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The supplementary health insurance and the voluntary health saving funds

SUMMARY: In this study I will try to present the principles of the activities and the major indicators of the voluntary health saving fund in order to analyze its future role, perspectives and problems.* The goal of my in-depth interview research was to identify and explore the problems in the field of voluntary insurance. During the interviewing process I took into account the criteria formulated by the data recording methodology, using semi-structured questions during the interviews, which then were recorded. The recorded text was then subjected to content analysis. The analysis of the in-depth interview research material revealed that there was a need to define the concept of voluntary insurance and convert already existing phenomena into a theory. As far as the „supplementary health insurance" market is concerned, we can say that there are institutions working side by side within the system without making the effort to cooperate. Although market players are aware of the benefits of synergy, they do not use it in practice.

KEYWORDS: healthcare insurance, voluntary saving fund, private funding, public financing
JEL CODES: I11, I18

In Hungary private health insurance can be obtained through two different institutional systems. One is a financial service provided under the Insurance Act XCVI of 1995, however it does not have a dominant role in the product range of private insurance companies. The other option is the supplementary self-care offered through membership in self-organized, non-profit Health Saving Funds, in accordance with Act XCVI of 1993 on Voluntary Mutual Insurance Funds.

THE ACT ON HEALTH SAVING FUNDS

Act XCVI of 1993 defines voluntary mutual insurance funds as follows: "Association created by natural persons on the principles of independence, mutuality, solidarity, and voluntarity that organizes and finances services complementary to or replacing social security care and promotion of health protection services. The services of the fund are organized, financed and provided from the members' payment, based on individual account management." Hereafter I am going to refer to the Act on Voluntary Mutual Insurance Funds as the Act of 1993 or the Fund Act.

The Act was created in 1993 after the political changes with the goal of motivating and promoting personal savings. In this sense funds provide an institutionalised form for self-care, where the sum that has been paid can be used for health protection or supplementary social security services by fund-members or their close relatives.

The French *mutualite,* which served as an

* The material contains some of the results of a broader research on supplementary insurances carried out for my doctoral dissertation.

example, was structured around municipalities and became an integral part of social security in many fields of services. However, this example only served as an objective, in reality a form essentially different from the operational principles of social security has evolved in the last sixteen years.

The establishment of health saving funds in Hungary was part of the reform of the social security system after the political changes, and the Act of 1993 was meant to play an important role in the process. The is also manifested in the Act's concept of approved funds. According to the Fund Act, the approved fund "organizes and substitutes for social security care or provides supplementary services in the given social security branch based on a special law…".

Since the introduction of the Act, the extent to which the governments have been interested in the assets of the Funds has varied, the role of the assets has been greatly determined by the existence of tax benefits. Their significance compared to social security is marginal, nevertheless not to be underestimated, since the assets of the voluntary health saving funds were more than HUF 52 billion in June 2010.

According to the Act of 1993 the operation of the funds is governed by the following principles: mutuality, independence, solidarity, autonomous operation, closed economic management, non-profit activity and the principle of association. The health saving fund is a legal person, which is registered by the regional court according to domicile. Until 2007 the state supervision of the funds was performed by the Hungarian Financial Supervisory Authority alone. From 2007 until September 2010, in compliance with Act CXVI of 2006 on the official monitoring of health insurance, it was executed together with the Health Insurance Supervisory Authority.

THE LITERATURE ON THE HEALTH SAVING FUND SECTOR

The number of professional articles dealing with the Hungarian voluntary health fund sector is negligible, considering its history of 15 years. It is mostly referred to as the alternative investment/deposit option to the voluntary pension funds and as an undeveloped field of self-care for the future. In most cases the authors of the publications are in some form related to the health fund system, so there are very few critical observations – they usually focus on the sector's development and the usefulness of fund services (Stabilitás, 2008; Kóti, 2003; Matits, 2005). Therefore, it is precisely people from these institutionalised systems, who thus create their professional background to substantiate the need of their own existence.

The plans for the reform of 2006 (Ministry of Health, 2007; Dózsa, 2006; Pinke, 2007) contain voluntary health funds as marginal parties. Their main task for the future is the same: financing co-payments. The reformers only placed them into the prospective health system without elaborating on their role in the system. The Green Paper[1] does not even mention voluntary health saving funds.

The Fund Act deals with voluntary, mutual insurance funds, thus providing the funds with the opportunity to operate as truly supplementary insurances (approved funds), however, in practice they function more like savings banks.

Although the Fund Act deals with voluntary, mutual insurance funds, they are not real insurances. Just like referring to social security as insurance in the Hungarian language, it is an inappropriate, but widely accepted term. According to *György Németh* (2003) 'the membership of the health fund is the social security of its micro society, based on solidarity with no legal obligation.'

Equity and solvency are not necessary for incorporation, therefore the Fund Act which

contains both insurance and fund terms is not about "real" insurances, but rather about insurance associations, which are not covered by the Insurance Act. In case of insurance the individual account is meaningless, since the insurance premium is determined by the probability of loss. In other words, the insurance premium depends upon the magnitude of the risk. The individual equivalence (parity) is an essential characteristic of the insurance activity, which is missing in the case of health funds.

