients and the rest of the population. More importantly a policy which would worsen the health status of both the rich and the poor, but more of the rich than the poor, would decrease health inequalities. Or a policy which improves on the health status of the rich and the poor alike, but more of the rich than the poor would increase disparities in health even if the poor were also better off. And does everybody matter equally? Is the average of certain population groups that matters or the outliers? Should rather we focus on people with the worst health status or the difference between some sort of averages?

II.3. The focus of the analysis: Production efficiency and waste

To avoid these pitfalls, I have chosen another objective for the focus of this policy analysis: production efficiency. Production efficiency requires that whatever we would like to achieve, achieve it at least cost, i.e. we should avoid wasting scarce resources. Production efficiency in its wider sense is not a controversial objective from the point of view of normative politics, because it is compatible with all the moralphilosophies. But how does it relate to the other objectives like equity? The answer is simple: if we can reduce waste, we can do the same from less resources, and the resources that have been freed can be used to improve equity, quality or financial

sustainability. This is the argument, which underpins the government's strategy of improving equity.¹

Nonetheless before we turn to the analysis of actual reform measures, it is important to clarify what do we mean by waste. Production efficiency requires that we should not use more resources to produce a certain output than it is necessary, and that we should select the combination of appropriate inputs which is the cheapest. In health care, however, the production process is complicated by asset specificity, which does not allow to promptly increase or decrease existing capacities, and by the substantial variation of need and demand for health care over time. Therefore, it is not possible to conclude that a health care facility is productively inefficient, just because its capacities are not fully utilized at a particular point of time. A certain level of reserve capacities is also needed to enable the organization to effectively cope with internal operational problems or external changes (see Hirschman's theory on organizational slack). Furthermore, it is possible that one would like to improve geographical access to care by designing two or three smaller health care facilities rather than one large one. In this case some of the economies of scale are sacrificed in exchange for better access to care. In these cases something is gained by having temporarily unused capacities, or by not utilizing the potential economies of the production process fully.

In contrast, this analysis focuses on "pure waste": the use of ineffective or dominated technologies, the provision of unnecessary services (supplier induced demand), the provision of the same service at higher cost by treating patients at unnecessary high levels of care. The elimination of these inefficiencies is of paramount importance for all health care system, because more can be done from the resources spent on health care, regardless of what the actual health policy objectives are.

It is worth noting that this paper will not examine allocative efficiency. Questions, like how much should we spend on health care compared to other sectors of the economy, or how much one unit of health gain worth would lead us back to the normative political debate, which was discussed before. This is not to say that the value of health is not an important question, but that there is not enough guidance provided by the government to make a meaningful analysis of this issue. While the sustainability objective calls for an overall spending cap, cost containment might come into conflict with the objectives of equity and quality. Instead of analyzing the trade-offs in detail, I will only point out, when an improvement in access to care, quality, or more cost-effective care (on the basis of the extrawelfarist notion of efficiency) require increased spending.

III. Second Principle: Evidence-based Policy Making

The principle of evidence-based policy-making requires that once the objectives of the health care system are agreed on, the definition of problems, the diagnosis of the causes of these problem, and the choice of policy interventions should be based on scientific evidence to the extent this is possible. Although we know much more about what does not work than what works, at least we can try to avoid repeating others' mistakes. Nevertheless, in the frame of this paper I am going to provide only a general summary of the evidence base without getting at the details.

¹ National Strategy Report on Social Protection and Social Inclusion 2006-2008. Section 4.2.2, p.59.

An elaborate problem diagnosis is beyond the scope of this paper, too. The aim of the analysis is to highlight the critical points in the reform proposal, and to introduce potential alternatives, thereby facilitate further discussions and debates about the future of the Hungarian health care system.

III.1. Problem diagnosis

By and large the problem diagnosis part of the document is correct, although it is certainly not complete. Geographical and professional inequities have been inherited from the state-socialist system, and it is true that the reforms of the 1990s had little impact on this legacy. There is strong evidence that informal payments have survived the reform era, but there is some evidence that they do not represent a barrier to access, at least as far as the first contact with the service providers is concerned. Understanding the motivation for informal payments is crucial for finding effective interventions for their elimination. Distrust in the system is certainly an important motivating factor, but there is some evidence that the motivation for informal payments is multifaceted, and therefore can not be addressed with a single intervention.

