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Learning Processes in Hungarian Health Policy 1990–2004: A Case Study of Health Resource Allocation[1]

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Hungary became a democracy and market economy in 1989–1990. As a result of the transition process, new ideas and solutions were adapted to the various problems of public policy. This paper analyzes the policy and political learning processes of Hungarian health policy within an advocacy coalition framework. We focus on a case study of health resource allocation reforms, and use it as a proxy for wider health policy analysis, given the pivotal importance of this field in health policy reforms, particularly at the beginning of the period observed. When defining the right principles and solutions, it appears stakeholders were influenced to a large degree by trial-and-error learning processes: this may be at least partially attributable to the technical nature of the policy problems.

KEY WORDS: policy learning, health policy, resource allocation, diagnosis-related groups, Hungary

1990-2004年间匈牙利卫生政策的学习进程关于卫生资源分配的案例分析

匈牙利在*1989-1990*年间实现了民主和市场经济。作为过渡阶段的结果, 新观念和措施都被用于适应公共政策的不同问题。本文分析了倡议联盟框架下匈牙利卫生政策的政治学习进程。考虑到卫生资源分配改革在卫生政策改革中 (尤其在观察期间开始时) 的关键重要性, 本文对其进行了案例分析, 并将其作为测量“更广泛卫生政策分析“ 的指标。在定义正确的原则和措施时, 利益相关者似乎都在很大程度上受到了试错法学习进程的影响: 这可能至少要部分归因于政策问题的技术性质。

关键词: 政策学习, 卫生政策, 资源分配, 诊断相关组, 匈牙利

Introduction

Over the past 25 years, the countries of Central and Eastern Europe have gone through substantial social and economic change. In an historic setting such as this, learning processes play an important role in most areas of social life, and the development of health policy is no exception. This paper focuses on health policy learning processes in Hungary, as reflected in health resource allocation reforms introduced throughout the period following the change of regime, i.e., from 1990 until 2004 when these reforms came to a halt. The analysis is supplemented by an overview of the transition process itself, concentrating on the years immediately preceding the 1989–1990 turning point.

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Resource allocation mechanisms have a particular importance because, as will be seen in the case study, they were considered by many stakeholders, especially at the beginning of health reform processes, as a cornerstone, and that changing them would trigger widespread positive evolution.

Within a very wide range of literature on transition politics and economics —an overview of which would exceed the limits of this contribution—Haggard and Kaufman (2001) analyze public policy reforms according to three main axes: (1) whether the reforms in question are carried out in a situation of acute crisis or in a more relaxed environment, (2) whether the political architecture of the given country supports swift executive decisions or consultative procedures, and (3) whether the nature of the problem to be solved is a coordination one, i.e., a relatively wide-shared goal to be achieved via new methods, or whether a whole new set of institutions and procedures will have to be created.

In Hungary, the crisis element seems to have played an important role. The country went through an acute economic crisis, and was therefore in need of immediate reform between 1989 and 1996.

On an institutional level, however, the situation has been relatively calm and supportive to centralized decision making. The Hungarian political landscape is characterized by a strong government, answering to a unicameral assembly, which has served through the entire duration of each of its mandates since 1990. This has given the executive substantial leverage for reform, though this was often perceived as limited by, among other things, the existence of multiparty governmental coalitions.

As for the nature of the problem in hand, i.e., health resource allocation reform, it appears to be less a coordination issue, but requires, first and foremost, the creation of a complex institutional system. Because the solution itself is complex, it is relatively difficult to reach a consensus on its detail and, ex-post, to evaluate precisely its effects.

This paper builds on May's (1992) distinction between political learning and policy learning, the latter comprising instrumental and social policy learning. It tries to answer the question: What was the respective role of political and policy learning processes in Hungarian health resource allocation reforms after the change of regime?

As will be seen, substantial policy learning processes have taken place both before and during the introduction and refinement of a resource allocation system based on diagnosis-related groups (DRG). They helped this technical solution emerge as a rational choice at the time of transition to a market economy. Later, they also contributed to the acknowledgement that health resource allocation reform was no panacea, and that its incentives alone could not transform the whole healthcare sector. Meanwhile, political learning guided stakeholders' behavior within the newly created system. May's (1992) article also draws attention to the importance of trial-and-error—as opposed to systematic evaluation—in the policy learning process, which is commonly observable in the case treated here.

The paper is organized as follows. The next section describes in more detail the concepts and methods used to answer the question. Third section gives a brief overview of the Hungarian health system. Fourth and fifth sections present the different phases treated within the case study of health resource allocation policy in Hungary between 1990 and 2004. Sixth section concludes.

