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Editorial correspondence

SOCIETY AND ECONOMY
Corvinus University of Budapest
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Phone: (+36 1) 482 5406
E-mail: balazs.szentivanyi@uni-corvinus.hu

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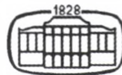

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THE SOFT BUDGET CONSTRAINT SYNDROME IN THE HOSPITAL SECTOR

JÁNOS KORNAI

Professor Emeritus, Harvard University and Collegium Budapest;
Research Professor of the Central European University, Budapest, Hungary.
E-mail: kornai@cdbud.hu

Research to date has focused mainly on the soft budget constraint syndrome in the corporate sector and in the credit system. This article concentrates on the hospital sector. It describes the motivations and the contradictory nature of the behaviour of the patient, the physician, the hospital director, the politician and the hospital owner. The motivations explain the reasons behind the strong inclination to overspend and the tendency of softening budgetary limits. The burden of overspending and debt is pushed upward at each level of the decision-making and financing processes. This article covers the relationship between the various ownership types (state, non-profit and for-profit non-state ownership types) and the soft budget constraint syndrome. Finally, it looks at the phenomenon from normative aspects: the favourable and unfavourable consequences of the hardening of the budgetary limit and how normative dilemmas are reflected in the minds of the participants of the events.*

Keywords: Hungary, soft budget constraint, hospitals

Journal of Economic Literature (JEL) code: G28, G33, H77, H118, I33.

* I cooperated closely with Csaba Dózsa in the collection and processing of the Hungarian data used in the study. His expertise and knowledge helped me a great deal in understanding the problems of the Hungarian situation. The Hungarian data were collected under his direction with the involvement of Nikoletta Malbaski. I am grateful for their thorough and careful work and substantial proposals. I have also received notable advice from professor Karen Eggleston, one of my former students and co-authors. I also thank Zsuzsa Dániel, Péter Forgács, Gyula Kincses, Mária Lipták, Melinda Makár and Péter Mihalicza for their valuable support. Eszter Nagy also provided untiring help to me in the collection of literature and editing of the study, just as she did in my previous works.

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INTRODUCTION

I consider it a great honor to be able to give you a lecture at the conference dedicated to the 60th anniversary of the founding of Corvinus University of Budapest. The sense of joy and honor I feel is only increased by the fact that I deliver my lecture on the ceremonial occasion when Eric Maskin, professor of the Princeton Institute For Advanced Study is presented with an Honorary Doctorate from Corvinus University of Budapest. I chose a subject that both Eric Maskin and myself are interested in, and in which we conducted joint research, and in relation to which we have written joint publications, namely, the analysis of the soft budget constraints phenomenon.

My study applies the theory and concepts of the soft budget constraints to the hospital sector.[1] In the first part of the study I will deal only with hospitals owned by the state, and later on will also move on to problems of ownership.

The group of organizations that I am referring to from now as the "hospital sector" does not only include hospitals caring mainly for inpatients, but also the outpatient clinics and diagnostic and nursing organizations operating as independent units. I describe all organizations in this category as a hospital in order to use a concise definition.

This study refers to the Hungarian experience at several points. At the same time, I wish to underscore in advance that my intention is not to provide a detailed analysis of the Hungarian system; the ideas I wish to express are of a more general nature. The soft budget constraint syndrome does not only occur in the Hungarian hospital sector. It is not only present in a socialist system or during the post-socialist transformation, as a residual factor of socialism. The soft budget constraint syndrome of necessity appears everywhere, even in places where the environment of the hospital sector has been and still is, shaped by a capitalist market economy.

I am looking for an answer to the following question: why is the soft budget constraint syndrome so common in this sector? Before starting to give a detailed answer, I wish to deal with an argument that can be raised against this topic. During the discussions before the publication of the study, several people asked me the following question: is there any reason for looking at the soft budget constraint syndrome specifically in the hospital sector? There are events shaking the world economy around us: various states and international organizations are executing bailouts involving hundreds of billions of dollars. The "softening of the budgetary limit" affects the international financial system and the world of hundreds of thousands of companies. By way of comparison, the hospital sector comprises only a tiny segment of the macro economy in any country.

This is undeniably true. However, I still believe that the analysis of this small (although vital) sector will result in an important universal lesson. The closing or

rescue of a hospital is not an event that makes headlines in the world economy; however, the majority of the problems that surface there can also be found beyond the boundaries of the hospital sector. Moreover, the motivation, behavior and moral and financial consequences of the actions of the parties involved in the events can be defined more sharply in some aspects of these events.

A TYPICAL SERIES OF EVENTS

Financially, some hospitals operate acceptably well. In other hospitals, revenues do not cover expenses for an extended period of time. Consequently, they are compelled to either take out a loan or simply to not pay their suppliers, i.e. they force them to provide credit. Debt continues to accumulate until the level of indebtedness reaches a critical size. Debt can swell to such an extent that the organization – if it happens to operate in the business sector – would legally go bankrupt and the court would have to appoint a receiver.

Figure 1 describes the series of events. What alternative positions can an organization resort to in a financial crisis? For logical explanation, we must distinguish between four clear scenarios. Naturally, in reality, these scenarios can overlap somewhat.

We shall not repeat what is said in *Figure 1.* Since we are talking about hospitals, it would also be appropriate to use medical terms metaphorically. The organization suffers from a severe illness. There could be four possible outcomes in the following period:

A) the illness still prevails.
B) The illness has been beaten.
C) The patient receives first aid and emergency treatment, and he is kept alive – while the causes generating the symptoms of the illness remain.
D) The patient dies. The medical profession and the business sector use the same term: an exit has taken place – the organization has ceased to exist.

For the purpose of our topic, the key issue is to what extent can a hospital expect the outcome under *C),* the rescue, or a *bailout,* as is widely used in English? What does a hospital think about this? Will it be pulled out of a jam if it gets into serious trouble?

In this context, there are many misunderstandings about the meaning of the "soft budget constraint" concept. This study is a good opportunity to clear any misunderstanding.

Some people think that if an organization (a company, a bank or a hospital) is rescued from financial trouble, then this is also a manifestation of soft budget constraints. This is an erroneous interpretation.

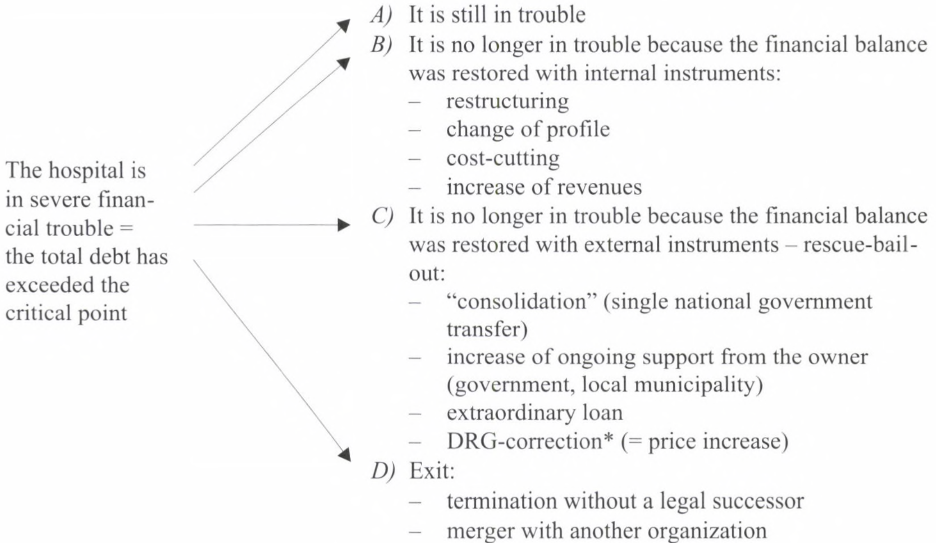

Figure 1. Outcomes of hospitals in financial trouble

* DRG = Diagnostic Related Groups – measuring unit used in the Hungarian literature for the points based on which settlement takes place between the National Health Insurance Fund and the hospital.

