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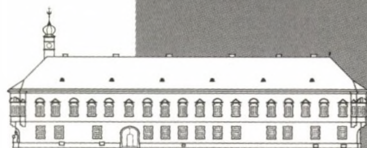

The Borderline between the Spheres of Authority of the Citizen and the State

Recommendations for the Hungarian Health Reform

János Kornai

Discussion Paper Series

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The Borderline between the Spheres of Authority of the Citizen and the State

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Discussion Paper No. 48

August 1998

Focus Group 1997–98, Collegium Budapest
'The Interaction between Politics and Economic
Policy in Post-Socialist Transition'

ISSN: 1217-5811
ISBN: 963-8463-63-5-775
Graphics: Gerri Zotter
Typeset by: James Patterson

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Focus Group 1997–98 at Collegium Budapest

'The Interaction between Politics and Economic Policy in the Period of Post-Socialist Transition'

Collegium Budapest plays host to one or several 'focus groups' every academic year. These special collaborative research formations offer the chance for a group of researchers in various disciplines to concentrate their attention on a common subject of their choice. The result is lively interdisciplinary collaboration. Members of the group spend shorter or longer periods at the Collegium. While there, they discuss their ideas at seminars with each other and interested members of the Hungarian academic community. The results of their research are made public at conferences organised by the Collegium for a wider professional public.

Members of the Focus group in the 1997–98 academic year examined various aspects of the interaction between politics and economic policy in the period of post-socialist transition. The group was convened by János Kornai, Permanent Fellow of Collegium Budapest. The group included economists, political scientists and sociologists from Germany, Poland, Romania, Russia, the United States, and of course Hungary. Lists are attached of the members of the group and of those who assisted the authors as discussants at the group's March conference.

Collegium Budapest has decided to publish the papers prepared for the conference in its Discussion Papers series. Some of these papers will be published later in a volume and others in journals, so that the versions presented here are to be considered as pre-publications.

Members of the group would like to take this opportunity to express their gratitude to Collegium Budapest, which hosted their research work in the true sense of the word, and to the Swedish and Hungarian sponsors: The Bank of Sweden Tercentenary Foundation and Magyar Hitel Bank Rt., for their generous financial support.

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The Borderline between the Spheres of Authority of the Citizen and the State

Recommendations for the Hungarian Health Reform

1. The Problem

The answer given to a question depends, of course, to a large extent on how the question itself has been phrased. In this study, and the book on which it is based,[1] I am far more concerned to persuade readers I have formulated the question correctly than to gain assent to the answers I give. I regard argument about the answers as inevitable, but let there at least be agreement about the questions.

Scarcity–in which human wants outstrip the ability to satisfy them with the resources available–is the central subject of examinations in economics. There is nowhere, at present, where the general problem of scarcity appears more acutely–one might say more brutally and mercilessly–than it does in the health sector. Human knowledge, science and technology offer many more opportunities for avoiding and curing disease, relieving suffering, and prolonging life than the health sector can apply in practice. *That is the*

1. Kornai (1998). The book and the present paper is a product of a longer research about the reform of the welfare sector. My research is going on under the auspices of the Collegium Budapest, supported by the National Scientific Research Foundation (OTKA 018280) and the Hungarian Ministry of Finance. The paper was written while I was a member of the Focus Group on 'The Interaction between Politics and Economic Policy in the Post-Socialist Transition' at Collegium Budapest in 1997–98. I am indebted for the invaluable help I got from the members of the group in the course of our stimulating discussions. I am also grateful to Nicholas Barr, David Cutler, Zsuzsa Dániel, Guy Ellena, Joseph Newhouse and András Simonovits for their advice and for the comments made in the discussions after my lectures at Collegium Budapest, Harvard University and the World Bank. I express my special thanks to Mária Barát, Ágnes Benedict, Karen Eggleston, Ica Fazekas, Béla Janky, Virág Molnár and Julianna Parti for their valuable help with the research and the editorial work, and to Brian McLean for his excellent translation.

fundamental problem of health care. There are patients who might be treated, as far as human knowledge is concerned, yet they are not treated, or not treated enough. This applies even to the richest countries, and within them, not just to the poorest members of society, but to richer people as well. Not even there is the provision taken to the limit where the marginal health-enhancing effect of an increment in health-care expenditure would become zero; they stop far short of that. The same holds true *a fortiori* for a country at a medium level of development, such as Hungary. If it spent several times the present amount on health, it would still not exhaust the opportunities provided by science and technology. This gulf between scientific potential and health-care practice causes all the more bitterness because Hungarian doctors, and many patients, possess a great deal of information about what medicine is capable of in more developed countries.

It is a ghastly thought: here is a patient suffering who might be helped, but assistance is not forthcoming because the resources are going on something else. If the argument is followed to its conclusion, there is no satisfactory solution to this cruel dilemma. Any decision reached implies not just help for some patients, but *exclusion* for others: partial or total denial of care. Thinking about health-care reform means addressing the frightful dilemma of 'inclusion' versus 'exclusion'. Recognition of this leads to a constructive rewording of the question:

- Who is authorised to decide 'inclusion–exclusion' matters?
- What are the principles on which the decision is made?
- What procedures and institutions should provide the decision-making framework?
- What ownership relations and incentives should develop, to motivate the participants in the process in the desired direction?