György Németh (2004a), in his analysis of the 10-year history of health funds, criticizes the correctness and terminology of the Fund Act in many places. In his study he describes voluntary health saving accounts as the last decade's governmental blunder.

It is a fact that the existence of the sector is highly determined by tax benefits. Nevertheless, I believe that for social reasons it is very important to strengthen the culture of self-care of the employees and to establish institutions of self-care to ease increasing pressure on public healthcare. This is also supported by the study about the forms of self-care (Ágoston et al, 2007). Based on the results of the survey the level of self-care is much lower relative to individual expectations.

Examining the growth of funds *Ágnes Matits* (2005) came to the conclusion (shared by others) that the growth of the health saving funds is fuelled mainly by the expansion of the employee benefits system (cafeteria). A survey made by the GKI-EKI (Adler et al, 2007) emphasizes prevention as the main task of the funds which cannot be replaced by others, since in their opinion the role of the funds in the organization of savings for healthcare had remained marginal despite of tax benefits. Contrary to that, the executives of the funds emphasize the rapidly growing fund membership and income from membership fees (MÖESZ, 2007). Besides health protection, their most important goal is to alleviate the burdens of financing disease treatment.

TRENDS AND DATA CHARACTERIZING THE OPERATION OF THE HEALTH SAVING FUND SECTOR

My analysis reviews the aspects and data of the institutional structure, membership fees, fund deposits, services and tax benefits, using the data of the Hungarian Financial Supervisory Authority (PSZÁF), the Health Insurance Supervisory Authority (EBF), the Central Statistical Office (KSH) and the funds.

The share of health saving funds in the fund sector, their institutional groups

Since the foundation of the health saving funds, their share of the voluntary funds market, which has three players, has been dynamic both in terms of income and membership. While according to PSZÁF data, health saving funds accounted for 20.8% of the voluntary fund sector's revenue in 2004, this number grew up to 35.2% in 2009. There was no positive in the mutual funds from 2006, and by 2009 their revenues decreased to one third, compared with five years ago (1,062 billions HUF). It is apparent that the growth of the health saving fund sphere is primarily due to the shrinking membership of the mutual funds and its decreasing revenues. This can be related to the stricter regulations on tax benefits after employer contributions and services. At the same time the health saving sector showed good development. Within the fund sector, the revenue of the health saving funds had the most dynamic growth in 2008 vs. the previous year, significantly exceeding the growth rate of the voluntary private pension funds. The 2009 results were probably influenced also by the fact that the payments to health saving funds were considered quasi-liquid investments relative to the payments to pension funds. This means that they are almost instantly available

for use, which, due to the crisis, made them more popular as short-term investments.

The health saving fund sector consists of three groups with different institutional backgrounds. Most of the *employer founded funds* have been present in the health saving fund market since 1996. The funds of state owned firms and government agencies with a large number of employees (e.g. Vasutas, Honvéd, ADOSZT, Postás, Tempo and Vitamin Health Saving Funds) belong to this group. The only interests taken into consideration at the time of their establishment were those of the respective large company. Most of their statutes do not even allow individual membership and some of them are determined as closed health saving funds. Their strength comes from the big number of employees working for these companies (5-20 thousand), which ensures big membership with the employer financing a substantial part of the membership fee. They had an initial advantage in terms of service infrastructure, because large companies already had medical and dental clinics, sport and recreational centres in which they could cost-effectively provide their members with supplementary health services. In 2003 the eight leading health saving funds from this group accounted for two thirds of the membership and four fifths of the assets.

At that time *funds with bank and/or insurance background* were only just emerging. They began operations based on the existing experience in fund management and health insurance. Their situation was special, since they could add health saving fund services to their existing products; moreover their extensive corporate client base facilitated the recruiting of members. The leading funds in this group in terms of membership and assets are OTP, AXA, and MKB Health Saving Fund. This sector shows the most dynamic growth in membership and wealth.

Funds organized by one or several healthcare providers belong to a separate group which is the youngest of all. Their advantage vs. the employer founded funds was their open structure, whereas their advantage over the closed funds (e.g. Vasutas, Honvéd) was in the opportunity for individuals to join them. The most prominent representative of this segment is Patika Health Saving Fund, which has the most members alongside the three big funds with bank/insurance background. Its wide network of pharmacies (2300 nationwide) represents a significant service base for the fund. Új pillér, Kardirex or Egészségért Health Saving Funds also belong to this group.

The number of health saving funds was 16 at the end of 1995, by 2006 their number had increased to 45, then it decreased to 37 by 2008 after significant consolidation. According to the data of the Health Insurance Supervisory Authority (EBF; 2009) in spite of the major increase in concentration values (Herfindahl-Hirschmann Index: 878)[2] the degree of market concentration remained low. However, the increasing trend continued and by June 2009 it reached the medium degree of concentration (HHI: 1037).