The concept of the *soft budget constraint syndrome* does not refer to a single event. (In contrast to a rescue action, which is an event.) The soft budget constraint is *a mental phenomenon* and is not an "event". It is present in the mind, thinking and understanding of the decision-maker. It is a particular expectation. Anyone's budgetary limit is soft if the person (either with good reason or wrongly) expects that he will surely be rescued if he gets into trouble. He then adjusts his actions to this expectation. Consequently, this is a hope or a belief which has an impact on the person's decisions, behavior and actions.

The more frequently that *bailouts* and rescue plans are used in one's context, the more one will expect it. (This, therefore, is not about one rescue event, but about many, the experiences of which have been processed and the basis on which expectations have been formed.) However, one can also have other reasons for expecting to be bailed out. One can be in a monopoly position, in which one's activities are indispensable and therefore one can expect not to be left in the lurch. Or one can expect to be rescued because of the good political or non-political con-

tacts with friends and acquaintances who dispose over the money required for a bailout action.

This is a self-generating process. If many expect a bailout and their expectations are fulfilled, and in fact the organization in trouble is often rescued, then many others will also expect this. After every bailout most organizations start over again with the expectation that they will be rescued once again.

The other misunderstanding occurs because often the "soft–hard" adjective pair is used as if there were only two clear-cut cases: a budgetary limit is either soft or hard. In reality, there are *degrees* of softness and hardness; there are many intermediate stages between the clearly soft and clearly hard status. Bailout expectations can also be considered as variables of subjective probability developing within the decision-makers of the organization, that is to say, the degree of probability they ascribe to the actual rescue. This probability indicator is not a discontinuous but a continuous variable, taking any value between 0 and 1.

Let us take a few illustrative examples from the Hungarian practice concerning the frequency of severe indebtedness and bailout.[2] The data of *Tables 1–3* cover the so-called publicly financed active inpatient institutions (financed by the National Health Insurance Fund).[3]

Table 1 was prepared on the basis of the following criteria: the hospital is in "financial trouble" if the total of its overdue debts to suppliers at the end of the year is higher than 3 percent of the annual expenses of the hospital.[4] The table clearly indicates the proportion of the hospitals in financial trouble. In most years, every fourth-fifth hospital struggled with severe financial difficulties; in 2006 their proportion was even higher, at 40 percent.

Table 1

Number and proportion of hospitals in financial trouble

	2000	2001	2002	2003	2004	2005	2006	2007
Total hospitals	137	137	137	136	135	133	132	131
Hospitals in trouble	31	30	21	12	36	24	53	39
Proportion as compared to the total number of hospitals (percentage)	22.6	21.9	15.3	8.8	26.7	25.6	40.2	29.8

Note: A hospital is "financially in trouble" if at the end of the year, the overdue debts to suppliers are higher than 3 percent of the annual expenditures of the hospital.
Source: Database built by Csaba Dózsa and his colleagues. The primary source of the data contained in the database is the hospital database of the Health Strategy Research Institute and the debt surveys of the Ministry of Health.

We followed the 42 units that were in financial trouble in the middle of 2002.[5] Column *A)* of *Table 2* indicates that a considerable number of the 42 hospitals had already been in trouble, and remained in critical condition, despite efforts made to overcome the financial crisis and despite bailout actions.

Table 2

Preceding events and outcome of the 42 hospitals in trouble in 2002

Year	A) In trouble	B) No trouble: recovered with internal instruments	C) No trouble: recovered with external instruments (bailout)	D) Exit
2000	17 (5)	17	8	0
2001	22 (10)	12	8	0
2002	19 (17)	4	19	0
2003	8 (3)	27	7	0
2004	19 (8)	17	6	0
2005	15 (5)	17	10	0
2006	21 (10)	16	5	0
2007	16 (9)	12	9	5

Note: The table contains the data as of 31 December of the year indicated. We focused on the situation prevailing at the end of June 2002 in the selection of the group of 42 units covered by the table. The figures in brackets in column A) indicate the number of units where the central government or the competent municipality conducted significant bailout actions during the given year, but even so, the total debt could not be reduced below the critical threshold, i.e. the unit was "still in trouble".
Source: Database built by Csaba Dózsa and his colleagues. The primary source of the data contained in the database is the hospital database of the Health Strategy Research Institute and the debt surveys of the Ministry of Health.

Please note especially the figures of the column in brackets. These figures show the bailout actions which gave some assistance to the hospital in trouble, but were still not enough to reduce the total debt below the critical threshold.

Column *B)* reflects the favorable developments of the series of events: the total debts were reduced below the critical threshold by internal efforts.[6]

Column *C)* indicates the bailout actions. Adding up the data of column *C)* and the data in brackets in column *A)* for a particular year, we can see the number of bailout actions for each year, resulting in a partial or full rescue, or in only easing the troubles. For example, bailout actions took place in 19 + 17 = 36 hospitals that were selected for the observed group in 2002. In several cases, this involved internal restructuring and other cost-cutting efforts. After six months of bailout actions only 19 organizations were still in trouble, according to the status report at the end of the year.

Hospital expenses were limited more strictly from 2004.[7] Although there is no doubt that cost-cutting measures were introduced in 2004–2006, *Table 2* still clearly indicates that there were no exits until 2007, i.e. survival was guaranteed. This is a strong indication of the existence of the soft budget constraint syndrome.

True rigour was introduced in 2007 when one-third of the hospitals in deep financial trouble were terminated by administrative procedures; they were either terminated without a legal successor, or were merged into another viable organization.

Some of the bailout actions were small, *ad hoc* type actions. Apart from these small "tailored" individual bailout actions, extensive bailouts occurred in 1996 and 2002. These were called "consolidation" in the Hungarian literature. *Table 3* illustrates some typical data of the two large consolidation processes.

Table 3

Some characteristics of the state "consolidation programs"

Characteristic feature	Consolidation in 1996	Consolidation in 2002
Number of organizations involved	38	30
Amount (HUF billion)	4	3.5
Proportion of this amount in the total NHIF payments to the organizations concerned (percentage)	6	3.8
Number of beneficiaries of the consolidation in 1996 included in the beneficiaries of the consolidation process in 2002	no data	16

Source: Database built by Csaba Dózsa and his colleagues. The primary source of the data contained in the database is the hospital database of the Health Strategy Research Institute.

Table 2 clearly illustrates that until 2007 there were no *exits* – i.e. survival was guaranteed. This was a strong indication of the existence of the soft budget constraint syndrome. It is notable that after the bailout in 1996, the number of hospitals in financial trouble decreased significantly. We should look back to *Tables 1* and *2* for a moment here, which clearly illustrate the decrease in the number of organizations in trouble. However, this was only a temporary phenomenon. Later on, the number of hospitals in trouble began to rise again. They counted on a bailout, it was built into their *expectations* and as a result, overspending revved up again. Almost half of the beneficiaries of the consolidation process of 1996 ended up in a worrying financial crisis again. The soft budget constraint syndrome could clearly be observed.