These are the questions that have to be answered first. Only then can there be cogent discussion of the foremost subject of debate today: is the Hungarian health-care system 'under-financed', and if so, by what percentage should the sums available for health care be increased?

This study takes a position on all the constructive questions just listed. However, the discussion does not follow the same order as the questions. Its

structure reflects the inner logic of how the tasks of reform present themselves. Section 2 presents the initial principles. Sections 3 and 4 cover the demand for the health sector's output, Section 5 the supply, and Section 6 the interaction between the supply and the demand. The economic and legal institutions, procedures, ownership relations and incentives so far applied and recommended for the reform are analysed first on the demand side and then on the supply side.[2] Finally, Section 7 looks at the reception the reform is likely to receive.

2. The Principles

Advocates of the reforms usually start out from the economic problems of the welfare sector or some sub-sector of it. They show there are troubles with financing the sub-sector (for instance, the pension or health system); these have already appeared, or if not, are due to appear. Expressly or implicitly, they consider it the reform's main task to raise the efficiency of the sub-sector in question and create the conditions for sustainable financial equilibrium. I also consider these to be very important assignments. Nonetheless, I place other criteria to the fore. My starting point is not financial sustainability or a value-free call for efficiency, but two ethical postulates.[3]

Principle 1 (sovereignty of the individual): The transformation must increase the scope for the individual and reduce the scope for the state to decide on welfare services. Respect must be shown for the autonomy of the individual. Let individuals have a greater right to choose, but let them be responsible for their choices, and if they have decided badly, let them take the consequences.

I am sure post-socialist society would still have to reform the paternalist, excessively centralised welfare sector it inherited from state socialism if the sector's financial equilibrium and efficient operation were assured. The

2. There is an extensive literature on reform of the health sector. Two works that I would single out for examining comprehensively the reforms taking place in the post-socialist countries of Eastern Europe are Precker and Feachem (1995) and Saltman and Figueras (1997).

3. The book on which this study is based (Kornai, 1998) deals in detail with other initial principles for the reform as well. I confine myself here to the ethical postulates among them.

reform's main mission is to widen the scope for consumer sovereignty, free individuals from the patronising care of the state, and tighten the connection between individuals' decisions and the provisions they and their families receive.

Principle 2 (solidarity): Help the suffering, the troubled and the disadvantaged. Everyone as an individual and all citizens as a community have an obligation to help their fellow human beings when they have need of it.

I recommend that these postulates be the starting point for examining what sort of institutional system and incentive mechanism to apply to handling the health sector's fundamental problem of scarcity. The history of society belies the notion that it suffices to ground institutions on efficiency criteria, and then superimpose some kind of redistributive scheme to correct their unfairness. Economic institutions almost inevitably have distributive consequences. These need to be calculated in beforehand when institutional reforms are being devised.

Suppose we were to apply principle 1 by itself, with no concern for principle 2. Even then, a 'pure' application of the mechanisms of market co-ordination could not be allowed. The economic literature on health care clearly demonstrates that the state has to intervene. The welfare sector exemplifies strongly shortcomings of the market mechanism known in other sectors: asymmetric information, adverse selection and moral hazard in insurance transactions, various beneficial and damaging external effects, and so on.[4]

Even if state intervention went no further than relieving these irregularities and averting the dangers of market failure, the distributive problem would remain: poorer people might be unable to pay for medical treatment. The very people coping with compound problems of poverty and of sickness would be denied the medical assistance they need.

Principle 2 calls for redistributive intervention. The question is how far to curb the application of principle 1 in favour of applying principle 2.[5] Where

4. On these questions, see the classic work by Arrow (1963), and also the writings by Besley and Gouveia (1994), Feldstein (1973), and Pauly (1986 and 1992).

5. Due to limitations of space, Sections 3 and 4 of the study concentrate on this question. In other words, I do not explore the albeit very important question of what kind of state intervention the health sector requires, irrespective of the redistributive problem.

should the compromise be struck between the two postulates, which conflict with each other to a large extent?

Hereafter in this study I shall often make use of the first person singular. I openly admit that the position I advance rests on my personal choice of values, not on 'objective' circumstances. Having said that, I would firmly reject any extreme egalitarian solution that gave everyone *strictly equal* access to health provisions.[6] Consistently egalitarian health care gravely breaches the first ethical principle by ignoring individual sovereignty, which in my view makes it unacceptable.