Concepts and Methods

This paper builds, first and foremost, on the theoretical grounds laid by Sabatier and Jenkins-Smith (1993), when defining their advocacy coalition framework (ACF). Although the framework has gone through some revisions, e.g., in Weible, Sabatier and McQueen (2009), these do not concern the concepts to be used here. Indeed, as Jenkins-Smith, Nohrstedt, Weible and Sabatier (2014) point out, those concepts have been used throughout the last 20 years to analyze different policy areas in a wide variety of countries.

The main concepts to be used here relate to coalitions, beliefs, and learning. The paper takes the ACF's approach of focusing on long-term (more than one decade long) evolution in given policy subsystems. It also stakes its epistemological position, in the sense that it wishes to analyze the policy arena as one of competing beliefs and world views—though it does not exclude considerations as to the stakeholders' pursuit of self-interest.

Within this context, advocacy coalitions are built around common beliefs regarding the positive or negative consequences of a given policy. Beliefs can be arranged into three categories. Deep core beliefs relate to basic values and the way one looks at the world. They separate optimists from pessimists and progressives from conservatives, but are rarely manifested directly in policy subsystems.

Conversely, policy core beliefs determine the fundamental orientation of actors relative to the issues of a given subsystem. For example, as Sabatier and Jenkins-Smith (1993) put it, the preference between economic growth and job creation on the one hand, and the protection of the environment on the other, may orient the stances taken and actions pursued by different stakeholders within the air pollution policy subsystem. One of the ACF's key hypotheses even affirms that the members of an advocacy coalition have to have similar policy core beliefs relative to the given issue. Though this hypothesis is not tested in this paper, policy core beliefs are regarded as constitutive of advocacy coalitions.

Finally, secondary beliefs relate to the technical details of a policy programme, i.e., what instruments best serve the pursuit of a policy goal inspired by policy core beliefs. Secondary beliefs are concrete, therefore easier to identify than deep core or policy core beliefs. They can also be the subject of policy learning: what May (1992) conceptualizes as instrumental learning. But policy learning can concern policy core beliefs, too. In this case, the interpretation of common good within the policy subsystem is altered. May (1992) calls this process social policy learning.

Within the ACF, policy learning—in connection with both secondary and policy core beliefs—can happen within and across coalitions. However, the alteration

of stakeholders' beliefs is not the only factor that leads to policy change: external factors, such as a change of government, or the rise of one coalition to a key position (e.g., ministry), play an equally important role. Although trial-and-error learning itself may perform an important function, the availability of good quality information on the policy issue can potentially lead to more intensive learning and more rapid policy change. Finally, policy forums and policy brokers may also have paramount importance as catalysts in the debate.

Political learning happens when stakeholders' beliefs stay the same, but they evolve in their methods and behavior in order to pursue their interests. Political learning typically comprises within-coalition learning on how best to act in favor of the given coalition's policy beliefs. However, in this paper, it is extended to the adaptation of stakeholders to the incentives created by a given policy instrument, and all their actions in order to gain power and resources within the predefined rules.

The health policy case study is based on: (1) the full bibliography of István Bordás, one of the chief architects of the health resource allocation system, complemented by (2) a full title scan of three major Hungarian health policy journals —Egészségügyi Gazdasági Szemle, Informatika és Menedzsment az Egészségügyben and Kórház—for the period 1998–2013.[2]

Against this background, it was subsequently deemed necessary to carry out interviews with a targeted sample of healthcare decision makers, managers, and technical experts. A total of six interviews were carried out: three with former policymakers, and one each with a technical expert later turned hospital manager, a key technical expert of the health financing system, and a former healthcare specialist at the Ministries of Health and Finance (see the list at the end).

The interviews were tape-recorded: three have been fully transcribed and three summarized. The transcriptions and summaries were then coded via the method of directed content analysis (see Hsieh & Shannon, 2005). The coding categories were derived from the above mentioned terminology of the ACF in order to identify coalitions, belief systems, learning patterns, and policy change. ATLAS.ti (trial version) was used to process the material.

The number of interviews this study is based on limits the robustness of its conclusions. Further research is needed to understand better the belief systems present in both policy arenas, and to be able to draw more generalizable conclusions.

Overview of the Hungarian Healthcare System

The following brief overview of the Hungarian health system is based on the WHO health system model presented on Figure 1.