Limitations of the length of this paper do not permit me to quote in detail the studies describing similar phenomena that show up in the public hospital sectors

of many other countries as well. Consequently, *Table 4* lists only those countries in relation to which information can be found about the existence of the soft budget constraint syndrome. The table also indicates the sources of literature, based on which I dare to claim that the soft budget constraint syndrome can also be detected in the countries covered by the table.[8]

Table 4

Sources of literature indicating the appearance of the soft budget constraint syndrome

Country	Source of literature
Austria	OECD (1997a)
Chile	Perry – Leipziger (eds) (1999)
	Eggleston – Shen (2008)
Finland	OECD (1998)
Greece	OECD (1997b)
Italy	Bordignon (2000); Bordignon – Turati (2003)
Luxembourg	OECD (1999)
Norway	Hagen – Magnussen – Kaarboe (2007); Tjerbo – Hagen (2008)
Switzerland	Colombo – Zurn – Oxley (2006)
Sweden	Rae (2005)
United States	Newhouse (1993); Duggan (2000); Capps – Dranove – Lindroth (2006)

Note: The list does not contain any post-socialist countries.

These are the bold facts of the drama. There is one thing that has not been mentioned so far: the *characters* of the drama.

BEHAVIOR OF THE MAIN ACTORS

Among the many actors, I would like to focus on five: the patient, the physician, the hospital director, the politician and the owner. Obviously, there are other important characters, too, including the pharmaceutical industry, the universities training the physicians, the ministry supervising the health sector and the managers and officials of health insurance. However, the analysis of the five main characters listed above seems sufficient for elaborating the main concepts of my study.

We are seeking to find an answer to two questions with regard to all of the characters: what motivates them, and how do they behave based on their motivations?

The patient

Ultimately the hospital sector performs all of its activities in the interests of the patient. The motivation of the patients is to fully recover as soon as possible and in the meanwhile, to suffer as little as possible and endure the least amount of discomfort and exposure.

All of this usually involves higher expenditures. Although obviously a patient does not find any pleasure in the increase of the hospital's expenses, in order to achieve his own objectives he encourages additional spending. The patient would like the hospital doctor to listen patiently to his complaints when they meet. If necessary, the doctor should collect new information and consult with his colleagues on the latest diagnosis and treatment of the problems detected in relation to the patient. All of this means that more physician time should be spent on his treatment. The patient has similar demands of the nursing staff: nurses should pay more attention to him and, what is often required in relation to this, spend more time with him. In financial aspects, this involves an increase in payroll expenses even if wages are at a particular level.

We can also add that the patient would welcome a wage increase for physicians and nurses in the hope that better paid people would show more devotion in their work.

Patients would welcome improvements not only in terms of personal conditions, but also in the physical conditions of medical treatment. They believe that they will suffer less and recover faster and more completely if modern equipment is used for the diagnosis and treatment, and if they receive the latest (and usually more expensive) drugs resulting from scientific research. In addition to the means of medical treatment, a patient would like to see hospital services supplied with as much comfort as possible. All of these requirements increase costs.

These are fully understandable and reasonable demands. In most cases, this additional spending is in fact to the benefit of the patients. It is true that there are contrasting examples, as more expensive treatment and more expensive drugs are not always better; nevertheless, there is still a close positive correlation between quality and expenditures.

As we have seen, there is huge motivation within a patient for additional spending. If the patient is also required to contribute to expenses with his own money, i.e. some sort of co-payment mechanism has been established, this can produce moderate counter incentives, although it does not terminate the patient's motivation to increase the expenses. If there is no co-payment, then the patient is truly interested in increasing the expenses.[9]

Let us think, therefore, about what it means for a patient if the hospital incurs a loss as a result of the increasing expenses. Let us assume that a hospital severely in debt has been closed down and the organizational exit has taken place.

The patient wins and loses. If the closed hospital merges with another hospital that operates well, or the services are concentrated without a formal merger, the quality of services may improve. This may also make it easier to concentrate the experts and expensive equipment.

The patient and his family are taxpaying citizens. The taxpayers' community can save the money, which would otherwise have to be paid out to cover the losses of an organization facing financial difficulties.

However, in comparison to these hardly perceptible advantages there are direct and immediately obvious disadvantages which usually occur after a setback. Once a hospital has been closed, the patient can lose his known physician and his known environment. A considerable number of patients and relatives may find themselves living further away from the hospital, which is still available to them. This involves discomfort, a longer journey and higher travel expenses. If any problem requires urgent treatment, any delay in getting to the place of treatment involves risk and may lead to severe or even irrevocable problems.[10]

Consequently, patients complain and sometimes publicly object to the news of the closing down of hospitals. A patient is a natural ally of the parties who argue for the bailout of the hospital.

The physician

A physician is usually presented from different angles. Some people describe him as a real saint, someone who is absolutely devoted to his profession and is not interested in anything else other than the recovery of the patient. Other people think that a physician is first and foremost a greedy person, someone who is interested only in money.

Both are distorted images. A physician acts based on various motivations. All of these motives have an impact on him, but of course to a different degree. Each motivation must be understood in order to more clearly understand the physician's place within the SBC drama.

The physician intends to help the patient recover. Earlier, we described the correlation between the patient's interests and the expenses of hospital care. The more that the physician identifies himself with the interests of the patient, the more he is motivated to increase spending from the hospital's budget. If he is separately rewarded by the patient for the longer time devoted to him, for the more

expensive drugs, the more expensive diagnostic and treatment procedures, then his motivations only increase.

Professionalism and professional ambition encourage the physician to increase expenses over and above and in relation to, the patient's services. He would like to keep up with the development of technology and science, therefore he is happy to use the latest drugs, diagnostic procedures and equipment, medical aids, surgery techniques, etc., which promise to be more effective than the previous ones (but also generally more expensive).

Common sense is contrary to the motivations for additional expenses: the available resources are limited. The willing recognition of this can be reinforced by administrative limits, strict control of expenses, or even financial incentives against higher expenditures.

Incentives for spending and administrative, financial and moral incentives for the limitation of spending – these are among the conflicting motivations faced by a physician. However, we must also understand that the first impact group is very strong and this is a factor permanently generating an SBC syndrome (i.e. intentions to overspend over the budgetary limit). This is "natural", this is what comes from the "inside" of the physician's mind – he must force the contrary motives on himself, or they will be forced on him externally.

If the budget limit is exceeded for a long time and the idea of closing down the hospital comes up, then the physician employed by the hospital usually objects to it in the majority of cases. Obviously, he is also worried about his job. But this is not the only concern he has, because there is a good chance that he will be employed elsewhere. He genuinely sympathizes with the patients' complaints and objections. The physician will ask for or angrily demand the bailout of the hospital struggling in a financial crisis. This objection has a dramatic effect, and if the participants wish to do so, then the event can be dramatized further. The publicity of the press, radio and television will also lead to an outrage in others, not just in the people concerned, because they are also worried about a similar event happening to them. All of this increases the social pressure for a bailout.

The closer that the hospital to be closed stands to a monopoly position, the greater is the impact of the objection (and the more convincing its justification to remain open). In this context, it is immaterial whether or not the monopoly exists only geographically (the only hospital on a particular area), or whether it is an exclusive hospital professionally (an exclusive institution specialized in the treatment of specific organs, or an exclusive organization with high performance and expensive equipment). Based on a clear recognition of the situation, bailout may be expected: people cannot just sit back and watch an organization in a monopoly position being closed down due to financial reasons. Consequently, expecting a bailout the physician can decide to overspend even more calmly. The more con-

centrated the hospital sector is and the less competition is within the sector, the less the activities of one hospital can be replaced with the activities of a different hospital and the better the chance is for a bailout, i.e. the budget constraint is softer.[11]

The hospital director

The motivation of a hospital director is similar to the motivation of the physician. On the one hand, he represents the interests of the patients and physicians. On the other hand, he feels the conflicting pressures more directly than the employees reporting to him. *He is the one* who will account for the debt (and not the physicians reporting to him). The hospital director struggles between the devil and the deep: he understands the spending inclinations of his employees, but he must restrict them.