On the other hand there is a *specific egalitarian* principle that I find acceptable.[7] I will express the principle in a general form and cite health care simply as an illustration of it. The requirement of equal access is specific in the following sense:

- It has to be targeted: not applicable to every good and service, just to those that meet basic needs. The scope of these is arguable, but they certainly include health care.
- It cannot be comprehensive; it cannot encompass the whole volume of the service concerned, only a specific part of it. In health care, for instance, there needs to be equal access to a respectable minimum package of care– to *basic* health provision–and acknowledgement that individuals' access to *auxiliary* provision will not be equal.
- The state has to *guarantee* the equal access to basic provision. This awards an appreciable role to the state, but a much more restricted one than it

6. Here and elsewhere in the study I draw a distinction between two kinds of transaction: insurance, which shares risk, and redistribution, which lessens income differences. Suppose that A and B take out medical insurance with the same private insurer, sign policies on the same terms, and pay the same premiums. Later it turns out that A has been healthy all along, while B has fallen ill several times, needing frequent medical treatment. In effect, A has paid some of B's medical costs. However, it might have been the other way round, if A's health had been worse than B's.

The situation differs if A is richer and B poorer, and their insurance is not commercial, but A pays a higher contribution than B. In this case there is a redistribution in B's favour irrespective of their state of health.

7. This expression was coined by Tobin (1970).

received under the socialist system, when there was direct state control and financing in every sector, including health care.

With some of the dilemmas of choice, principles 1 and 2 can be applied so that they augment and reinforce one another. In other cases they stand in conflict, and there is a need to compromise. But what should the compromise be? No economist or other outside analyst could give a well-founded answer, and it is not from *them* that the answer should be awaited. The answer has to come from the persons actually concerned, within institutional frames and by procedures capable of promoting viable compromises in such situations of conflict. This idea accords with some of the more recent theories of social choice.[8] Often there is no way of establishing what the 'socially optimal' decision is, but society can still manage to agree in a constructive way on a procedure for taking the decision.

Operation of the health sector is a 'game' in which a variety of organisations and individuals join: Parliament, the government, the central social-insurance organisation and private insurers, doctors, other medical staff, health-care institutions, and the state health-care bureaucracy. Last but not least, there are the individuals: the patients and their relatives, and individuals as taxpayers and voters in parliamentary elections.[9] This game has been conducted so far under a specific set of rules. The reform entails introducing a new set of rules, which change the decision-making provinces and relative powers of the players, and thereby the dynamics of the health-related policy-making process. The new rules will mark an advance above all if they apply the principle of legitimacy more strongly, if the new distribution of decision-making spheres is more compatible with the operating principles of democracy.

8. See first of all the pioneering works of J. Buchanan (1954a, 1954b). A. Sen (1995) gives an excellent summary of the present state of the theory of social choice.

9. The ideas about institutions and procedures I advance in this study refer mainly to Hungary, although they can be applied to other post-socialist countries with requisite caution and adjustments, so long as political democracy prevails there. I do not extend what I have to say to countries where the political regime remains a dictatorial one, even though there have been radical economic reforms.

3. Reform on the demand side: alternative mechanisms for financing basic provision

Let us return to the distinction between basic and auxiliary care. According to principle 1, the domain of optional, auxiliary care should be as wide as possible, while principle 2 requires a widening of basic care. Where can the dividing line that represents the compromise be drawn? This cannot be deduced from the value judgements themselves, but it is possible, from what has been said, to devise a *procedure* for arriving at a distinction between basic and auxiliary care. It will be seen later that this ties in with the question of how to finance the demand for health provisions. There are various possible institutional mechanisms for performing this function. Here I will take two of them, to illustrate the dilemma of choice. They differ in the way they finance basic care, but coincide on auxiliary care.

A. Compulsory individual insurance. In this case the law obliges every citizen to have compulsory, minimum medical insurance cover, in his or her own right, or as a family member. This has to meet the costs of basic provision. Those whom the letter of the law does not induce to take out this insurance must be forced to do so by legal means.[10] The compulsory minimum insurance may be obtained from the state system or a private insurer–any member of a decentralised insurance system, chosen voluntarily by the insured.

The solidarity principle applies when the state undertakes to pay the compulsory insurance premium for those who are in need of that assistance. This is the form in which the state guarantee that all citizens will have access to basic health care applies.

10. Legislators, in enforcing minimum insurance cover, are not motivated only by the paternalist aim of saving citizens from their own mistakes. Suppose a citizen, through his or her own fault, has no insurance cover and is therefore not entitled to medical treatment, even if seriously ill. No morally upright society will leave that patient to suffer. Treatment will ultimately be received. Relying on this, many people will develop a 'free-rider' attitude: 'I will not insure myself because society will help me anyway.' Society, in its own interest, is defending itself from such 'free riding' when it makes minimum insurance cover compulsory. On this, see the study by Lindbeck and Weibull (1987).

B. A basic health service financed out of public funds. In this case, citizens pay the compulsory contribution to a designated institution that covers the costs of their basic provision. The contribution is not uniform, but redistributive. The service, on the other hand, is uniform; all citizens have the same basic provision *available* to them. (Obviously they will not have *recourse* to the provision to the same extent, which will depend on their state of health.) Under mechanism B, the state guarantee manifests itself in a universal entitlement, whereas under mechanism A, it applies through targeted assistance to those in need.