The healthcare system of Hungary operates under thorough state control, although one of the main objectives of transition reforms was to ease this. Resource generation has been tightly overseen by central government throughout the entire period from 1990 to this day. Service delivery was first substantially decentralized, and then later re-centralized. Since the change of regime, revenue

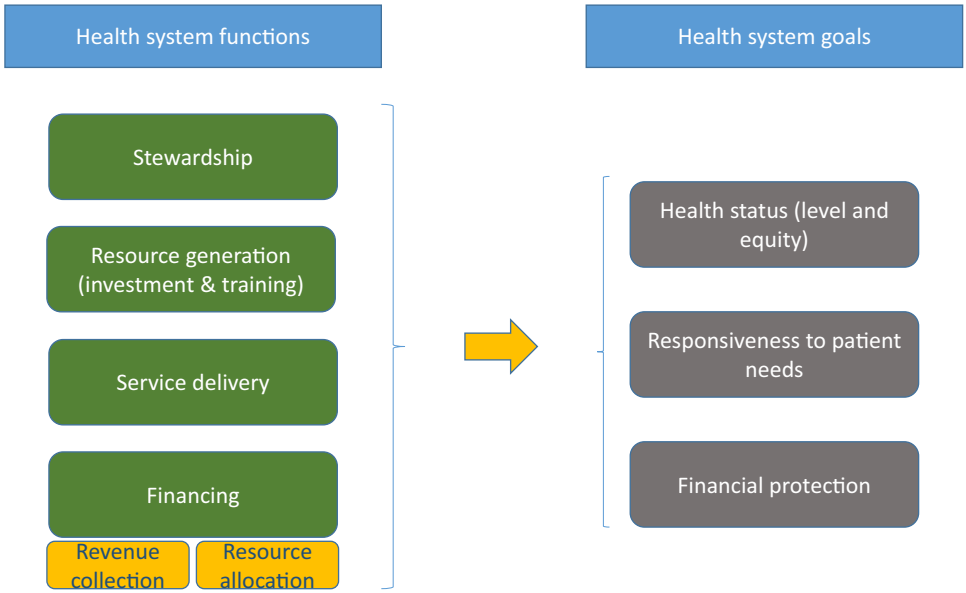

Figure 1. A health system model.

Source: Kutzin et al. (2015), based on WHO (2000).

collection has taken place in a single-insurer social health insurance (SHI) model. Finally, resource allocation has also been the subject of various reforms in different directions, some of which will be detailed in this case study.

Resource generation in healthcare has been under strong state control throughout the period. Central government makes detailed decisions concerning medical and allied health specialist training, as well as relating to investment in buildings and equipment. In an early move of decentralization, the ownership of healthcare provider infrastructure was transferred from the state to local and county authorities as early as 1990 (Orosz, 2001, p. 238–39). However, from 1996 onwards, hospital and outpatient capacity (measured by bed numbers and consultation hours) has been determined by law (Orosz, 2001, p. 77–78). The National Health Insurance Fund also pursues a strategic buyer function, triggering important changes in the provider infrastructure (Dózsa, 2010, p. 28–29). Since 2012, all hospitals and a substantial number of outpatient clinics have again belonged to the state, with a central administration responsible for their management (National Healthcare Service Center 2016, p. 8; hereafter: NHSC). In 2014, the share of centrally funded investment (European Union and central government funds) in inpatient care—building and equipment in hospitals and hospital-integrated outpatient clinics—amounted to 71% (NHSC 2014). European Union funds are attributed via flagship projects and open calls, the latter enabling municipalities with healthcare providers to realize their own investment initiatives. Since 2012 however, municipal ownership of health providers has been only marginal (Figure 2).