The soft budget constraint occurs mainly for the hospital director as an expectation. If the bailout is not 100 percent certain, then it is primarily the hospital director who must lobby for it. The stronger his bargaining position is towards the superior agencies of the hospital, the financiers and the institutional owner providing support, the more certain he can be of his hopes for a bailout. Consequently, he very often leads the objections against the exit, or he himself initiates the protest.

The ambivalent nature of the hospital director's behavior can be explained by the fact that there is no clear relationship between the financial crisis of the hospital, the bailout, and the recall and appointment of the responsible manager. If a hospital is in financial crisis and there are strong arguments against its closure, i.e. for the bailout, then at least an in-depth analysis should be prepared identifying *who* is responsible for the problem. An intensive analysis should identify the degree of responsibility borne by the hospital director. It is not the purpose of this article to answer this difficult question. However, it gives cause for concern that six of the directors who were saved within the framework of the large consolidation actions described in *Table 3* continued to remain in their positions.[12]

The politician

Politics can be excluded from the coordination of hairdressing services or beer production and sales. (Perhaps not entirely, but we can still maintain that it is a coordination process that is free of politics.) On the other hand, the exclusion of politics from the regulation of health services *is impossible.* In a modern welfare state,

the direction, degree and method of health financing and state intervention is always a political issue.

There are two distorted pictures of a politician for many people. According to one picture, a politician is driven only by the desire to gain power and no other motives; for this reason, he will do anything to be popular, to obtain votes and political supporters. The other distorted picture that has spread among devotees of certain politicians is the image of the politician as the apostle saint of large and noble ideas.

In fact, a politician is also driven by various motivations. Let us put this in the framework of our topic, the closing of a hospital due to financial bankruptcy. Our politician does not welcome this event because he sincerely sympathizes with the patient and the physician, and shares their despair and outrage. In addition, since he is a politician, regardless of whether or not he is genuinely empathetic, he is also afraid of their anger because the patients, their families, friends and acquaintances are also his voters. He needs their political support. According to Robinson – Torvik (2006) the influence of politicians in pursuit of popularity on a bailout injunction is the *fundamental* reason leading to a soft budget constraint syndrome. In my view, this is a one-sided and exaggerated statement; however, it is true in part.

On the other hand, a politician also knows that overspending and tolerating the soft budget constraint increases the phenomenon and leads to problems. Even if a politician has not thoroughly thought through the entire cause and effect chain, it is obvious to him that an organisation's frequent overspending of the budget limit and the costs of repeated bailouts contributes to a macro-level budget deficit. This leads to painful macro-economic problems often involving severe political difficulties.

A politician especially understands and experiences the risks of repeated bailouts and burdens on the budget if he belongs to the political parties forming the current government. On the other hand, the position of the opposition attracts the politician to join those who protest against the closing down of hospitals. The Norwegian experience is very useful on this topic.

Dagfynn Hoybraten, a Christian-Democratic politician who was the health minister of a liberal-conservative government between 2001 and 2004, said the following about the turnaround of the previously governing Social Democratic Party: "The Labour Party [when it was in government] complained about the softness of the budget constraint, ... and proposed a hospital reform.[13] But when they became the opposition, everything said earlier was forgotten and they opened fire [against the current government] as soon as the hospitals began to complain about their crises."[14]

According to Bordignon (2000), an Italian economist, it is particularly difficult for a government to assume a strong obligation in advance not to bail out the loss-making organizations, if the government is based on a fragile coalition which breaks up frequently and easily. Consequently, he connects this phenomenon to the proportional election system. It is possible that this may also have an impact. However, it is not easy to demand hardness when the government serves the parliamentary cycle, or if it is re-elected.

The Norwegian and Italian examples also show that the SBC syndrome occurs in the public sector under conservative, liberal and social-democratic, right wing and left wing governments (Hagen – Magnussen – Kaarbo 2007; Tjerbo – Hagen 2008; Bordignon 2000; Bordignon – Turati 2003).

It can be observed that a politician will increasingly seek to use his influence when fighting for the bailout of an organization whose leader belongs to the same political group as the politician himself. A hospital stands a better chance of being consolidated if its manager belongs to the governing political parties. Based on an article by S. A. Dasgupta, A. Dhillon and B. Dutta that was written on the basis of the Indian experience, this phenomenon is also described as the *alignment effect* (Dasgupta – Dhillon – Dutta 2008). The study by Bordignon – Turati (2003) describes the econometric model analyzing the budget constraints of the Italian state hospital sector. The alignment effect is a separate variable among the variables pointing towards the softening within the model – and the effect of this variable proves to be significant in their calculations.

Similar conclusions can be drawn from the observation of Hungarian events, too. For example, within the framework of a large consolidation project a hospital has a better chance for a bailout which – using the term often used by Hungarian journalists – "is close" to the governing political parties.[15]

The alignment effect is reinforced by the well-known phenomenon that when the political regime changes as a result of parliamentary or local elections, this change is reflected not only in terms of political functions (personnel changes in ministers, mayors and people directly below them in the hierarchy reporting to them), but also in terms of a much more far-reaching succession of staff replacements. The new local government will seek to appoint people of the same political persuasion for what it considers to be all of the important positions, regardless of whether this appointment is for the director's position in a publicly owned company, school or a theatre.[16] It would appear that the hospital sector is not an exception to such changes in managers either.[17]

A politician has good reason for this behavior. In their articles on the political motivations of the soft budget constraint the two authors referred to earlier, Robinson and Torvik (American and Norwegian economists), used the following expression: what we face here is a "clientele"-based exchange transaction (Robin-

son – Torvik 2006). Within the framework of the patron-client relationship, the politician obtains a redistribution benefit in exchange for political support.

DIVERSION – CENTRAL AND LOCAL GOVERNMENTS

It is especially worth taking note of when a local government interpolates itself into the sequence of events, even if only on an intermediary level.[18] In many countries, a considerable number of publicly owned hospitals are owned by the local governments instead of the central government.

It is a rather general phenomenon, especially in Europe, that the constitution or law states that the local government is responsible for providing health services to residents. At the same time, the constitution or law that has long been in effect does not prescribe the financial resources from which the local government can fund these needs. Are there sufficient revenues to finance the expenditures (including also development) that are not covered by health insurance or by the co-payment of patients? How should the central and local governments divide the burden if the local government generally needs support from the central government (especially with regard to health expenses)?

Different countries and governments of differing political persuasion apply various burden-sharing processes and distribution ratios. There is always some bargaining between the government and the local powers. The question is who should pay for the bailout if one of the organizations controlled by the local government (for example, the local transport company, school or hospital) is in financial crisis. This heated conflict is a phenomenon accompanying the SBC syndrome.[19]

Hungarian readers are familiar with this phenomenon. However, it also frequently occurs elsewhere. For example, in Italy the local government is also responsible for providing health services, although it cannot cover the expenses alone; yet the central financing contribution is not defined as a fixed amount. Bargaining takes place repeatedly, and central bailout actions follow each other again and again (Bordignon – Turati 2003). Hospitals are restricted in terms of bank loans, but local governments are not. Consequently, debt is not accumulated directly by the hospital (or similarly by a school or an old folks home, etc.), but rather by the local government which supports or bails out such institutions when they overspend. And what incredibly large debt local governments can incur! In the end, it is the local government directly financing the hospital that needs to be bailed out instead of the hospital (or the other organizations owned by the local government). This phenomenon is illustrated by the data in *Table 5,* which indicate the high proportion of bailout expenses assumed by the central government from the local government.