Membership and number of members

There are two major forms of health saving fund membership: membership motivated by employer support and individual membership. Within the total number of members the former is predominant.

Previously, the health saving funds founded by large corporations dominated the market, but since 2004 the market shares have been changed with the increase of the number of funds with bank/insurance background.

TEMPO and Patika Health Saving Funds caught up with Honvéd and Vasutas health saving funds. Increasingly important social groups expressed a growing demand for individual health saving fund membership. This

demand was not met by the funds founded by large companies, contrary to market-based funds, which essentially counted on individual membership. A great progress was achieved in 2001: since then the health saving funds have been entitled to the tax benefits previously applied in the case of voluntary pension fund payments – with this the initial differences in receiving benefits disappeared. Further progress lies in widening tax benefits from 2004 accompanied by stricter regulations for the utilization of savings in the health saving fund accounts. Fund membership is created by the employee (fund member) by filling in a registration form, to which a clause is then attached by the fund. The employer can assume the membership fee in the form of employer contribution (based on a contract with the health saving fund).

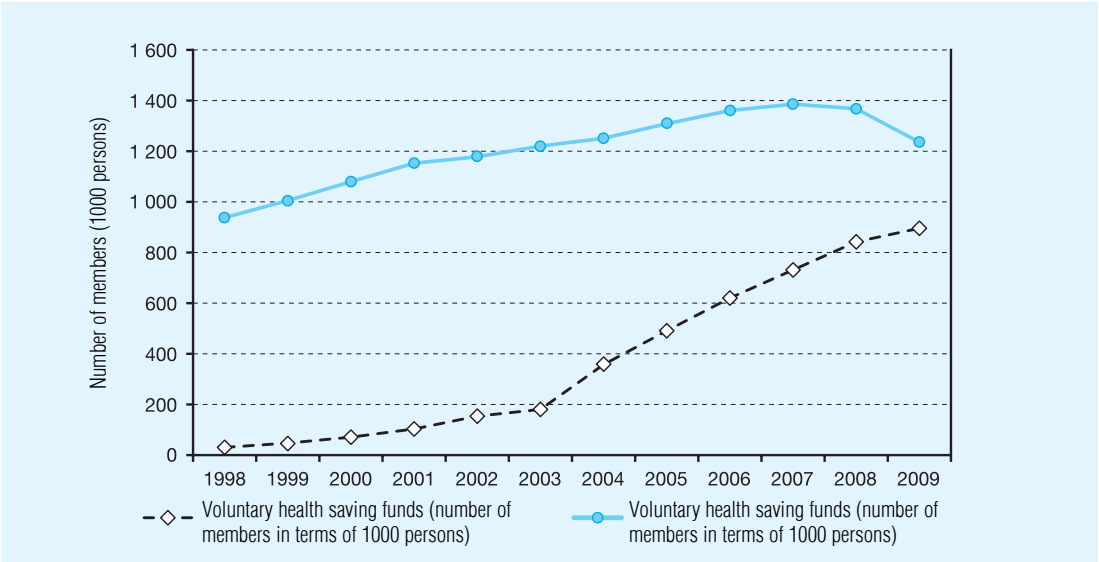
Based on valid membership, the member is entitled to receive the services of the health saving fund, unless the statute of the fund stipulates a waiting time. This practise is not common for health saving funds, but the law makes this option possible. The employer's contribution can be the same amount of money or the same percentage of the salary, however if there is an employee benefit (cafeteria) system, health saving fund contributions can vary. Voluntary pension funds have significantly greater membership compared to health saving funds, but membership growth in the former group has slowed down in recent years and the market has reached a phase of saturation.

As shown in *Chart 1*, from 2004 the growth dynamics of health saving funds have overtaken voluntary pension funds in terms of membership. However, the growth dynamics in the health saving funds are very similar to that of the first, exponentially growing phase of the voluntary pension funds. It is worth taking this trend into consideration also when determining the prospective number of health saving fund members.

The annual growth rate has increased since 2003, which may have various explanations:

Chart 1

MEMBERSHIP DEVELOPMENT AT VOLUNTARY PENSION AND HEALTH SAVING FUNDS, 1998–2009



Source: Hungarian Financial Supervisory Authority's data

- the appearance of funds founded by financial institutions and their efficiency in recruiting members,
- the prevalence of the self-care notion, as well as the views on the deterioration of the healthcare system,
- the appearance of health saving fund contributions in the employee benefit (cafeteria) system,
- the funds themselves and advertising the opportunities provided by funds,
- the standardisation of applicable tax benefits.

Revenue and assets

Revenue and wealth have exhibited similar growth dynamics to that of the membership in recent years. The assets of pension funds were more seriously affected by the financial crisis because of their investment structure. By 2008 these assets had decreased by 11.3%. Only the health saving funds experienced growth in the funds sector, but their growth also slowed down compared to previous years.