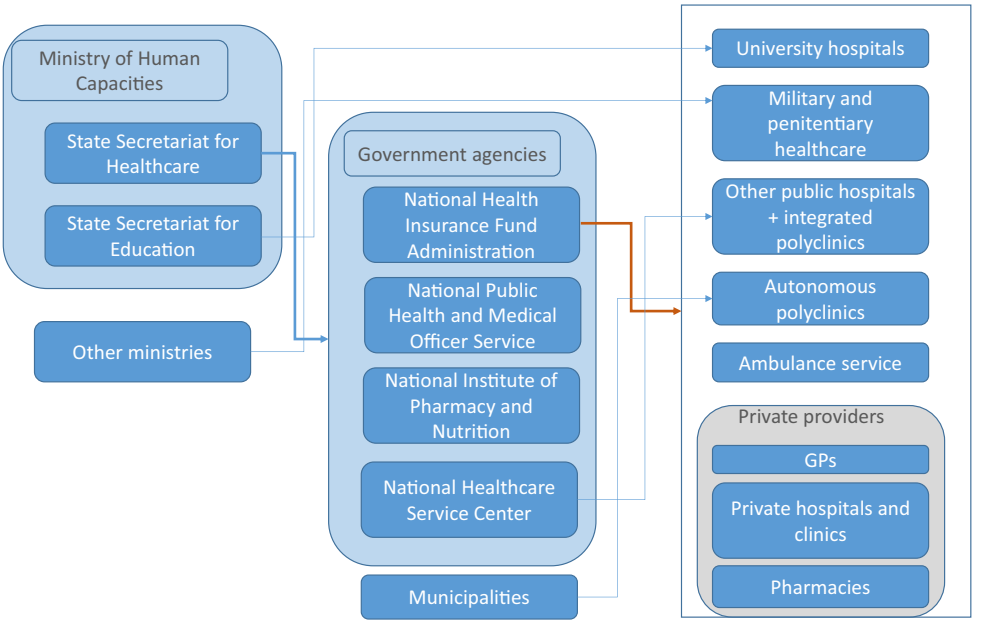

Figure 2. Governance structure of the Hungarian publicly financed health system[2].

Source: National Healthcare Service Center (2016).

Health service provision is divided among the distinct subsystems of primary care, outpatient and inpatient healthcare. Primary care is the responsibility of local authorities who create GP practices and assign a territorial obligation for them to care for. However, patients are free in their choice of provider, and may change once a year, provided they can find a non-obligated doctor to take them on (MoH Decree 4/2000). GP practices are operated by individual enterprises or small companies, and financed by the Health Insurance Fund through—principally age-weighted—capitation. GP out-of-hours services are often provided through different contracts. In addition to GPs, primary care also includes dental services and a system of maternity and childcare nurses. Currently, the government is planning to introduce group practices (NHSC 2016). Primary care officially has a gatekeeper role; however, outpatient clinics are accessible without referral in a number of important medical specialties, e.g., surgery and ophthalmology (Gov. Decree 217/1997).

Outpatient specialist care is, for the most part, provided by polyclinics employing their own personnel, including doctors. The majority of polyclinics operate independently from hospitals. Some of these are overseen by the state's hospital holding, but most belong to local authorities. Seventy-five percent of the outpatient cases treated and interventions performed take place in hospital-integrated polyclinics, which are under central government control (National Health Insurance Fund 2015).

Though inpatient care capacities and service profiles have always been subject to close central government scrutiny and regulation, day-to-day operations and management were organized in a decentralized way until 2012. The so-called "managed market model" was built on the assumption that hospitals belonging to local authorities and county councils would respond to central government's financial incentives and adjust their operations to stay competitive. The 2012 centralization move has given the government a much closer insight into the daily management of hospitals, although the key responsibilities have remained with the director general of each institution (designated, since 2012, by central government, not local authorities). Most recently, there have been plans to shift financial management competences from individual hospitals to regional administrations, but these have not yet been put into practice (Medical Online 2016).

The above concerns only the publicly financed health system. Providers who choose to charge more than the reimbursement price of social security cannot contract with the latter and so operate on an entirely free-market basis. These include mostly private outpatient providers—individual doctors or clinics—but there are also a small number of non-contracted hospitals. Other privately owned providers, e.g., GPs, private diagnostics and dialysis providers, etc., are contracted with the Health Insurance Fund, and their services are entirely reimbursed to the patients using them.

Concerning revenue collection and pooling, a compulsory single-payer health insurance model has been in place since the beginning of the transition period. Every citizen with a permanent residence is required by law to be part of the health insurance system, either through the payment of contributions proportional to their earnings, or the remittance of a fixed monthly amount for those without formal income, or through a settlement paid by the central budget for certain groups (students, pensioners, etc.).

In practice, the proportion of salary-based contributions and budgetary transfers within the revenues of the Health Insurance Fund vary considerably from one year to another, due to the frequent modification of the legal framework governing the different transfers. In addition to this, a fraction of public health spending —most notably capital expenditure—does not pass through the Fund, but is channeled through the central and local budgets, as described above (Gaál et al., 2011, p. 67–69).

The National Health Accounts in Figure 3 suggest that in 2014 compulsory health insurance added up to only a little more than 57% of total health spending. A further almost 10% came from government sources distinct from statutory health insurance, and the rest from—mainly out-of-pocket—private payments. Nevertheless, as the bulk of these private payments are spent on drugs co-payment, it can still be claimed that the health system is driven predominantly by providers under state control and/or state financing. How this financing is allocated is, therefore, of pivotal importance. The aim of the following case study is to shed some light on the evolution of this public resource allocation system.