Table 5

Italy – deficit and bailout ratio 1995–1999

Region	Amount allocated to bailout by the central government per accumulated deficit (percentage)	Region	Amount allocated to bailout by the central government per accumulated deficit (percentage)
Piemonte	55.45	Lazio	53.31
Lombardia	50.96	Abruzzo	56.41
Veneto	44.60	Molise	–2049.00
Liguria	34.57	Campania	36.82
Emilia-Romagna	47.19	Puglia	33.36
Tuscany	40.77	Basilicata	–577.49
Umbria	8.41	Calabria	26.81
Marche	56.08	Total	52.56

Note: There is a minus sign for two regions. This means that the region received more transfers than its accumulated deficit.
Source: Bordignon – Turati (2003), Appendix A1 table

What will solve the problem? Will it be the centralization or decentralization of the ownership right and financing obligations of publicly owned hospitals? Norway tried centralization first – there was some overspending. Later on, they tried decentralization – the result was overspending again. Then they applied centralization again – and once again overspending appeared (see Tjerbo – Hagen 2008).

The tendency to overspend, i.e. the emergence of the soft budget constraint, stems from much deeper roots and is a more strongly motivated social phenomenon than can be eliminated by mere restructuring, centralization, decentralization and recentralization campaigns.

DEFICIT AND DRIVING THE DEBT UPWARDS

Let us take a look in *Figure 2* at the vertical relations between the main characters analyzed so far. The small circles at the lowest level represent the patients. The top level illustrates the central government and Parliament. At each level, the participants are interested in pushing the consequences of overspending and exceeding the budget constraint upward. The patient encourages physicians to overspend. The physician drives a hospital into overspending and increasing debt. The hospital tries to transfer the deficit and debt caused by its overspending to the central or local government, depending on which government is its owner or which government has customarily financed additional costs before. The local government tries to transfer the debt to the central government. If the local government has a multi-level structure (for example, town, county, region in large countries), then

the process of driving debt upward may take place even between such intermediary levels. If the problem occurs, i.e. the deficit can no longer be managed and the debt is unbearable, then the decision-making levels above the patient start shifting the responsibility to each other and blaming each other.[20]

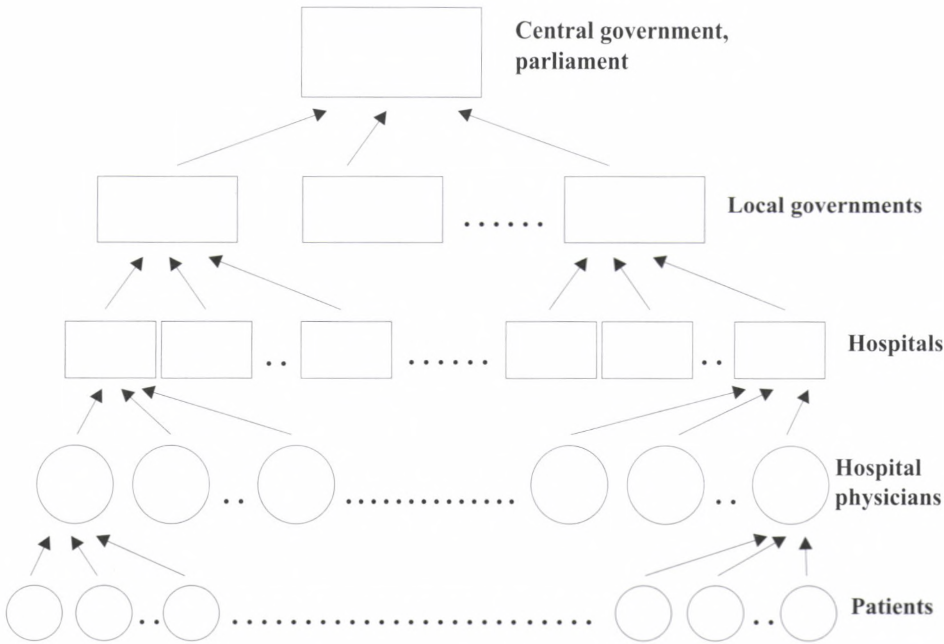

Figure 2. Vertical relations: pushing the deficit and debt upward

We can interject the description and analysis of the situation with a methodological remark. The approach described here is similar to the "behavioral economics" approach. We cannot content ourselves with making generalizations about the participants' goals in terms of profit maximalization. Instead, we must try to understand the special motivations that are important for the analyzed phenomenon (in this case, the softening of the budget constraint). We wish to identify the motivation that triggers the behavior creating the phenomenon in the participants of the event.

At this point we will even exceed the description that is generally typical of behavioral economics. We will devote special attention to motivations that are *contradictory to each other*. Each participant is motivated by driving forces that are in conflict with each other (as seen, for example, in our analysis of the hospital director or the politician). To repeat the image referred to above: the hospital director is

between the devil and the deep. With whom should he sympathize? With his employees and ultimately with the patients? Or with those who appointed him to be a good manager of public funds? Internal conflicts also wreak havoc within a politician: will it be popularity or his responsibility as a statesman? If he is a member of Parliament who happens to belong to the governing party, to whom is he more responsible: to the citizens of his electoral district who object to the closing down of the local hospital, or to the national community as represented by Parliament, the interests of which are being severely violated by the budget deficit or the high taxes required for funding the series of bailout actions?

The situation described in this study is only one example of a more common phenomenon. There is no systematic arrangement in the mind of the decision-maker who is forced to take a position in difficult problems. There are no established, solid, consistent preferences. The decision-maker struggles with conflicting thoughts, hesitates and sometimes says and wants contradictory things.

One current of thinking in the theoretical modeling of the soft budget constraint focuses on the time inconsistency of the bailout institution, the "rescuer". (This is the topic of a seminal study by Dewatripont and Maskin (1995), which has been followed by many other theoretical studies.) The rescuer promises in advance that he will not save the organization in trouble, thus trying to encourage and warn it to respect financial discipline and constraint. However, if trouble nonetheless occurs, he changes his mind and does not keep his previous promise. Later on, he comes up with reasonable arguments as to why the bailout action was also practical for the rescuer. One of the psychological bases of the inconsistency of the events *following each other in a sequence* (advance promise and subsequent rescue) is the inconsistency between the motives *concurrently* existing in the decision-maker's way of thinking (and emotions).

IMPACT OF THE OWNERSHIP RELATIONS

Following this methodological remark, let us return to the main concept of the study. We set out to describe five main characters, but so far we have only touched upon the owner's behavior.

The study so far dealt only with the publicly-owned sector, where the owner is either the central or the local government. As we saw, here the tendency to overspend and exceed the limit is deeply ingrained. And as there is strong motivation for bailout actions, too, the organization inclined to overspend (the hospital in our topic) expects to be justifiably bailed out. This continually perpetuates an overspending spiral of → bailout → overspending → bailout, etc.

What is the situation in the case of private ownership? There are two types of private ownership: for-profit and non-profit organizations. According to English language terminology, both are *private,* not *public* organizations. Private organizations may be owned by a foundation, an association, a non-public educational institution, a church, etc.[21] In many countries non-profit organizations are entitled to tax allowances, therefore implying that the state financially contributes to their operation.

M. G. Duggan, an American economist (Duggan 2000) conducted an interesting study. A state program provided a special grant to hospitals for a specific health purpose. Nothing changed in terms of the hospitals owned by the local governments. The local governments used the money for their own purposes, and reduced their support to hospitals by exactly the same amount as the additional grant provided under the special program. In the non-public sectors, however, the impact of the additional funds was perceivable and more or less identical in the non-profit and for-profit subsectors.