Mechanism A and mechanism B both offer the public broad opportunities to buy auxiliary health provision, openly and legally, either paying out of their own pocket or taking out private, voluntary insurance.

Neither mechanism has a *laissez-faire* character, but they differ in the *degree* to which individual sovereignty is curtailed by state intervention and income redistribution. The procedural and institutional choice made by citizens will certainly be influenced by what general attitude they take to limiting individual sovereignty, state intervention and income redistribution. The administrative costs of financing the health sector out of public funds are considerably less, and it eliminates the danger of a decentralised insurance institution becoming insolvent. On the other hand, the usual drawbacks of monopolies appear: defencelessness of clients, enfeeblement of service, and loss of the incentives provided by competition. However, let us lay aside for now the debate about the advantages and drawbacks of mechanisms A and B. There is another criterion that must be considered: the question of what is *feasible*, institutionally and politically. Here the initial state is decisively important.

There are debates going on about health-care reform in many developed market economies that have an extensive and sophisticated decentralised insurance sector. In the United States, for instance, most people are familiar with the decentralised system and attached to it. They would not be prepared to abandon it in favour of a nationalised, redistributive system of health-care financing paid for by taxation.[11] With that as the initial position, the feasible

11. This was confirmed when President Clinton's health care reform plan suffered a political defeat. Most people recoiled from the idea of a comprehensive state (federal) insurance system.

institutional means of applying principle 2, the solidarity principle, is mechanism A–provided the democratic political process is prepared to accept it.

The situation is different in post-socialist Central and Eastern Europe, including Hungary. Here the initial position is a system of comprehensive state financing of the health system, in an extreme paternalist form. There is hardly a trace of any system of decentralised, private medical insurance. A jump to mechanism A from an initial position like that would certainly cause the system of provision to collapse. The old institutions would cease to work before the new had begun, causing an institutional vacuum. A vacuum of that kind sometimes occurred in the narrowly defined business sphere during the first phase of the post-socialist transition. That was among the main reasons why there was a dramatic drop in production and the transformational recession. Though the slump in the business sphere caused grave hardship, it remained endurable. It would be unbearable in the health sector. The public cannot be left without an appropriate system of financing basic health provision, irrespective of where the dividing lines are drawn. The changes must take place smoothly, without any upheavals.

So my recommendation is to have two phases of reform. The first introduces mechanism B. This substantial alteration in the state financing of the health-care system will include a significant strengthening of individual sovereignty, but retain many aspects of the previous mechanism. The development of decentralised private insurance will already begin in the first phase.

The beginning of phase two is conditional. One condition concerns the *institutions*. Let us assume that this condition is met, *i.e.* that a system of sound, reliable medical insurance providers has developed, as the advocates of mechanism A hope, and that satisfactory legal regulation and state supervision of their financial situation is in place. This development has occurred in an evolutionary way. The decentralised insurance industry has shown it is viable and increasingly gained the confidence of the public. That confidence will be shown not by declarations, but by a mass move to take voluntary medical insurance cover. Decentralised medical insurance needs to reach a critical, threshold level of development before the introduction of mechanism A can

gain the requisite political support. This constitutes the second, *political* condition for the beginning of the second phase. There is no way to predict what preferences the public will show on this question. It would not be right to thrust mechanism A upon them. It can only be introduced generally by law if the majority of the public, in possession of the requisite information and experience, agrees with that course of action.

Having looked at the dilemma over the institutional mechanism, let us return to the question put earlier. Where should the dividing line between basic and auxiliary provision be drawn? When I seek an answer to this question, I assume that the framework just described pertains–that the first phase of the reform I recommend has begun. In other words, people have decided that basic health provision shall still be provided mainly out of public funds.

4. Reform on the Demand Side: Distinguishing Basic from Auxiliary Provision

One idea often heard during the debates on the health-care system is that the doctors should decide where to draw the line between basic and auxiliary provision. I think this statement is untenable in this simplified form. It is a cheap piece of evasion to replace this dilemma with other problems of choice, for instance by considering instead the dividing line between interventions absolutely necessary from the health point of view and operations of a purely cosmetic character. The latter are obviously a 'luxury service' for those who want to pay for it. This distinction can be drawn without any great crisis of conscience; that is not the dilemma that I tried to point out in the opening section. The truly hard decision occurs when medically-justified health-care expenditures cannot be placed within the scope of basic provision to be guaranteed and financed by the state.

Deciding the total expenditure on basic provision–placing an upper limit on the aggregate, macro-level volume of these items of spending–is *not* a medical decision, in my view. It has to be realised that wherever the line is drawn, there will always be some medically justified course of treatment for some patients that cannot be squeezed into the macro budget.