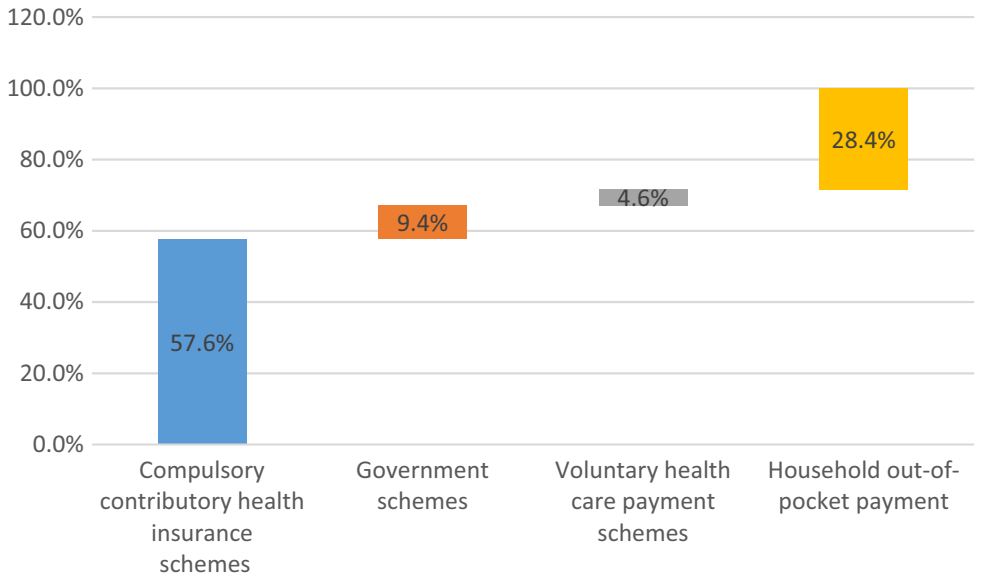

Figure 3. Distribution of healthcare revenues by financing agents (National Health Accounts, 2014).

Source: OECD Statistics.

Initial Reforms

Within the framework of Kutzin, Evetovits, Jakab and Thomson (2015), based on the established terminology of the World Health Organisation (WHO), health resource allocation encompasses all the functions and mechanisms of a health system responsible for paying healthcare providers from an insurance pool of funds. As a consequence of this, the incentives provided by health resource allocation systems determine the behavior of most health system actors, and therefore have a potential influence on the quality, quantity, and distribution of healthcare supply (see Moreno-Serra & Wagstaff, 2010).

At the end of the socialist era, health resource allocation was decentralized and arbitrary: local and county councils were responsible for the allocation of most funds, and they were using the block contract method, i.e., providers received a predetermined budget, intended to cover all expenses, unrelated to the number and severity of cases treated.

Within a general context of economic reform (see Adam, 1987), efforts were made to rationalize these mechanisms. There was a general move away from central planning and rationing, and toward a better remuneration of actual performance. Its first target was industry: in Hungary, the so-called "New Economic Mechanism" of 1968 allowed the management of corporations more control over the way they spent profits and invested resources (For an assessment of the reform, see, e.g., Bauer, 1983). After some hesitation, as well as a period of counter-reform (see Verbászi, 2004), in the 1980s the government sought to extend this form of reorganization to the institutions of the welfare sector. There was a search

for measures capable of reconciling the control and allocation mechanisms of state and market.

In this context, an expert coalition arose, composed of technocrats from both the Ministry of Health and the Ministry of Finance, with a double aim of creating a centralized system of resource allocation (independent of local councils) and of introducing performance-related payment instruments. Advice received from various international organizations pointed in a similar direction, as one of the interviewees recalls (Interview A). Policy core beliefs of this coalition included a need for more transparency and accountability, also the superiority of decentralized, market-based incentives above central planning and administrative measures, but equally a need for strong state regulation and universal coverage in healthcare (Bordás, 1990).

The superiority of performance-related financing has indeed become a key policy core belief of this technocratic coalition, and has been exercised, from 1987 onwards, principally within the Reform Secretariat of the Ministry of Social Affairs and Health. Secondary beliefs on what payment instruments would best fit the new model varied within the Reform Secretariat. But a powerful wing of young experts advocating the hospital financing method of diagnosis-related groups (DRG), utilized in the United States since the mid-1980s, finally prevailed (Interview B). Although their composition and beliefs have changed in many ways over time, this line of thinking will hereafter be referred to as the DRG coalition.