As far as pure waste is concerned, the diagnosis offered by the strategy paper is correct, but not complete. The new payment mechanisms which were introduced during the first half of the 1990s had a significant impact on production efficiency within levels of care (although there is no evidence how service quality had been affected), but the incentives embedded in the payment techniques encourage providers to treat patients at unnecessary high levels of care, e.g. to hospitalize patients, who could be treated in the primary care or outpatient specialist care setting. The strategy paper, however, fails to identify that this inefficiency can be attributed to the missing care-coordination function, and lacks of a systematic solution to the problem. It is not surprising then that no alternative options are considered, and unfortunately this systematic analysis is also missing regarding the new, competing health insurance model.

III.2. Analysis of proposed reform measures

In this section, I will review the various reform measures according to the government's strategy paper. To the extent it is necessary the analysis will be updated with the most important changes that happened since the strategy paper was submitted. Notably, I have added the functional privatization of the social health insurance system to the analysis, given that Ministry of Health is committed to introduce health insurance competition instead of the original proposal of strengthening of the purchasing function of the National Health Insurance Fund Administration.

III.2.A. Co-payment (user fee)

This measure is controversial for several reasons. First, there is evidence that user fees prevent necessary, not just unnecessary utilization. Given that we are talking about a flat fee, the burden is the highest for the poorest, and those who are ill, and consequently are frequent users of health care. Even if there is an exemption scheme in place, there is no system without error. The narrower the definition of who is considered socially indigent, the more likely that some people, who are in real need will be excluded, while the broader the inclusion base the weaker the incentive is. In this respect the technique of exemption also matters (no payment – no incentive,

ex post reimbursement – most likely to prevent necessary utilization). Second, the patient has little discretion over the utilization of the really expensive outpatient specialist and inpatient care, while preventing access to primary care does not make sense from the point of view of production efficiency. Primary care is the cheapest form of curative care, if the disease in question can be managed by the family doctor, and an early diagnosis usually entails better prognosis. Third, the costs of administration of the payment and the exemptions are usually high. The additional revenues and potential savings have to exceed the cost of administration to gain anything from this measure.

The introduction of user fees will indeed decrease informal payments, but only to the extent user fees decrease the ability to pay of households. There is evidence that informal payments in Hungary are not motivated by the ignorance of patients about official entitlements or the cost of care. Attempts to formalize informal payments will unlikely be successful unless the whole transaction (in situ) is formalized, for instance by allowing patients to pay the doctor directly.

III.2.B. The introduction of protocols

The development and introduction of protocols is an appropriate reform measure to increase quality and decrease inequalities in access to care, if there is an incentive and/or enforcement mechanism behind it to ensure its implementation.

Nevertheless, diagnostic and treatment protocols will not only reduce waste, but will also increase cost by uncovering unmet need (there is no estimation in Hungary how much money does the public purse spare with patients, who do not receive adequate care, or die before they get access to expensive technologies). More so, if protocols are based on the most effective therapies, which often do not coincide with the cheapest or the most cost-effective ones. When a therapy is more effective, but at the same time more expensive decision-makers face with an allocative efficiency dilemma: does the extra gain worth the extra cost, or the extra money should rather be spent elsewhere?

III.2.C. Rethinking the referral system

It is not clear what the proposal would like to change. There is a referral system in place in Hungary, although it is true that patients can bypass it and administer the process with the family doctor afterwards. If the proposal would like to strengthen the supervision and control of referrals than it would be good to know which actor is supposed to assume this role and how will it be implemented.

III.2.D. COORDINATING PRIMARY CARE ON SUB-REGIONAL LEVEL

It would be important to know, who exactly will coordinate primary care and how. In any case, it seems that capacity increase is proposed in disadvantaged regions, which is in line with the objective of improving equity in the system.

III.2.E. HOSPITAL CORPORATIZATION

The corporatization of hospitals provides more discretion for the management to react to purchasing incentives and signals. This measure makes sense together with the strengthening of the purchasing function of the NHIFA. It may improve production efficiency and quality, but it is not clear why would a more profit-oriented functioning improve access to care, especially for unprofitable product lines, unless prices and tariffs are revised and corrected for all services.

III.2.F. WHO WILL BE THE CARE COORDINATOR? STRATEGIC PURCHASING, ESTABLISHMENT OF THE HEALTH INSURANCE SUPERVISORY AUTHORITY

I am going to analyze the last two proposals together, because they are related to the most important production efficiency problem of the Hungarian health care system, for which they provide one, albeit inconsistent answer. Who will coordinate the patients' pathways in the system across the various levels of care, so that patients will be treated at the lowest possible level, which is able to provide definitive care?