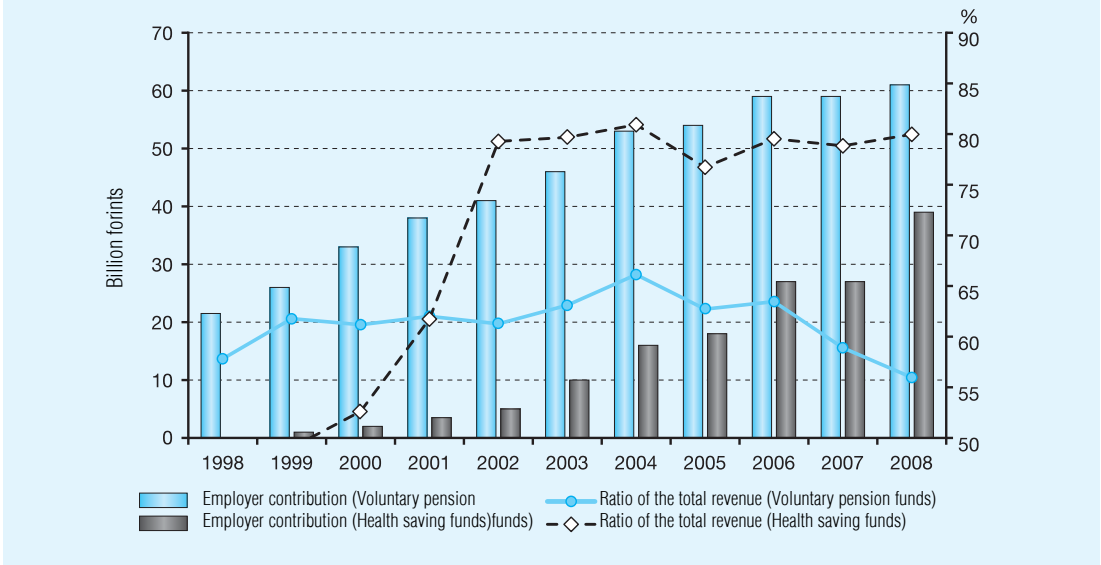
Employer contributions accounted for the predominant part of primary and secondary sources of health saving fund revenues. Their share of 80% has been stable since 2002 *(see Chart 2)*.

The primary sources of revenue include individual membership fees (14.5%), ad hoc payments by members (4%), and subsidies (1.5%).

There is seasonality in primary revenues. The fourth quarter is usually strong and a decline occurs in the first quarter. This information is especially interesting and worth analysing with respect to individual payments. Although the funds (Stabilitás, 2009) explain this with the fact that "members are willing to pay their membership fees out of their own pockets or from their family's budget", I think this is due to opportunities provided by legislation. Since the regular membership fee can be paid not only monthly, but also semi-annually or annually, members who want to get tax benefits "quickly" will opt

Chart 2

THE PERCENTAGE OF EMPLOYER CONTRIBUTION WITHIN FUND REVENUES



Source: Hungarian Financial Supervisory Authority (2009)

for the year-end payment. Members, motivated by getting tax benefits, are interested in keeping their money in the fund for as little time as possible, therefore the payments in the last quarter are significantly greater than during the previous quarters, while the number of fund members increases similarly to the other periods.

There are particularly large differences in the members' other/miscellaneous payments and subsidies (*see Chart 3*). Based on the data of the Stabilitás Fund Association, the value of other/miscellaneous payments paid into the funds of the Association is five times larger and the value of subsidies and individual membership fees is two times larger during the 4th quarter compared to the 1st quarter, while the growth of employer contributions is not higher than 8%, which is slightly lower than the quarterly increase in membership. Therefore, some members seek to maximize opportunities given by tax benefits. Since payments can be used almost instantly and there is a wide range of services, fund members have cheaper access to them than non-members.

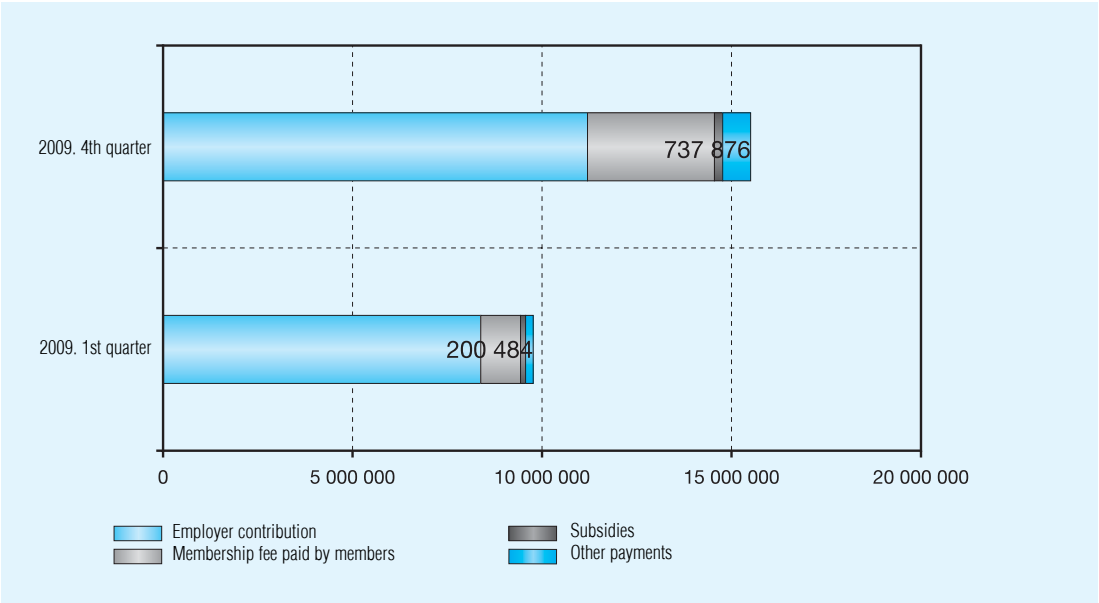
However, this type of system, which manages increasing amounts of money, does not motivate long-term savings for health purposes in my opinion – instead, it stimulates quick spending of individual payments and subsidies.