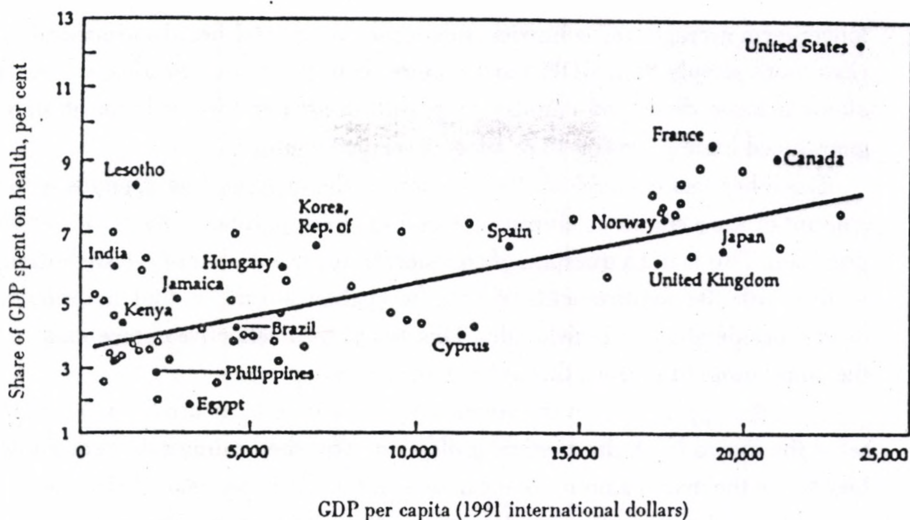

Figure 1 *Income and Health Spending in Seventy Countries, 1990*

Source: World Bank (1993), p. 110.
Note: The data for Hungary are 6% and 6080 international dollars respectively. (See World Bank, 1993, p. 297.)

The dividing line depends on two interdependent factors.

One is how developed the country is–how much the public can afford to spend on health care. The line drawn in Belgium will differ from the one drawn in Pakistan, though Belgians and Pakistanis may need the same total amount of treatment from a purely medical point of view.[12] International experience suggests not only a strong relation between economic development and total health-care spending, but that the proportion of GDP spent on health care rises as a function of level of development (see Figure 1 above).[13] Looking at the

12. Disregarding the geographical and climatic factors.

13. Too much significance should not be attached to the exact position of the regression line in the figure, because there is a high degree of uncertainty about the data behind it. However, it is worth noting that the point representing Hungary is *above* the line. So the calculation suggests that Hungary spends no less, indeed it spends more on health care than its level of development would warrant.

longer-term averages for countries, this means their total health-care spending rises more steeply than GDP. Furthermore, if this relation pertains, it clearly allows a more developed country to provide a greater total volume of state-guaranteed basic provision than a less developed country.

The other factor on which the position of the dividing line depends is the amount of tax a country's citizens are willing to pay to finance the basic health provision. This is not a question of commercial insurance, but of redistribution, in line with the requirements of specific egalitarianism, so that households cannot decide about it individually. This has to be a collective choice made by the community of citizens through the democratic process.

Once the upper limit on the amount to be spent on basic provision has been set at the macro level, the medical profession takes the leading role in deciding how to use the macro amount that can be spent on basic provision.[14] In practice this includes drawing up a schedule of the items that can be financed as basic provision, allotting the funds, and taking other allocation decisions on the micro level.

More will be said later about micro-allocation of the macro sum available. For the moment, let us return to setting the macro limit and the democratic political process this entails. I have no naive expectations in this respect. I realise that this process will not reflect the 'popular will' perfectly. There are several factors that affect the development of voters' preferences, including some that are undesirable according to my system of values. Furthermore, once these preferences have formed, there are frictions and distortions in the way they find expression in the political process. Nonetheless, I am certain there cannot be any substitute for the democratic political process, once the premise is accepted that the *state* will guarantee equal access to basic health provision.

The aim must be to reduce the distortions and frictions appearing in the political decision-making process that governs state financing of health care.

14. I say the leading role, not exclusive responsibility. Committees deciding about micro allocation should also include experts conversant with the economic, legal and ethical aspects of the health system. It is also worth considering the idea enabling voluntary associations of various groups of patients to have a say.

Most such problems arise because the financing of the sphere is opaque. The average citizen is uncertain what is going on. Many people are misled by lies and half-truths into misjudging the situation. These lies and half-truths must be swept aside, so that the state financing gains *transparency*. The following rules would help greatly to achieve this:

1. Let us abolish the misleading term 'social-insurance contribution'. To call a spade a spade, this is not an insurance contribution but a specific kind of redistributive tax (which has an insurance premium component.)

The term applied is not immaterial for two reasons. On the one hand, it has a psychological effect on tax-paying, voting citizens. On the other, it has implications in constitutional law. There is no direct connection here between what citizens *individually* pay to the state and what they *individually* receive from the state. By contrast, an insurance transaction can be expected to provide greater compensation (if there is a claim) to those who pay a higher premium.[15]

2. Let us abolish the misleading distinction whereby employers pay part of the health-care contribution and employees the rest. In fact the employer views the whole contribution as a component of wage costs and effectively subtracts it from the total compensation paid to the employee. Since the whole social-insurance contribution is reckoned against the employee's total gross wage, it is the employee who really pays it. So wages have to be 'grossed up' when the reform is introduced, and the health-care contribution then deducted from them. Employers have to be made responsible for withholding and transferring the contributions.