According to this coalition's secondary belief, a DRG system would promote free competition of providers for patients, with revenues allocated as a function of the number and severity (resource-intensity) of cases treated. Given that the DRG system sets unit prices of healthcare interventions at the average level observed across all providers, it was also envisaged less efficient providers would need to refine their management techniques, or, if they failed to compete with the cost level of others, to shut down their given services. The system was designed to promote transparency, cost-efficiency and competition among hospitals.

These secondary beliefs extended over the strict boundaries of resource allocation: the coalition believed resource allocation would be a trigger for a series of other reforms, brought about by the incentives created in the new, competitive environment for healthcare providers. Accordingly, the coalition aspired to realize most of its policy core through the DRG instrument (and the related financing system). Some of the most important goals were the following (after Nagy, Dózsa & Boncz, 2008):

- reducing or eliminating unneeded hospitalization
- focusing the care profile of hospitals on the diseases strictly requiring inpatient care
- streamlining patient pathways and assuring proximity care, where possible
- increasing the technical efficiency of hospitals (i.e., reducing the cost per case)

- balancing the territorial disparities of access to hospital care within the country
- keeping budgetary costs down.

Meanwhile, following the first democratically elected government taking office in 1990, power relations outside of the health policy subsystem underwent changes. The Hungarian Democratic Forum (MDF), the main center-right government party, had its own policy core beliefs, at the center of which stood the idea of independent, entrepreneurial doctors. To aid the development of such a model, it was planned to introduce a German model of social insurance. Apart from a multiple-insurer system, the German system would also have meant a fee-for-
service method of resource allocation, perceived as being more advantageous than DRG, as far as the revenue of health providers and professionals was concerned.

Despite the apparent differences in their approaches, there were several factors that allowed a compromise of the two coalitions. First, as for the policy core belief of decentralized (market-like) control mechanisms and performance-related remuneration, there was relative consensus between the two sides. In fact, both were starkly opposed to the existing system of global budgets, deemed both inequitable and inefficient, and debate centered instead around the secondary belief of which payment method to employ.

Second, the policy core belief advocated by the Ministry of Finance that cost control mechanisms had to be put in place, was successfully opposed to the policy core of the MDF that doctors' pay needed an urgent rise. Given the difficult and rapidly deteriorating economic situation in the country—an outside factor that seems to have played an important role—the government leaned increasingly toward the more economical DRG model.

Third, the DRG model had already been elaborated in detail, and tested on data provided by several hospitals. The coalition advocating German-style health insurance did not have such detailed technical information at its disposal, a deficiency especially critical in matters relating to cost control. Political considerations and personal factors also played an important role, as certain MDF politicians supported the DRG model which, this way, appeared less like a "communist" invention (Interview C).

In the end, the DRG coalition took over, and an American DRG-based system was introduced for hospital financing, complemented by capitation in primary care—both in conformity with the secondary beliefs of the DRG coalition. For secondary outpatient care, the German fee-for-service method was introduced, via literal copying of the points system in use there (It was subsequently amended to reflect the Hungarian cost structure).

According to certain experts (Interview D), the introduction of fee-for-service in outpatient care corresponded to the policy core of the DRG coalition that aimed at shifting care volumes from the inpatient to the outpatient setting, deemed more

cost-efficient. Nevertheless, this solution appears rather as a compromise of the circumstances, with plans to be fine-tuned afterwards.

Experiences with Performance-related Financing

The new system of health resource allocation was put in place in 1993. It was the first time in Europe that a full-scale DRG-based reimbursement system had been used for hospital financing, and was, in some ways, the anticipation of the general direction of later reforms elsewhere on the Continent (Nagy et al., 2008). It also created a coherent system, with, for the most part, a purposefully planned design.

The reform included the creation of an independent institutional structure for health insurance, under the control of union representatives (workers and managers). This reflected the German model, in accordance with the secondary beliefs of MDF health and social policymakers. It was also meant to establish a stricter, contract-based relationship between the insured and the institutions of social security, in order to increase the market element within the system. The state, with its redistributive powers deemed arbitrary and inequitable, was to take a step back (Orosz, 2001, p. 71–72). It also helped establish a complete purchaser–provider split, with the perspective of developing a strategic buyer function for health insurance (On this issue, see Dózsa, 2011).

The general line of reform was to increase the degree of responsibility—both of the insured for paying their contributions and of healthcare providers for reducing their costs. There was a strong belief that individual responsibility and market-like forces would help make the healthcare system more efficient and achieve better results. The question was how to balance these moves against the attempts for national solidarity and comprehensive healthcare services for all (Table 1).