Services provided by health insurance funds

Services provided by health insurance funds can be categorized in several ways. Prior to 2007 a good starting point for this purpose was the Fund Act, according to which a fund is an association "that organizes and finances supplies helping health protection and services complementary to, or substituting for social security care". This makes it possible to group funds into service provider and financial categories according to their tasks.

Chart 3

THE DISTRIBUTION OF PRIMARY SOURCES OF REVENUE IN THE FIRST AND FOURTH QUARTER OF 2009



Source: Stabilitás Association's data, edited by the author

A special opportunity provided by the funds allows not only the member but also close relatives (usually three relatives mentioned in the contract) to use the services provided that, as a result of regular payments by the member, there is enough money in his/her individual account.

Fund services were first regulated by legislation in 2007 (MÖESZ, 2007). Until then, unfortunately, the Act did not specify what services should be included, and the range and conditions of taxation of services changed continuously. This situation lasted until June 2007, when services were divided by legislation into two groups based on taxation.

Therefore, the statutes of the funds distinguish between the *supplementary health insurance services* and the *lifestyle improving services*. While therapeutic services are supported by tax benefits, services aimed at prevention are taxable.

Tax benefits

Payments into the funds are regulated by the relevant provisions of the Personal Income Tax Act and the Social Security Act. Health saving funds react very sensitively to changes in these acts, it could also be said that their very existence depends upon these acts.

Since 2004 the magnitude of available tax benefits has significantly increased, and social security was no longer capable of satisfying the extra demands in health services – both factors had a favourable impact on the foundation and popularity of funds. Further opportunities for expansion were provided by the fact that free capacities after the saturation of the pension fund market could be channelled into the health saving funds. This expansion was slowed down by the taxation of employer contributions from 2010.

Individual payments, which include membership fees and ad hoc payments, continue to be eligible for 30% tax benefit to be credited directly to the health saving fund account. This benefit rate was initially 25% or 50% in the case of voluntary pension funds. The le-gislation, which was changing year after year, had favoured voluntary pension funds compared to health saving funds until 2000. Considering the dynamic development of the sector, the standardization has also greatly contributed to the growth of both memberships and assets: it doubled every two years after the standardization.

The following serves as a great example of the extent to which payments depend on tax benefits: in 2007, when the tax-exempt part of employer contribution was 13,100 forints, payments stayed at the level of the previous year. In 2008 the limit of payments increased to 20,700 forints, so the amount of payments increased from HUF 35 billion to HUF 48 billion.

In the case of all fund payments the tax credit cannot be more than HUF 100,000. This translates to an annual payment of HUF 333,000 or HUF 27,770 per month. An additional 10% tax benefit can be used by the fund member in case he/she spends the amount on preventive services. Moreover, a fund member is also eligible for a further 10% tax benefit after payments on minimum 2-year fixed deposits. Membership fee contribution paid by the employer is considered as a cost of production, which does not increase the employer's income tax base.

Grants or donations to the fund (apart from membership fee contributions) are considered as commitment of public interest, and donors can get tax benefits amounting to 20% of the positive tax base. Services provided by funds are income tax free unless cash withdrawal is requested in case of termination of membership or death of the fund member.

THE APPLIED RESEARCH METHODOLOGY

According to *Lincoln-Guba* (1985) and *Silverman* (2000) one of the great advantages of qualitative over quantitative research is that

qualitative research can also be implemented for the examination of phenomena, where preserving uniqueness and realism is highly important. Moreover, it also enables the contextembedded description and comprehension of current social phenomena. The research focussed on conducting a sufficient number of in-depth interviews, which were most useful in the process of identifying and exploring the problems. During the interviewing process I took into account the criteria formulated by the data recording methodology (Heltai–Tarjányi, 1999) and other researchers (Babbie, 2004; Majoros, 2004; Seidman, 2002). In order to increase the reliability and validity of the interviews, I took them myself. Furthermore, I always clarified the purpose of the research and the methodology of data management as *Kvale* (2005) suggests. The interviewees and I agreed that the first version of the material would be available to them on demand and their opinions would be taken into consideration during the construction of the final version.