3. In the light of points 1 and 2, a new kind of 'earmarked' *health tax* needs to be introduced. Basically, this will be a levy of an income-tax nature. At the

15. This criterion came up when the Constitutional Court was examining Hungary's 1995 package of economic stabilisation and adjustment measures. The Constitutional Court called for the kind of 'proportionality' between the social-insurance contributions and the services provided that can be expected of an *insurance* transaction. This cannot be required of a tax, although there are, of course, constitutional limits on taxation as well.

moment of introduction, it will not raise by a penny the fiscal load on any employee who has previously paid social-insurance contributions (along with his or her employer). It will simply express openly and make it transparently plain who is paying for the state-financed health care and how much they are paying.

4. Taxation experts disagree about whether the advantages deriving from the transparency of earmarked taxes outweigh their disadvantages, above all their inflexibility, the way they tie the administration's hands by preventing reallocation. Without wishing to commit myself in the general debate, I would maintain my proposal for an earmarked tax in the health sector. The clear correspondence between the health tax and basic health care could be an effective weapon against the still prevalent fiscal illusion inherited from the socialist system, the false notion that health care is 'free'. There must be legal regulation of all the compulsory, direct co-payments to be paid by patients under the state-financed system of basic provision.

5. It must be emphatically declared that the 'earmarked' health tax and the compulsory direct co-payments are to be used exclusively for financing the basic health provision. Conversely, the same declaration must state that the health tax and the co-payments are the sole source from which basic health provision can be financed. Other items of budget revenue may not be used for that purpose. There must be a one-to-one correspondence between the compulsory payments for basic health provision and the macro sums of the payments made with them.[16]

By these means it will become clear that the community of citizens has to decide, within the frames of legislation, how much the total compulsory payment for basic health provision should be, and thereby, what should be the macro limit on expenditure for basic provision. That will end the intangible spectre of 'under-financing'. Basic health provision will only be under-financed

16. A reserve fund will have to be built up, to bridge any short-term gap between receipts and expenditure. The budget can only be allowed to cover such deficits temporarily, until the reserve fund has accumulated.

if the public, through its political representatives, has voted for a certain health tax and compulsory co-payments, but these have not been collected, through negligence by the authorities charged with doing so. If the sum has been collected, that must be taken to be the macro volume of financing desired and endorsed by the community of citizens.[17]

If some members of the medical profession think this sum is too small, they can 'lobby' to have it raised. They can try to persuade citizens to vote, through their representatives, for a higher rate of health tax and higher direct, compulsory co-payments. If they succeed, they will have a larger macro volume available for basic provision. If they fail, the limit is *determined*, and further argument can only be about allocation of it.

6. Institutional forms and procedures for micro-allocation of the macro budget have to be devised. I think some of this task could be performed by expert committees; there could be a territorial decentralisation of this process. A Health Council would have to be formed, to give direction in principle to the allocation. The members should be doctors and other professionals whose expertise and personal integrity would guarantee that objective and humane decisions were taken. What is needed is a respected body free of political influence, analogous, for instance, to the Federal Reserve Board that runs monetary policy in the United States.

Allocative decisions of two kinds will have to be taken. On the one hand, guidelines, criteria and perhaps itemised lists will have to be compiled, to show what activities can and cannot be covered by basic care, at the prevailing level of macro funding. This is a highly difficult and intricate task, but it has to be

17. Dr Attila Kiss, head of a large Hungarian hospital, interviewed in the country's largest-circulation daily (Tanács, 1998), expressed a view widespread among doctors when he spoke, and I quote, of the 'chronic under-financing' of the health-care system. Compared with what? Did he mean by comparison with the level of financing that doctors working in the hospital could spend to the marginal positive utility of the patients? That is certainly the case, but the same could be said of every hospital in the world.

tackled, to prevent a mass of arbitrary, ad hoc decisions being taken.[18] The starting point can be present practice: basic care consists of the what patients in Hungary generally receive at present. Subsequently, this initial state will have to undergo corrections. As time goes by and the macro budget increases, further activities can be included in the sphere of basic care.

On the other hand, the total will have to be divided among various groups of costs (for instance, wages or equipment), or among various medical treatments and branches (for instance, preventive spending versus treatment of the sick, or internal medicine versus surgery). The simple arithmetic of this kind of allocative decision-making will have to be acknowledged: more for one purpose means less for another. The institutions entrusted with the micro-allocation will have to establish the desirable proportions and priorities. There will be no evading this by demanding a higher macro limit.

7. Patients should receive a detailed bill from the hospital or out-patients clinic, showing as accurately and exhaustively as possible what tests and items of treatment were received and how much they cost. The bill should also show how much of the expenditure is financed out of public funds and how much out of co-payments. If the auxiliary care is later financed by a private insurer, let the insurer's contribution appear on the bill as well.