So far, I have not found any study from which assuring conclusions could be drawn, or which could give a comprehensive answer to the following question: what is the correlation between a soft–hard budget constraint and the ownership type? Most comparative studies have been conducted in the United States, where the various ownership types have existed side-by-side for a long time and where a lot of data is available. Certain guesses can be made based on the studies that I have reviewed (e.g., Succi – Lee – Alexander 1997; Chakravarty – Gaynor – Klepper – Vogt 2005; David 2005; Capps – Dranove – Lindrooth 2006; furthermore Eggleston 2008; Eggleston – Shen 2008 as well as Shen – Eggleston 2008), although let me stress that these are only guesses, which need to be verified. The conjectures are reviewed in *Table 6.*

Table 6

Relationship between the types of ownership and the soft budget constraint syndrome

Type of ownership	Chance of bailout in the case of financial trouble
Owned by the state *(public),* central or local government	Rather high
Non-public *(private)*	
– Non-profit	Not big, but not negligible (depending on various conditions)
– For-profit	Small, but not excluded (depending on various conditions)

In terms of behavior, the important line of demarcation is not between publicly owned and non-profit organizations, or for-profit organizations. Of far greater importance in this respect is the dividing line separating the publicly owned public sector from the non-public private sector.

As was already explained in the previous part of the study, in public ownership the budget constraint is inevitably more or less soft. Non-public ownership provides more opportunities for hardening of the constraint, but this is not in itself a guarantee.

Concerning the two types of non-public ownership, a non-profit hospital has a better chance for a bailout than a for-profit organization (Capps – Dranove – Lindrooth 2006). However, even the for-profit form does not guarantee the total elimination of a bailout in the hospital sector. Even a for-profit hospital can force a bailout, for example, if it has a geographic or professional monopoly; or if its representatives have good contacts with the governing political forces.

As I already explained in my previous works, I support the coexistence of various types of ownership in the health sector (Kornai – Eggleston 2004: Ch. 7). I would not propose launching a hospital privatization campaign in any country, but I would propose not imposing prohibitions or legislative barriers on central or local governments in the sale of part or the entire hospital owned by them to a non-profit or for-profit organization, or the transfer of operation of the hospital to a non-public enterprise without transferring ownership rights. And what is even more important is to open the door wide to non-public enterprises that wish to establish a new hospital. This cannot take place on the basis of an unlimited "free market" principle; only such non-public enterprises should be allowed into the sector that strictly comply with the special quality requirements of the health sector. The investments of non-public companies and private investors must be accompanied by stronger government regulations and control. (See my earlier book on the health reform written jointly with Karen Eggleston: Kornai – Eggleston 2004: mainly Ch. 7).

There are several arguments for permitting the entry of non-public (non-profit and for-profit) enterprises into the sector. This type of initiative should be supported primarily when it brings an investment, i.e. it undertakes an obligation for modernization and expansion. There is a great need to supplement public resources and also mesh private investment with the development of the health sector. There is hope that the non-profit and for-profit enterprises can make health services more economically efficient. These are the primary arguments, but as a secondary argument, it is also worth considering that in respect of non-public hospitals compliance with financial discipline can be more readily enforced and budget constraints can be more easily hardened.

Regardless of the share of the various types of ownership in the hospital sector, hospitals should compete for the patients instead of the other way round, patients competing for hospitals. Competition should develop on the supply and not on the demand side. This is one of the key requirements of hardening the budget constraint. An organization that is in a monopoly position cannot be forced to close

down, regardless of its bad economic performance. It is a self-defeating and self-contradictory policy to implement large-scale concentrations and proclaim financial rigor at the same time. The threat of exit will only materialize if an organization exists that can replace and substitute for the organization which becomes insolvent.

NORMATIVE INFERENCES

I have applied a positive approach to the soft budget constraint syndrome in my study so far. I would like to very briefly cover the normative problems, too. Many economists tend to draw extremely simplified normative conclusions about the soft budget constraint based on empirical observations and theoretical principles, as follows: a hard budget constraint is good, a soft budget constraint is bad. Since bailouts generate a soft budget constraint, bailouts should be rejected.

Let me start with my own position: this primitive and extreme normative position is not my own, nor can it be found in any of my articles. The same can be said about many other researchers focusing on the soft budget constraint; they do not veto bailouts either.

This issue is especially important these days in relation to the events currently taking place in the financial world, including the gigantic state interventions in the United States, Europe and on other continents. Only a fundamentalist economist blindly trusting in the infallibility of the market would think that under no circumstances do financially troubled entities need to be rescued. It is not the purpose of this study to take a position on the bailout of banks and other financial institutions, or insolvent manufacturing companies that do not have access to loans at a later stage of the crisis. What should be considered in these cases is the destruction triggered by the spillover effects on the financial system, and ultimately, on production and employment. With regard to the topic covered by this article other indirect effects must be taken into account (for example, consequences on the state of people's health and the quality of health services). However, I should add that there are analogies to be found in the raising of these questions, but to delve into them would go beyond the bounds of this article.

The ethical content of the dilemma is clearly obvious because the topic is hospitals, and not banks or car manufacturing plants.[22] There is no doubt that the hardening of the budget constraint may deteriorate the quality of services and make access more difficult. Karen Eggleston and Yu-Chu Shen have studied how hospitals react to the hard budget constraint (Eggleston – Shen 2008). The result of their analysis: a softer constraint does not only involve the well-known unfavorable cost implications, but also makes it easier to employ certain more expensive activities with better quality performance. A hospital less worried about

bankruptcy will find it easier to take on such activities. This way, it can contribute to the strengthening of the "safety net" and reduction of the mortality rate.

Let us now define the decision-making dilemma more generally. What happens if a hospital facing financial difficulties is closed down? What advantageous and disadvantageous effects occur?

The disadvantages are felt by all parties concerned *immediately, individually, within themselves,* i.e. in a manner affecting their respective lives. (It is more difficult to have access to the usual treatment, and the physician loses his general working conditions.) On the other hand, the advantages of rejecting the bailout will present themselves *only later* in the form of stronger financial discipline, more effective operation, slowing expenditures, and a lower burden on taxpayers.[23] Although all of this is favorable to the entire society, people do not experience this as an individual achievement but rather as an almost incomprehensible external impact.

Do we wish to help the patient now, or are we thinking also of the future? Does it occur to us that if the resources allocated to health services are used improperly, then we ultimately deprive future patients of better treatment? The repeated execution of bailout actions in the long-term is a tool of destruction, it is bad pedagogy. It leads to irresponsibility.

There is no obvious answer to these ethical dilemmas. This is why my study does not lead to a clear-cut practical conclusion. I cannot offer a simple rule of thumb which would give clear guidance to potential bailout organizers (the competent minister, Parliament, mayor, municipality, etc.).

Consequently, I cannot recommend either *"if a severe financial crisis has already occurred in a hospital, then it must always be rescued",* or just the opposite, *"regardless of the size of debt accumulated by a hospital, the hospital must never be bailed out"* as a universal rule. The execution or refusal of the bailout must always depend on the specific conditions, and the joint consideration of all favorable and unfavorable circumstances of the closing down or the bailout.