Sample selection

In order to ensure the quality of the research, only executives and recognized experts from different fields of health insurance were selected to be interviewed, such as present and past executives of the National Health Insurance Fund, representatives of private insurance companies, directors of health saving funds, health insurance consultants, brokers, academics and researchers working in the health insurance sector. All participants of the survey are experienced professionals with both theoretical knowledge and practical expertise in the field of health insurance. All of the seventeen interviews were taken between 2008–2010. Interviewees are listed by codes consisting of a combination of a letter and a number *(see Annex Table 1)*.

The final form of the in-depth interview questionnaire was realized during and with the help of the first interviews. The semi-structured interviews and the open questions made it possible for my interviewees to freely expound their opinions. They shared some invaluable insights which, in many cases, proved to be more valuable than those found in the professional literature on the topic, since up-to-date and profound knowledge, ideas and opinions often arise in verbal form first. The interviews lasted approximately 60–70 minutes on average. They were recorded, from which I wrote a verbatim transcript. Finally a 150 page research material was comprised. The text was analysed with the help of the content analysis methodology, described by *Strauss* and *Corbin* (1998) in their demonstration of the "grounded theory".

The analysis of the in-depth interview research material identified a number of issues, which appear and generate debates among people working or teaching in, or affected by the health insurance sector.

RESULTS OF THE EMPIRICAL RESEARCH

Different interpretations of the concept of health insurance and problems caused by them

Since supplementary health insurances available in institutionalised form in Hungary contain health insurances provided by health saving funds and private health insurance companies, this chapter goes beyond the health saving fund sector in order to investigate the various interpretations of the concepts in a wider context.

In the interviews, the vast majority of interviewees defined supplementary insurances as "operating in the area not covered by social security" [A1], a so-called second level [A3], or a second and third pillar [D3]. This means a

type of insurance existing in parallel with and complementing social security. "Supplementary is a paradigm, it means complementary to the dominant public funding" [A1]. It represents a type of functional distinction to denote the part not included in the basic package of health insurance.

There was no clear distinction between the concepts of supplementary and private in many interviews: "Supplementary and private mean the same, because supplementary segment only exists in the private insurance, there is no supplementary public [insurance]... I would rather distinguish between mandatory and individual form of insurance."[D1].

In addition to the fact that supplementary insurance functions in parallel with social security, it is important to distinguish it from the so-called alternative supplementary insurances.

"The meaning of alternative is that it \[functions] instead of social security." [A2]. There are countries (Germany, Romania) where social security is not mandatory, and there are social strata or groups, which for different reasons are not a part of the social security system. In this respect the alternative (insurance) can exist also beside social security. This phenomena was not mentioned by the professional literature, although it exists in practice and contains the elements of the institutionalized structure of the future, therefore, I consider it important enough to be emphasised.

Private expenditures account for a considerable part of the total health expenditures in Hungary, their proportion is high even compared with the EU average. However, it was surprising that more than half of those interviewed questioned the amount of private expenditures. "Am I sure that it is not that much...private [expenditures] are only estimates, deviation is very high." [D1, E2]. The researchers of GKI-EKI [A1] tried to estimate the total amount of private expenditures, which can serve as a starting point. However, comparison between the EU countries is difficult because national health accounts may have different meaning in different countries: it is not only the problem of the amount of gratuity payment, but also the specifics of health saving fund accounts (e.g. the cost of sports shoes is also included in the private health expenditures and is entitled to tax benefits, which is questionable from several points of view).

Only one interviewee [A1] mentioned that apart from the abovementioned two institutions there are other private institutions, foundations, associations, which take part in the private funding of healthcare. In my opinion the experts interviewed are aware of the fact that these institutions exist, but no one takes them into consideration. Although they are few in number, they should not be neglected as forms of private financing. The household is also a type of supplementary private funding. "The supplementary forms – especially the business ones – when taking over functions from the household, are interested in making profits... We really need a paradigm shift here with respect to the inclusion of supplementary insurance in public tasks." [A1].

Another type of alternative supplementary insurance should also be mentioned, which already exists in its initial form and is widely known. The individual discontinues social security payments and chooses private insurance instead, because he/she is not satisfied with the services of social security or has a demand for a quality service, which social security cannot satisfy. "This is an emerging trend in Hungary and it is already operating in Poland. Quality is what matters, I would rather pay the entire price and leave social security... and I believe that we are heading towards this." [A2].

In conclusion, the functions and the role of supplementary insurances beside social security, being the dominant public funding, cannot be questioned. In a narrow sense, supplementary insurances include the ones provided by (business) private insurance companies. A

broader definition would also include voluntary health saving funds and other institutionalized private financing opportunities, such as foundations with health related activities, private enterprises and associations. Nevertheless, supplementary or private funding should always be considered in its relationship with public funding, since the areas not covered by social security are always changing. "It is always society that decides." [D1].