The strategy paper seems to assign this care coordination function to the one, national payer: the National Health Insurance Fund Administration (NHIFA). Selective purchasing is a very strong tool to influence the behavior of health care providers in order to eliminate unnecessary services and to ensure that the patient is treated at the lowest level of care, which is appropriate. In light of this, it is not clear why the quality control function should be assigned to a separate agency, unless the newly established Health Insurance Supervisory Authority will rather control the health insurance market, which makes sense only if the management of the social health insurance scheme is opened up for private insurance companies. Indeed, the Ministry of Health's position has changed, and they are currently supporting the introduction of competition between health insurance funds, as a means to eliminate waste from the system. Then the question obviously arises: which option is more efficient in eliminating the production inefficiencies from the system? Which actor is better at the care coordination and cheaper regarding administrative costs?

In this paper I am going to consider the competitive health insurance model in detail, because there is a fairly extensive evidence base (from countries such as the USA and Chile) about its shortcomings.

Pros and cons: Is competition on the financing side a good idea?

The basic assumption behind the insurance competition model is that competition between insurance companies forces them to be efficient, which requires that they force the contracted providers to be efficient. The first problem with this assumption, however, is that the success of insurance companies equally depends on whether the insurance premiums cover the expected costs of the insured and the cost of administration (insured, providers, marketing, profit). In a system which is based on solidarity, the introduction of private insurance companies inevitably leads to the fragmentation of the national risk pool, and because the risk status of the individuals is heterogeneous, risk pools may be bad (worse risk status than the national average) or good (better risk status than the national average). These differences are vital for the insurance companies, because they may go bankrupt because of the bad risk pool, even if they do an

excellent care coordination job. Allowing the insured to choose among insurers can amplify the risk differences (risk selection), and make it even more difficult to distinguish whether a particular company has failed, because it had a bad risk pool or because it was an ineffective, poor care coordinator. Furthermore, risk selection is cheaper and pays off more than the troublesome management of service providers.

Unfortunately the evidence shows that risk selection practices can not effectively be prevented with regulations (for instance by forcing insurance companies to accept everyone regardless of his/her risk status). Eventually, it is the consumer-oriented approach that the government has to reproduce with regulations, which is difficult and costly to do, unless there is an incentive for the insurer to be customer-friendly with each client, as is the case among ordinary market conditions. The enforcement of accepting bad risks (patients, whose expected costs exceeds the premium the insurance company gets from the central fund) is not even desirable from the point of view of policy making, since we would like the most efficient care coordinator insurers to prevail, not the ones, who are either lucky, or sophisticated in risk selection. One potentially effective tool to prevent risk selection is risk adjustment. The better the risk adjustment, the weaker the incentive is for the insurer to engage in risk selection. Risk adjustment, however is a complicated "business": there are no good risk predictors, which are easy and cheap to collect (or at least are collected for other purposes anyway) and the more sophisticated the risk adjustment formula, the more expensive it is to administer. Carving out is another possibility, but carving out fundamentally deviates from the original idea of competition for clients, and therefore rather represents a third option, which is closer to the idea behind the care coordination pilot, which will be discussed in the next section.² Prevention and the management of chronic diseases are two key areas of the efficient management of contemporary health services, and health insurance competition fails to provide a solution for neither of these challenges. Chronic diseases are not insurable, therefore can not be managed on a pure health insurance basis, while prevention in a competitive environment is not in the interest of the insurers, since it requires upfront investment, which pays off in the distant future, and these investments are wasted should the insured decide to switch insurer.

Nonetheless, even if it was possible to eliminate risk selection totally, are competitive insurers the most efficient managers of service providers? First, the effectiveness of competition-based care coordination is limited by the information asymmetry between the provider and the insurer. As a third party, the insurer is not part of the service delivery process and obtaining information is costly. Second, at what price of this care coordination comes? There is a wealth of evidence from other countries that a competitive insurance based system is very expensive to run. On one hand, it requires strong central regulation, while on the other hand the insurers' administration costs are much higher and multiplied compared to a single payer system. This is in line with the logical foundations of the model. Not just the administrative systems are multiplied (separate systems for the registration of and contracting with the insured and the providers, and monitoring of service delivery), but the more intensive the competition is, the more expensive its administrative costs are. The increased marketing costs are coupled with increased administrative burden on the insurance company and the providers alike. If the insurers operate in the territory of the whole country and are successful to attract patients from all over the country, they have to contract with several providers scattered around the country, as it is unlikely that a

² Carving out is a technique to handle complex, usually chronic diseases by making insurance companies to compete for the management of certain diseases, not for patients.

patient would be satisfied with having to travel long distances to access care. Conversely, providers may have to have a separate contract with each insurer, just because patients in their catchment areas enroll in different companies. This multiplication of the administrative burden is further multiplied if insurance companies are allowed to set the terms of the contract, such as the methods of provider payment or the reporting requirements, freely.