Nevertheless, the new system soon had to face substantial problems—and opposing coalitions. First, providers started increasing the volume of their output at a very high pace. In fact, even if the DRG system is less inclined to funding an unlimited additional volume of services than a fee-for-service model (see Cots, Chiarello, Salvador, Castells & Quentin, 2011 for the economic consequences of the system), it still provides, by design, incentives for volume increase.

There appeared a coalition, based first and foremost on Ministry of Finance experts, which was in favor of stronger cost control in healthcare, and demanded a refinement of the DRG system to this end. One of their policy core beliefs—at least perceived by the actors in the health system—was that healthcare is, in a sense, a budgetary burden, which can only be paid for when "the economy" (in a sense restricted to private, market-based actors) has produced a surplus large enough to cater for its needs. In the words of one interviewee (Interview C): "We have to develop the economy first, and then we'll have the resources to develop healthcare." The second important belief attributed to this coalition was—and remains—that health providers were cheating when reporting their performance to the Health Insurance Fund.

Table 1. Coalitions and Beliefs Within the Health Resource Allocation Arena

Coalition	Policy core beliefs	Secondary beliefs	Principal measures suggested
DRG experts	Transparent and equitable resource allocation is needed. Market-based incentives work better than administrative control.	DRG is the most cost-efficient way to achieve the policy core. DRG introduction would also help solve other problems in healthcare.	DRG introduction Floating reimbursement values Volume caps (partly)
MDF health policy specialists	Transparent and equitable resource allocation is needed. More autonomy and more funding is to be given to doctors.	The German health insurance model is to be adopted in Hungary.	Fee-for-service reimbursement
Ministry of Finance representatives	Healthcare is costly and hinders economic growth. Healthcare providers are inclined to cheat.	Cost control and efficiency are to be put in place.	No special suggestion, but advocate all DRGs, floating reimbursement and volume caps.
Socialist health policy specialists	Market-based incentives do not work. The healthcare system needs administrative changes.	The DRG system is insufficient as healthcare reform.	Centrally planned capacity adjustments Volume caps (partly)

In fact, the original DRG idea included features to avoid cheating. Unlike the American version, the Hungarian DRG system was designed in such a way that it classify cases into resource groups automatically, based on the diagnosis written on the medical record. In the end, however, this solution was not applied by the National Health Insurance Fund. One of the interviewees—a senior policymaker of the time—considers that the management of the Fund was reluctant to develop the general IT support, and hence the anti-fraud features of the system. It might have been because some of its managers believed more in administrative control than in market-based incentives (Interview B—review).

Fortunately, though, for DRG advocates, the system was introduced in a progressive manner, continuously unifying the initially highly diverse payment/case ratios of providers. A degree of uniformity was thus created, gradually eliminating the reimbursement differences stemming from historic global budget negotiations. This benefited equity as well as efficiency, all providers being required—at least in theory—to operate at or below the average cost.

Before this unification process took place, discrete payment restrictions had been introduced, in a so-called floating manner. This means that the total budget allocated to hospital (and similarly to outpatient) care was announced, and unit reimbursement prices were calculated by dividing this budget by the volume of performance actually reported by providers. In this sense, the more volume reported by providers as a whole, the less unit reimbursement they received individually.

As a result of the above system, the healthcare budget was placed under effective control, but providers, and certain practitioners, developed a belief that the resource allocation system was fundamentally unjust. This belief was advocated, among others, by the Chamber of Medical Doctors. The floating of prices was finally discontinued in 1998, year when—after continuous technical refinement of the DRG system—the convergence of unit prices finally took place. After this, the same unit price was paid to all providers, and was no longer adjusted according to the volume reported.

Now, for a second time, cost containment became the key issue. The Ministry of Finance pushed continually for the introduction of new methods, which incited the DRG experts of the National Health Insurance Fund to come up with ever newer proposals. Finally, in 2003, the government convened an expert group composed of representatives of the Fund and of providers' organizations, and asked them to put forward a solution to the MPs' congress of the governing Socialist Party. The solution finally retained was a system of provider-level caps, limiting the DRG-based budget of each hospital to 95% of its 2003 level. Any excess in volume would, from then on, penalize the institution that produced it, through reduced reimbursement, and keep the rest of the providers safe.

The problem had now escalated to a high level of decision making, where there was a strong policy core belief in the necessity for cost containment. Compared to the time of DRG introduction, the decision this time was made quite swiftly, the technical details of the cost containment method—provider volume caps—having to be worked out in haste. Nevertheless, it marked the end of a longer period of trial-and-error experimentation with different methods.