The bailout actions cannot automatically be executed under any circumstances. Each individual case must be considered separately. If after thorough consideration a decision is made on the bailout, then it must be made with the awareness that certain detrimental long-term consequences, mainly the ruinous effect on financial discipline, cannot be avoided. In such a case, this harmful consequence should at least be eased to a certain extent by, for example, objectively exploring what has led to the crisis. Was it only external circumstances? Or, and this is true in most cases, was there also human negligence, typically on behalf of the management? Who is responsible? It is not enough to establish who bears responsibility; we must also deal with personal consequences. It is unacceptable to use public funds to remedy the problem while those responsible for it remain in their mana-

gerial positions and continue to draw high salaries. Increased rigor is required whenever bailout actions are repeated.

Any external assistance should be closely related to the use of internal instruments: cost-cutting, better organization of work, increased control over expenditures.

As there is no generally effective rule for the acceptance or rejection of the bailout, any vacillation before the decision-making is also part and parcel of the hard facts of life. The normative dilemma can now be brought back into a positive analysis. When a difficult ethical dilemma is being faced by each character (the physician, the hospital director, the central and local politician, the owner and other characters not mentioned so far, for example, the journalist commenting on the events or the scientific researcher analyzing the problem) and he struggles within himself, this can serve to further strengthen the resistance of society against the hardening of the budget constraint.

SUMMARIZING CONCLUSIONS

The appearance of the soft budget constraint in the hospital sector is not a Hungarian phenomenon. It is not a unique feature of the post-socialist region either. This is a *necessary inclination* of any democratically governed modern capitalist society, in which state ownership, state regulation and state financing definitely have significant roles. These aspects are reproduced, and if they are repressed, then with time they are regenerated again.

This does not mean that we should just stand there and look at them helplessly. A lot can be done *to prevent this inclination from becoming too strong.* Moral and material incentives must be found to hold back overspending tendencies. Overspending cannot be automatically given free reign. When weighty arguments are used to justify the bailout with public funds of a hospital struggling with a financial crisis under the given circumstances, these must be accompanied by an extensive analysis of the source of the problem and the people responsible for being negligent must be called to account. Non-public ownership types must also be allowed for various reasons, including a better chance for a hardening of the budget constraints in privately owned enterprises. It is also desirable to have competition in the hospital sector on the supply side.

All of this requires a great deal of effort. However, while fighting against the softening of the budget constraint we should not act blindly or dogmatically or go to extremes, or act like fanatical market fundamentalist; rather, we should act humanely, taking consideration of both the well-founded resistance of patients and physicians as well as their mistakenly based anxious aversions.

NOTES

[1] The opening points of the theory were initially published in a Kornai study (1978) and a book entitled *Economics of Shortage* (Kornai 1980: 315–338). Since then, many other authors have carried out research on this subject. The latest review of the main theoretical concepts and research ramifications of the soft budget constraints are contained in the Kornai – Maskin – Roland study (2004).

[2] The building of a database containing the financial and other operational data of Hungarian hospitals for many previous years began in the framework of the research preceding this study. Csaba Dózsa and his colleagues will continue expanding the database and preparing further analyses on the basis of the data, which will clarify the economic and management problems of the hospital sector.

[3] Concerning the types of ownership, the sector covered by the tables contains institutions owned by the state and the church, i.e. organizations, which will be classified as "non-profit non-state sub-sector" in a later part of the study. The data of the tables cover only hospitals providing active services and do not contain the data of any independent outpatient care institutions.

[4] The threshold was defined by the same criteria that are applied to hospitals in debt when state commissioners are assigned to them (treasury, municipality). This approximates the criteria applied for the appointment of receivers in the corporate sector.

[5] We made this selection deliberately looking at the situation in the middle of the year instead of the situaton at the end of the year. We understand that in the accounting system, the end-of-year data are in the focus of attention and hospitals (and other organizations) report to their owner institutions, the tax authority and other parties based on those figures. Because the situation prevailing on 30 December is so important, status indicators on this day can be improved with some resourceful creativity. Some revenues may be brought forward, expenses may be deferred, etc. There are no incentives related to the figures prevailing on 30 June, there are no reasons for creativity, therefore, the real troubles may be shown more clearly on that day.

[6] On the basis of the data available to date, we could not highlight cases from the group of 42 units where the internal and external instruments were related to each other. In other words, cost-cutting and revenue increase actions took place in parallel with the bailout event. We were forced to classify these mixed cases into one of the two clearly defined categories, depending on the stronger process applied in the management of the financial troubles.

[7] The restrictions on expenditure began much sooner, in 2004, with the introduction of the so-called performance volume limit, which limits the performance of each organization to a certain level, above which the National Health Insurance Fund does not provide 100% financing. Above this limit, hospitals receive lower payments for their services, decreasing according to a degressive scale. Many people dispute whether or not this strongly centralized intervention in the expenditures is an effective instrument in reducing expenses, and whether or not it facilitates economic operation. More detailed analysis of this issue would go beyond the topic of the present article.

[8] Part of the literature listed in *Table 4* uses the terminology of the soft budget constraints (SBC) theory. The other sources of literature use different expressions (for example, describing the causes, distribution and impacts of bailout actions and organizational exits), although the presence of the SBC syndrome can be clearly concluded from the description.

[9] Co-payment has existed in numerous foreign countries for a long time, including many Western European countries. The various forms of co-payment, including the nursing fee paid for hospital services, were introduced in 2007, then abolished after a referendum in 2008 in Hungary.

[10] American researchers completed cost benefit calculations on the profits and losses following the closing of hospitals (Capps – Dranove – Lindrooth 2006). The loss was primarily approached

with the following calculation: time of transportation by car to reach the closed hospital and the nearest still active hospital. The time differential, in hours, multiplied by the average hourly wages, is equivalent to the additional transportation efforts expressed in money. Naturally, the authors consider this indicator only a "proxy", a symbolic approach to the consumer loss. As was stressed also in the above description, the loss consists of many components, including also the prospects of recovery and the risks of life or death.

11 The improvement of the performance of the hospital sector with mergers and concentrations is a problem also in purely economic aspects. It is true that economies of scale bring along some savings, and a larger unit operates with lower average costs. Nonetheless, the restraints of competition thus created weakens the motivation for cost-cutting, undermines financial discipline and develops the soft budget constraint.

12 These days, when large bailout actions are taking place in all sectors of the economy all over the world, the demand for replacing responsible managers of the organization in trouble (bank, industrial company or any other organization) is increasingly being vocalized within the framework of the bailout. Some countries are developing draft bills which would make such action obligatory.

13 Regardless of whom I would support in the conflict of the political powers, I must say that it flatters me as an author that Norwegian politicians use the term "soft budget constraints" when they argue with each other.

14 I took the quotation from the article by Tjerbo – Hagen (2008: 15).

15 A politically impartial follow-up analysis would be required for each individual bailout action to determine the strength in Hungary of the alignment effect, the influence of the "nearness to-distance from" factor on political powers in terms of the allocation of bailout benefits. Without such an analysis, the above remarks reflect only *impressions* of the experts who are aware of the situation. It would be desirable that objective researchers continue analyzing this problem.

16 Our family dictionary describes this as "changing room attendant effect". A taxi driver explained to my wife during a journey that formerly he was a changing room attendant and earned more money than in his current job as taxi driver. – Why did he leave his job? – Because after the elections, a new director was appointed for the swimming pool and he brought along his own staff to manage the changing rooms.

17 Everything that I said about the allocation of the bailout amounts in footnote No. 15 also applies to the replacement-bailout practice. As there are no intensive politically objective studies, we can only make assumptions. We only hope that future research will also comprise this important problem.

18 In Hungary, we use the term "local selfgovernment". As the topic of this study is not confined to the analysis of the Hungarian situation, I use the more general expression.