So far, we have discussed the problematic areas of the competitive insurance model: risk selection and inefficient care coordination. Although none of these features are exclusive to the model (risk selection is just an enhanced version of the general sustainability dilemma of publicly financed systems) it is legitimate to ask the question: why does the Ministry of Health support a “solution”, which is known to cause more problems that it can potentially solve? Most probably, the very attractive feature of private insurance companies and banks is that they have a lot of money to invest, which the government is currently (chronically) short of. While this is a valid argument on the short term, one should not forget that the public will have to pay for this in terms of profits in the not too distant future. This would be perfectly acceptable if the source of these profits was the elimination of waste. However, as it has been discussed before, one can not exclude the possibility that the profit will be realized from risk selection, and even if we assume that insurance companies will be very effective care coordinators, the savings first has to offset the increase of other administrative costs. According to the Chilean experience this may be as high as 10-20% of the budget, which would be a stunning increase compared to the currently 1.5% of the NHIFA.

In summary, insurance competition does not seem to be a good idea for Hungary to adopt. Anything this model has to offer comes at a very high price. A more efficient model for care coordination is needed, which focuses on the care coordination function: where this function has to be placed in the system and how should it be implemented to maximize effectiveness and minimize administrative costs. The Hungarian care coordination pilot project has done exactly this, but it seems that the decision makers have undeservedly forgotten about it.

A third option: the care coordination pilot

In its parts the Hungarian care coordination pilot, which was initiated in 1998, resembles to the two other well known care coordination models: the managed care in the US and the fundholding experiment in the UK. However, there are significant differences, which relate it conceptually more to carving out.

The common feature of managed care and fundholding is that they integrate financing and provision: both the fundholder and the managed care organization (MCO) are a purchaser and a provider at the same time. They both manage budgets, but unlike the MCO the fundholder has no revenue collection responsibilities. They provide services themselves and contract with other providers to purchase care. Most importantly, however, they both manage resource allocation at the micro level: they manage the patient pathways in the delivery system and carries out the gate keeping function at lower levels of care. That is they both coordinate care.

The most important conceptual difference between fundholding, managed care and the Hungarian care coordination experiment is that the care coordination organization (CCO) assumes responsibility only for the care coordination function and leaves revenue collection,

pooling, budget setting, financial resource allocation, contracting and purchasing with the NHIFA, i.e. at the central level, where the administrative costs of these activities are the lowest.

The essence of the Hungarian care coordination pilot is as follows:

- The care coordination organization (CCO) can only be a health service provider (group of primary care doctors or polyclinic or hospital).
- For an adjusted capitation payment it assumes responsibility for virtually the whole spectrum of services (from primary to tertiary care) of a population signed up for primary care (family doctors) in a geographic area of concern.
- The budget calculated on the basis of the capitation payment is not transferred to the bank account of the CCO. The CCO is only a “virtual fundholder”.
- The CCO provides care and can collaborate with other providers to optimize the treatment of their patients.
- All health care providers are paid for on a monthly basis for the services they provide according to nationally uniform payment techniques (capitation in primary care, fee-for-service in outpatient specialist care and DRGs in acute inpatient care). Payments are made by the NHIFA to all providers, who provided services for the CCOs’ population. Payment data are available for each individual patient, because health care providers are obliged to report their activities to the NHIFA using a social insurance identification number unique to each patient.
- The balance is calculated at the end of each year; savings are transferred to the CCO and can be used for remuneration and investment purposes.

There are three types of CCOs:

- group of GPs (family doctors),
- polyclinics (outpatient specialist service provides),
- hospitals.

In the case of GPs, people on their practice lists become the population of the CCO. Polyclinics and hospitals on the other hand are obliged to contract with local GPs to have people to care for, but GPs can refuse to take part in the experiment.

Of course the success of the care coordination activity depends on the involvement of and cooperation with other health care providers. But, how can the CCO coordinate care and influence other providers? First, there is a financial motivation: savings can be shared with cooperating providers. Second, there is professional and ‘legal’ motivation. The CCO can analyze utilization data, which are provided by the NHIFA on the basis of the social insurance identification number of patients.