Naturally this proposal cannot be applied from one day to the next. First of all, the accounting bases for it have to be established. Presenting a bill would encourage financial discipline and more efficient operation. Most importantly of all, it would help to dispel the fiscal illusions by increasing patients' tax and cost-awareness.

18. Although there is no one case that can be clearly taken as a pattern, there is experienc available of setting guidelines of this kind. Much attention has been aroused in the United State by the list compiled in the state of Oregon, containing the health provisions available free to th elderly. Rather than the list itself, the political and professional procedure for compiling it and th principles that lie behind it are what merit careful study. (Among the works setting out th principles for establishing priorities among treatments and international experiences with these including the Oregon project, see T. J. Ho, 1998.)

I have put forward seven practical institutional and procedural proposals. Implementation of these could promote acceptance of the reform among those concerned in it, above all among the general public. It could have a cleansing effect on political debates surrounding health care. The more transparent the connection between public revenue and public expenditure in the health system becomes, the easier it will be to counter the cheap demagogic arguments in favour of less tax but more spending.

It is desirable to reduce the rate of health tax, which will be quite high at the initial state from which the recommended reform begins.[19] However, if the conditions just described are respected, this can only be achieved in the following way:

(i) Most importantly, let GDP grow, and the country's national health expenditure can rise accordingly. However, it should happen in a way that changes the ratio between 'basic provision' and 'auxiliary provision' in the latter's favour. The macro limit to what can be spent on basic provision may rise, but only at a rate lower than the growth of GDP. This will allow the rate of health tax to fall.

(ii) Widen the tax base. The health tax has to be levied also on income that has legally escaped from the social-insurance contribution so far.

(iii) Within the macro limit on financing, raise the proportion of the direct, compulsory co-payments, in other words, reduce the part to be financed by the health tax.[20]

By combining these methods, the rate of tax can be gradually reduced, and to a significant extent, while raising, not lowering the macro limit prescribed for basic health provision.

19. The first, rough calculation was based on the following assumptions: (i) the tax will be levied only on income previously liable to social-insurance contributions; (ii) the direct, compulsory co-payments will not increase; (iii) the total expenditure on basic health care will not fall. Under these circumstances the rate of health tax would be almost 20% of grossed-up wages.

20. It should be noted that although the principle of supporting the needy can apply to direct co-payments, they are far less redistributive in character. Although patients pay only some of the cost, their expenditure is a function of the service received.

Now let us turn to auxiliary provision. The total macro-level volume depend
solely on the combined effect of decentralised individual decisions: how muc
of their money individuals want to spend, directly or through voluntar
insurance, on health care for themselves and their families. I am sure this sur
would be sizeable right from the start and steadily increase thereafter. It is no
only the rich who are prepared to reach into their pockets for the health o
themselves and their families, but many people in the middle and lower incom
brackets as well.

One grave shortcoming of the present system is that it leaves very little scop
for citizens to finance their own health costs if they insist on doing so unde
legal, transparent institutional conditions. The law allows people to spend thei
money for all kinds of extravagant purposes. Yet it leaves no way, under openl
recognised institutional forms, for people to pay themselves for more tests tha
would be paid for out of public funds, or openly to pay more for the doctor o
their choice, who charges a higher fee on the basis of his or her authorit
expertise and reputation. This is a serious breach of principle 1, the autonom
of the individual. One of the main tasks of the reform is to over-come thes
shortcomings and ensure that consumer sovereignty applies to this field, at lea
in part.

When this change has occurred, along with the reform of public financ
described earlier, it will emerge what total health-care demand is generated b
the two main kinds of financing, public and private. With some distortion an
friction, this will express how much the country is willing and able to spend o
the sector.[21] This is the level of health-care financing that the community o
citizens accepts, through the mediation of the political process and the healt
care market. In my view, financing the demand in this way constitutes th
complex procedure whereby a democratically arranged market economy, und
present Hungarian conditions, can address the fundamental problem o
scarcity of health-care funding.

21. Mention has not been made so far of the curious 'grey economy' in the health secto
financing in the form of gratuities to staff. This is considered later, in the next section. So long
gratuities continue, they augment the financial resources of total demand, of course.

To conclude the sections on the financing of demand, it becomes possible to sum up the answer to the first question put in the introduction. The question was, who is authorised to decide on inclusion-exclusion matters? The procedures and institutions recommended in this study break this overall decision down into several partial decisions, and divide the spheres of authority as follows:

1. All citizens have a right of access to basic provision, guaranteed by the state.
2. The community of citizens, by way of the democratically elected parliament that represents it, alone has the right to establish the macro budget for the basic, publicly financed provision accessible equally to all. This is where the main dividing line runs between the competence of the state and the competence of the individual.
3. The bodies of doctors and other professionals have primary responsibility for deciding the specific micro-allocation of the macro budget voted for basic provision.
4. In addition to that, all citizens may decide in a sovereign fashion what auxiliary provision to buy with the intermediation of the market.