Actually it is the judgement of society and of course the productivity of the economy, which determines public funding and the degree of freedom of supplementary insurances. In Hungary supplementary insurances actually means individual voluntary based private financing.

I believe that "alternative supplementary insurance", which already exists in practice and is yet to be featured in professional literature, will have a more important role in the future as a type of insurance with complementary functions to social security. It currently exists in two different ways in Hungary. One is the private insurance available for individuals who are not part of social security care. Although it does not offer the basic package for its customers, it provides them with an alternative. The other is for those who are not satisfied with social security services and are willing and able to pay more for better quality healthcare even if they have already paid the mandatory health insurance contribution to social security.

Possibilities and problems related to cooperation between voluntary health saving funds, private insurers and the National Health Insurance Fund

The efficiency of health saving funds could be greatly improved if they provided their services in collaboration with the social security and private insurers, instead of as an isolated system. This concept is well-known and accepted as a basic principle by health saving fund top executives, National Health Insurance Fund directors and the chief executives of private insurance companies. However, it has not yet been put into practice. "For a long time I believed that it was worth sitting down and thinking about the issues together, but now I cannot see the point of it." [C1]. The individual interest of the institutions always comes before the cooperation, which will benefit society.

Examining the possibilities of collaboration, however, we can say that, unlike private insurers, health saving funds perform functions similar to those of social security, therefore there is a better chance of cooperation between them in the future. This idea has supporters who put a special emphasis on the financing for health purposes provided by funds, most of which was directly related to health services financed by social security. "I believe that cooperation is the only possibility." [C2, D3].

During the process of data collection I experienced a high degree of mistrust from the executives. This is surprising because it would be important to know whether the activities and services of the health saving fund sector would/could benefit the social security budget. If a fund member uses services protecting his/her health, will this decrease the need for services to be financed by the National Health Insurance Fund? It seemed that market players were not interested in this question, although it could be an important argument for the their future existence. "I am not going to give any data, because it will be abused." [C1]. The lack of interest and trust is decisive with regard to this question.

In terms of cooperation several of the interviewed experts mention the lack of a basic package as one of the main obstacles to har-

monization [C3, C4]. Executives of health saving funds with different backgrounds have different opinions on this question. Funds with bank or insurer background consider it a major reason; others believe it is not a matter of collaboration but a matter of regulation, which no government has dared to introduce so far.

I believe that if the cooperation only included the opportunity of National Health Insurance Fund experts to observe/monitor the activities, administrative and control systems of funds or private insurers, they could get a lot of useful ideas and suggestions. This is definitely true in the area of control. Both funds and private insurers put special emphasis on the quantitative and qualitative control of services. "Service providers are not checked at the National Health Insurance Fund... the Fund does not have a control function." [C1]. This results in excessive use of the social security system.

In terms of cooperation we can say that there are institutions acting side by side within the Hungarian healthcare system, which are not interested in synergy-based cooperation.

SUGGESTIONS

In my opinion the survival and further support of the health saving fund system will contribute to the development of the population's self-care culture, which is currently at a low level. Moreover, it can alleviate the anticipated increase of costs, due to expected demographic changes and the technical progress in future decades.

A cooperation based on synergy between the institutions of the healthcare system can be made more efficient by the elimination of the lack of trust and interest experienced by health saving funds and in the social security system.

The more precise specification of the basic package would determine the exact boundaries of social security, and this, in turn, would help determine the areas of activities and tasks of supplementary insurances.

Due to the favourable tax system, the funds have achieved a significant growth in the past years in terms of assets, revenue and membership. If this trend continues in the future, it will help suppress gratuity payments and tax evasion in private healthcare services. This process could be supported by the invoice-based accounting and control systems of the funds.

NOTES

[1] Discussion document, published by the European Commission, to stimulate debate and launch a process of consultation, at European level, on a particular topic.
Following consultations, the Commission formulates its posiiton and proposes new legislation.

[2] The Herfindahl–Hirschmann Index (HHI) measures the competitiveness and concentration of the market. A value above 1800 means a high degree of concentration, a value under 1000 shows a low degree of concentration.

[3] http://www.pszaf.hu/data/cms1744443/riskoutlook_0905.pdf

NOTES

ADLER, J – PÉTER, J – SKULTÉTY, L – SZABÓ, L. (2007): *Az egészségpénztárak lehetőségei az egészségügyi reformban. (The potentials of health saving funds in healthcare reform.)* GKI-EKI Healthcare Research Institute Ltd.