19 My study relates at this point to the continuously growing body of literature that analyzes the correlation between fiscal decentralization and the soft budget constraint. See Qian – Roland (1998); Rodden (2000) studies, and the book by Eskeland – Litvack – Rodden (eds, 2003).

20 This situation is described well with an English expression: the *blame game*. A game develops between the participants, whereby each party blames the other.

21 It is interesting to look at the changes in the ratios of ownership types in the United States over a long period of history. In 1928, there were in total 371,000 hospital beds, of which 31 percent were owned by the state, 53 percent were owned by private non-profit and 16 percent by private for-profit hospitals. By 2000, the number of hospital beds increased to 824,000, i.e. they nearly doubled. There was a drastic change in ratios: 16 percent of the beds were in public hospitals, 71 percent in private non-profit hospitals and 13 percent in private for-profit hospitals. The non-profit form became the dominant form. (See American Hospital Association, Hospital Statistics.) The coexistence of the various forms can be used as a basis for various comparative

studies, including also a more thorough analysis of the correlation between the soft–hard budget constraint and ownership types in the United States.

[22] Concerning the normative dilemma related to the hard budget constraint and its correlation with the social safety net, see Hardy (1992).

[23] Lindrooth – Lo Sasso – Bazzoli (2003) describe the favourable impacts of the closing down of inefficient hospitals in a detailed empirical study.

REFERENCES

American Hospital Association, *Hospital Statistics,* http://www.aha.org.

Bordignon, M. (2000): "Problems of Soft Budget Constraints in Intergovernmental Relationships: The Case of Italy". *Inter-American Development Bank Working Paper,* R-398.

Bordignon, M. – Turati, G. (2003): "Bailing Out Expectations and Health Expenditure in Italy". *CESIFO Working Paper,* No. 1026.

Capps, C. – Dranove, D. – Lindrooth, R. C. (2006): *Hospital Closure and Economic Efficiency. Center for Health Industry Market Economics.* Evanston: Kellogg School of Management at Northwestern University.

Chakravarty, S. – Gaynor, M. – Klepper, S. – Vogt, W. B. (2005): "Does the Profit Motive Make Jack Nimble? Ownership Form and the Evolution of the U. S. Hospital Industry". *NBER Working Paper,* 11705.

Colombo, F. – Zurn, P. – Oxley, H. (2006): *Switzerland.* Paris: World Health Organization.

Dasgupta, S. – Dhillon, A. – Dutta, B. (2008): "Electoral Goals and Center-state Transfers: A Theoretical Model and Empirical Evidence from India". Under preparation *Journal of Development Economics,* http://www2.warwick.ac.uk/fac/soc/economics/staff/faculty/dhillon/wp/grantsmail4.pdf (Downloaded: September 2, 2008).

David, G. (2006): "The Convergence between For-profit and Non-profit Hospitals in the United States". *Annual Meeting Allied Social Science Associations,* 2006.

Dewatripont, M. – Maskin, M. (1995): "Credit and Efficiency in Centralized and Decentralized Economies". *Review of Economic Studies* 62(4): 541–555.

Duggan, M. G. (2000): "Ownership and Public Medical Spending". *The Quarterly Journal of Economics* 115(4): 1343–1373.

Eggleston, K. (2008): "Soft Budget Constraints and the Property Rights Theory of Ownership". *Economics Letters* 100: 425–427.

Eggleston, K. – Shen, Y. (2008): "The Effect of Soft Budget Constraints on Access and Quality in Hospital Care". *NBER Working Paper,* 14256.

Eskeland, G. S. – Litvack, J. I. – Rodden, J. (eds) (2003): *Fiscal Decentralization and the Challenge of Hard Budget Constraints.* Cambridge: MIT Press.

Hagen, T. P. – Magnussen, J. – Kaarboe, O. M. (2007): "Centralized or Decentralized? A Case Study of the Norwegian Hospital Reform". *Social Science & Medicine* 64(10): 2129–2137.

Hardy, D. C. (1992): "Soft Budget Constraints, Firm Commitments, and the Social Safety Net". *IMF Staff Papers,* 39(2).

Kornai, J. (1978): "A hiány újratermelése" [Reproduction of the deficit]. *Közgazdasági Szemle* 1978(9): 1034–1050.

Kornai, J. (1980): *A hiány* [The deficit]. Budapest: Közgazdasági és Jogi Könyvkiadó. In English: Kornai, J. (1980): *Economics of Shortage.* Amsterdam: North-Holland Press.

Kornai, J. – Eggleston, K. (2004): *Egyéni választás és szolidaritás. Az egészségügy intézményi reformja Kelet-Európában* [Individual choice and solidarity. Institutional health reform in Eastern Europe]. Budapest: Nemzeti Tankönyvkiadó. In English: Kornai, J. – Eggleston, K. (2001):

Welfare, Choice and Solidarity in Transition. Reforming the Health Sector in Eastern Europe. Cambridge: Cambridge University Press.

Kornai, J. – Maskin, E. – Roland, G. (2004): "A puha költségvetési korlát" [Soft budget constraint]. *Közgazdasági Szemle* 2004(7–8): 608–624, and 2004(9): 776–809. In English: Kornai, J. – Maskin, E. – Roland, G. (2003): "Understanding the Soft Budget Constraints". *Journal of Economic Literature* 41(4): 1095–1136.

Lindrooth, R. C. – Lo Sasso, A. T. – Bazzoli, G. J. (2003): "The Effect of Urban Hospital Closure on Markets". *Journal of Health Economics* 22: 691–712.

Newhouse, J. P. (1993): "An Iconoclastic View of Health Cost Containment". *Health Affairs* 12: 152–171. http://content.healthaffairs.org/cgi/reprint/12/suppl_1/152.pdf.

OECD (1997a): *Economic Surveys Austria 1996/1997*. No. 5. Paris: OECD.

OECD (1997b): *OECD Economic Surveys Greece 1996/1997*. Supplement 1. Paris: OECD.

OECD (1998): *OECD Economic Surveys: Finland 1997/1998*. No. 15. Paris: OECD.

OECD (1999): *OECD Economic Surveys: Belgium/Luxembourg 1998/1999*. No. 4. Paris: OECD.

Perry, G. – Leipziger, D. M. (eds) (1999): *Chile: Recent Policy Lessons and Emerging Challenges*. Washington D.C.: World Bank.

Qian, Y. – Roland, G. (1998) "Federalism and Soft Budget Constraint". *American Economic Review* 88(5): 1143–1162.

Rae, D. (2005): "Getting Better Value for Money from Sweden's Healthcare System". *OECD Economics Department Working Papers,* No. 443.

Robinson, J. A. – Torvik, R. (2006): "A Political Economy Theory of the Soft Budget Constraint". *NBER Working Paper,* 12133.

Rodden, A. (2000): "Breaking the Golden Rule: Fiscal Behavior with Rational Bailout Expectations in the German States". A *European Fiscal Federalism in Comparative Perspective* study prepared for the workshop, Center for European Studies Harvard University; http://web.mit.edu/jrodden/www/materials/brescia2.pdf (Downloaded: September 2, 2008).

Shen, Y. – Eggleston, K. (2008): "The Effect of Soft Budget Constraints on Access and Quality in Hospital Care". *NBER Working Paper,* 14256.

Succi, M. – Lee, S-Y. F. – Alexander, J. A. (1997): "Effects of Market Position and Competition on Rural Hospital Closures". *Health Services Research* 31(6): 679–699.

Tjerbo, T. – Hagen, T. P. (2008): *Deficits, Soft Budget Constraints and Bailouts: Budgeting after the Norwegian Hospital Reform*. Manuscript, Institute of Health Management and Health Economics, University of Oslo.