Provider volume caps also proved to be a victory for another advocacy coalition, encompassing officials in the Ministry of Health, MPs and local politicians, predominantly from the Socialist Party, in power between 1994–1998 and from 2002 until 2010. Certain officials of the National Health Insurance Fund also took part in this group, hence the reluctance of the Fund to develop the DRG system. This coalition is basically what experts like referring to as "politicians"—even those experts who themselves are considered by some of their peers as being part of it.

The coalition of "politicians" was reported to have the policy core belief that market-based mechanisms were inappropriate for the regulation of healthcare, which, instead, deserved direct administrative control. The original idea of competition advocates—that under-performing services would be closed down for financial reasons—was refuted by the course of events. Competition advocates had to acknowledge that administrative capacity planning was needed, at least to a certain extent (Interview E).

After 2004, much less attention has been given to health resource allocation reforms, the health policy emphasis being placed instead on other issues and areas. This way, the system that had forged by then has remained largely in place.

Conclusion

From a learning point of view, the policy change period of 1989–1993 can be characterized as one of cross-coalition policy learning. The DRG coalition, though represented at several administrative and political posts, had fairly limited direct power. However, through the level of sophistication of its proposals and with the endorsement of the cost control advocates, it managed to persuade the leading political forces of the superiority of its beliefs. Technocratic information, collected through years of tests and analysis beforehand, seems to have played a key role in this process.

In contrast to this, the learning processes of subsequent years took place much more within coalitions. Despite the build-up of a very significant health intervention database, thanks to the DRG system, reliable information of actual hospital costs has become more and more scarce. This, along with the policy core belief that the health intervention database is highly biased by unfair reporting, may have contributed to the defensive position of DRG-minded health administration officials. As a response to the cost-containment pressure, they often had to improvise solutions, some of which lived on, while others gave way to new trial-and-error experiments.

Finally, it was the DRG coalition—or at least several members of it—which has exhibited policy learning when acknowledging that the DRG system was no panacea for goals beyond the strict boundaries of resource allocation. Perhaps most importantly, the closing down of (over) capacity in healthcare supply proved to be impossible without some kind of direct administrative intervention.

Political learning took place primarily via accommodation to the incentives offered by the different payment systems. Providers, their organizations and their political advocates rapidly understood how to present financing problems and anomalies as threats to the continuous treatment of patients, and therefore put pressure on successive governments to act in their particular interests. It would be difficult to claim that the political agenda was substantially responsible for shaping health resource allocation reforms. The health resource allocation reform process is rather one of continuous trial-and-error technical experiments, with compromises between the different stakeholder coalitions allowing new courses of action.

Hungary found itself in an entirely new situation after the change of regime in 1989–1990. Both political and policy learning processes began, in order to face the challenges of transition and create a new economic and social framework. In health resource allocation, a coherent initial system model evolved in a largely trial-and-error manner, ending up in something which is in many ways different from what featured in the original ideas, while the main underlying beliefs and assumptions stayed largely the same. The primary role was that of policy learning, presumably also because of the highly technical nature of the problems.

List of interviews

Interview A: High-ranking former Ministry of Health and Ministry of Finance official. Date: 14th November 2014

Interview B: High-ranking former administrative official and secretary of state of the Ministry of Health. Date: 16th January 2015

Interview C: Former MP and high-ranking health administration official. Date: 8th March 2016

Interview D: Leading DRG expert of the National Health Insurance Fund. Date: 18th February 2015

Interview E: Former minister of health. Date: 23rd May 2016

Relevant Legislation

Act No. CLIV of 1997 on healthcare

Act No. LXXXIII of 1997 on the services of compulsory health insurance

Government Decree No. 217/1997 on the execution of Act No. LXXXIII of 1997

Government Decree No. 43/1999 on the detailed rules of financing health services from the National Health Insurance Fund

Ministry of Welfare Decree No. 9/1993 on certain questions of the social security financing of specialist healthcare

Minister of Health Decree No. 4/2000 on the services of general practice, children's general practice and primary dental care

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Notes

1. An earlier version of this paper was presented by Balázs Babarczy at the 24th World Congress of Political Science Poznań 2016.
2. Eötvös Loránd University, Budapest.
3. Állami Egészségügyi Ellátó Központ (National Healthcare Service Center), Budapest.
4. The main focus of the full title scan being other than health resource allocation, a limited level of omission is possible.
5. Subject to reorganisation in early 2017.

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