So, the Hungarian pilot does not change the ownership structure of the system, it does not reduce patient choice, and it does not change the payment systems for providers. The CCO does not manage revenue collection, does not decide on insurance premium levels, does not collect contributions, does not decide on the package of the services covered. Furthermore the CCO does not hold a real budget („virtual fundholder”), does not purchase services, does not contract for service provision, does not set prices and does not pay for service provision. As it has been mentioned before, the CCO carries out only the care coordination function. It manages the patient pathways in the delivery system, and focuses on gate keeping.

In conclusion, why does this model seem to be superior to insurance competition, a dominant option? First, revenue collection does not distract the focus of the CCO from care coordination, thereby risk selection and cream skinning can be minimized, if not eliminated totally. Second, if the CCO fails, patient will still be cared for, thereby the risks associated with insurance bankruptcy can be minimized. Third, efficiency gains can be realized if savings stem from the elimination of unnecessary services, or the rationalization of service provision by providing care at the lowest possible level. It is important to note, however, that savings can also be realized if the virtual budget is not based on actual costs, but some form of a need based formula, which was unfortunately the case so far. The objective of the reduction of regional inequities may be better achieved by a separate, need based budget, which can only be used for the restructuring and development of existing capacities. Furthermore, savings can theoretically be realized from under-treatment, which logically follows from the incentive structure.

Nonetheless, there are some remarkable features of this model, which works against under-treatment, still on the basis of incentives. First, providers have to generate enough income to survive until the end of the year, when savings are actually transferred to the CCO. Second, the CCO (and the collaborating providers) has no incentive to deny care for patients, because patients can choose other providers freely, whose service provision is not under the control of the CCO. Third, if care is denied, patient will cost much more later on. Fourth, because the CCO is a provider at the same time, doctors face directly the consequences of ruthless cost saving. Fifth, to a certain extent, it is sensible to build on the sense of duty of providers.

In conclusion, the experiment separates the care coordination function from other purchasing functions, revenue collection and the pooling function, and it assigns the various functions to the actor, which can implement the function at the lowest possible transaction cost (i.e. where the function can be realized most efficiently). While revenue collection, pooling, budget holding, contracting and payment are all centralized, the care coordination function is decentralized. Centralized payment for instance has the advantage that it is uniform and standardised, comparable, and therefore its administrative costs are low. Decentralized care coordination on the other hand is more efficient, because:

- The CCO is a provider itself: trusted player of the delivery system, especially if we compare them with insurance companies.
- It operates with low administrative costs, because the cost of the collection of information is lower and it does not have to manage a real budget. The CCO is close to the people, patients and other providers: know what is going on and able to build up social capital (trust), which has been eroded a lot in the past 60 years.
- It has the incentive for efficient use of scarce resources and has the capacity and position to influence this on the basis of the information that is collected for payment purposes anyway.

Therefore, the care coordination pilot is a practical example of the theory of functional deconstruction. Functions in the health care system are often bundled traditionally (e.g. insurance, purchasing), similarly to the market-government debate and dilemma (e.g. ownership and competition), but the logic and experience implies that different functions can be carried out at different levels and by different actors most efficiently. Bundled functions can not be carried out most efficiently, because the components of a bundled function, may be carried out most efficiently at different levels of the system by different actors, so functions should be separated

from each other as much as possible (functional deconstruction) and placed where they can be done at lowest administrative cost (centralization vs. decentralization).

IV. The third principle: Feasibility-orientated policy-making – the cost of disagreement

The last, but equally important principle of problem-based policy-making is feasibility. So far we have concentrated on the analysis of problems and potential solutions, but the benefits of any solution can be realized, if the solution is implemented in practice. In the frame of this paper I will concentrate only on two issues.

The implementation of health care reform takes time, which extends over election cycles. Therefore, a broad national consensus regarding objectives and interventions is a critical success factor of health care reform, especially in the case of reform measures that rewrite the foundations of the health care system. If for instance there is no agreement at least among the major political parties about the directions of changes, how can the necessary continuity in implementation be ensured? How much will it cost for the society, if a reform, which has been urgently pushed through will be reversed?

But can all decisions be reversed at all? The theory of path dependency suggests that there can be and are reforms that are irreversible. Is it worth to rush into reforms, whose outcome is at least dubious, but which are impossible to abolish should they prove not to deliver what was expected of them?

The evidence suggests that the competitive insurance model is such a risky “business”.