ÁGOSTON, K – KOVÁCS, E – KOVÁCS, GY. (2007): „Forms of self-care: Information sources and choices of clients during the selection of self-care forms." *Biztosítási szemle. (Insurance Review)*. Vol. 53, Issue 1, pp. 43–55

BABBIE, E. (2004): *A társadalomtudományi kutatás gyakorlata (The Practice of Social Research)*. Budapest: Balassi Publishing House (Transl. by Gábor Kende and Mariann Szaitz) p. 700

BUSA, K – KÓTI, T – TATAY, T. (2009): "Proposal for the development of the voluntary health fund system." *Pénzügyi Szemle (Public Finance Quarterly)*. Vol. 54, Issue 1, pp. 172–183

DÓZSA, CS. (2006):"Hungarian healthcare and health insurance reform." Lecture.

HELTAI, E – TARJÁNYI, J. (1999): "Conducting sociological (in-depth) interviews.", online: http://adatfelvetel.hu/modszertan/interju.pdf

KÓTI T – SZABÓ B. (2003): "The position and role of supplementary health insurances in Hun-garian healthcare." *Egészségügyi Menedzsment (Health Management)*. Vol. 5, Issue 3, pp. 53–56

KÓTI, T. (2008): "Proposal for the development of the voluntary fund system." manuscript

LINCOLN, Y. S. – GUBA, E. G. (1985): *Naturalistic Inquiry*. Thousand Oaks, CA, Sage

MAJOROS, P. (2004): *A kutatásmódszertan alapjai. (Fundamentals of research methodology)* Perfekt

MATITS, Á. (2005): "The position and importance of voluntary funds." *Hitelintézeti szemle (Banking Review)*. Volume 4, Issue 4, pp. 1–16

NÉMETH, GY. (2003): "Health funds in Hungary. Part 1." *Egészségügyi gazdasági szemle (Healthcare Economic Review)*. Vol. 41, Issue 6, pp. 39–46.

NÉMETH, GY. (2004a): "Health funds in Hungary. Part 2." *Egészségügyi gazdasági szemle (Healthcare Economic Review)*, Vol. 42, Issue 1, pp. 38–43.

NÉMETH, GY. (2004b): "Health funds in Hungary. Part 3." *Egészségügyi gazdasági szemle (Healthcare Economic Review)*. Vol. 42, Issue 2, pp. 39–46.

PÉTERI, J. (2005): "Thoughts on the private financing of healthcare expenditures." manuscript

PINKE, I. (2007): "Health insurance in mid-reform." Lecture. (June 8th 2007)

SEIDMAN, I. (2002): *Interviewing as Qualitative Research.* Budapest: Műszaki Publishing, Budapest

SILVERMAN, D. (2000): *Doing qualitative research*. London: Sage

STRAUSS, A – CORBIN, J. (1998): *Basics of Qualitative Research*. Thousand Oaks CA: Sage Publications

Act XCVI of 1993 on Voluntary Mutual Insurance Funds

EBF, Health Insurance Supervisory Authority. "Comprehensive review of the voluntary health fund sector in 2008." 2009, online: www.ebf.hu

EBF, "Comparative analysis of voluntary health funds in 2009." 2010, online: www.ebf.hu

EUM, Health Ministry. "Opening the insurance market." (material for professional debate). 2007, online: www.eum.hu

KSH – Central Statistical Office. Online: www.ksh.hu

MÖESZ, "Pillars of healthcare financing." Association of Hungarian Voluntary Funds. 2007, online: www.penztarszovetseg.eu

MÖESZ, Association of Hungarian Voluntary Funds. Press releases. 2009, online: www.penztarszovetseg.eu

PSZÁF – Hungarian Financial Supervisory Authority, 2010, online: www.pszaf.hu

STABILITÁS. Stabilitás Fund Association Yearbook, 2008.

STABILITÁS. „1st quarterly report of health funds." 2010, online: www.stabilitas.hu

Appendix

RESEARCHERS, PROFESSORS	
A1	GKI – EKI, researcher
A2	Head of School, Health Insurance
A3	Associate professor and Head of Department
Representatives of private insurance companies	
B1	Director, Personal insurance, deputy CEO
B2	Director, Life insurance
B3	Financial consultancy general manager, ex-sales and marketing deputy CEO of a private insurance company
DIRECTORS OF HEALTH SAVING FUNDS	
C1	Health savings fund executive, Budapest
C2	Health savings fund executive, countryside
C3	Fund executive, fund taking part in the reform of 2006
C4	Fund executive, fund taking part in the reform of 2006
PRESENT AND PAST EXECUTIVES OF THE NATIONAL HEALTH INSURANCE FUND (NHIF)	
D1	NHIF ex-deputy director responsible for information technology
D2	NHIF head of division responsible for professional policy and co-ordination
D3	NHIF chairman, technological evaluation committee and pharmaceutical reimbursement
INSURANCE CONSULTANTS AND BROKERS WORKING IN THE HEALTH INSURANCE SECTOR	
E1	Private insurer, consultant
E2	Insurance broker
E3	Ex-private insurance consultant
PHARMACEUTICAL COMPANY EXECUTIVE, PUBLIC RELATIONS, STRATEGY AND CUSTOMER RELATIONS	
E4	President of the Association of Brokers