5. Reform on the Supply Side

The two previous sections examined the financing of the demand for health care. Let us now turn to the supply side, the provision of health care. I had a curious feeling of *déjà vu* as I studied the present state of Hungarian health care. What I found was reminiscent in many respects of the reforms conceived in the final stages of Hungary's Kádár period, in a spirit of 'market socialism'. The situation then was described as 'neither plan nor market',[22] but a mixture of the two that tended to combine the drawbacks rather than the advantages of each. While the 'business segment' of the present-day economy operates according to the rules of a real market economy, most of the health sector is a whole chapter behind, still immersed in 'market socialism'.[23]

22. Bauer (1983).

23. What I term the business sphere is the sum of the sectors of the economy that operate outside the welfare sector (or social sector in American parlance). This is commonly called the 'competitive sphere' in Hungarian economic jargon, which reflects a public conception–a feeling that competition is admissible in the business world, but not in the welfare sector.

State ownership continues to dominate the secondary and tertiary levels o health provision: specialist outpatients' clinics and hospitals. However, th assignment of real property rights is muddled and opaque. According to th letter of the law, the owner of such facilities is the local government. The loca government appoints the responsible head of a hospital or a clinic, but i practice it has no say in its financial matters, not least because it has n resources for the purpose. Again according to the letter of the law, the head o a hospital or clinic has wide powers and responsibilities. In actual fact his o her hands are tied in sundry ways, and there is frequent intervention fro above, just as there was under the ambiguous system of market socialism. O the other hand, the head of a hospital or clinic can take advantage of the fac that the budget constraint is a soft one. Although there is a budget that has bee passed, exceeding it does not have dangerous consequences; eventually th unpaid bills will be met and the debts written off. If the financial authoritie should try to impose some financial discipline, a protest movement immediatel springs up, outraged that patients may be left without treatment on inhuma fiscal grounds. In cases like these, no attempt is made to tackle the fundamenta problem of scarcity in health provision in a constructive, co-operative way. It i approached in a destructive fashion, with 'each man for himself', which create anarchic conditions. The money goes to those who shout longest and loudes The outcome is that budgets are regularly exceeded and costs soar unrestraine

In some ways the situation is worse than it was under 'market socialism'. Th allocation of investment, meagre in any case, is almost totally centralised, an depreciation procedures are unsettled. The system of wage control is mor centralised and rigid than it ever was during the market-socialist reforms, an even under the extreme, classic command economy that preceded the Doctors and other health workers count as public employees, which constrain their pay within a rigid, narrow scale.

Conditions incompatible with a market economy are also conserved by the fac that the social-insurance system is the sole buyer from a hospital or a clini Although the social-insurance system has no administrative authority over th providers, its dominant, monopsonistic position allows it to dictate its own term

As with the business sphere under market socialism, one of the mai

achievements of the post-socialist health system is that a legal private sector has appeared, operating in a narrow sphere in various forms:

- The most important reform so far has been privatisation of the primary level of provision. Most primary-care physicians[24] have ceased to be public employees since the reform, and have contract relations with the social-insurance system. Although the privatisation has not been consistent, so that there are still many strands tying primary-care doctors to local government, it has been a great step forward towards creating a health-care market.
- Many doctors and some other health-service employees (physiotherapists, masseurs and so on) whose main job is in a state hospital or outpatients' clinic, run a private practice as a sideline. However, individual private practice accounts for only a tiny fraction of all medical provision.
- There already exist a very small number of privately run hospitals, clinics, laboratories and other health-care institutions employing a larger number of staff. (See Table 1 overleaf)

Alongside this legal, restricted private sector there is a flourishing and widespread 'grey economy'. It is a widespread practice for patients to give gratuities to the doctor or other medical staff who treat them.[25] The main recipient is the doctor in direct contact with the patient, although with hospital treatment, a gratuity is often given to that doctor's superior, the chief physician of the department. It is customary to give gratuities to nurses, masseurs, physiotherapists, and others who administer diagnostic tests. Patients feel they are not only expressing thanks, but paying for the special attention or even privileges they have received–for instance, not having to queue for a test or an operation, or simply for admission to hospital. Patients give gratuities so that they will be placed in a smaller ward or even a private room. There is no transparent scale of tariffs, of course. Patients are unsure of themselves, and ask

24. *I.e.* general practitioners, who are known in Hungary as 'house doctors'.
25. The Hungarian euphemism is 'gratitude money'.

Table 1 *Private Specialist Practices in Budapest*

Number of specialists practising in Budapest[a]		Number of private practices in Budapest[b]		Ratio of sel[f-] employe[d] specialists (column 2/column [1] per cen[t])
Internists	1 979	Internal medicine	319	16.
Surgeons	927	Surgery	111	12.
Obstetricians/ gynaecologists	410	Obstetrics/gynaecology	230	56.
Paediatricians	639	Paediatrics	83	13.
Lung specialists	249	Lung	36	14.
Ear, nose and throat specialists	249	Ear, nose and throat	80	32.
Oculists	275	Ophthalmology	96	34.
Dermatologists/ venereologists	174	Dermatology and venereology	127	73.
Neuropsychiatrists	562	Neurology and psychiatry	165	29
Urologists	161	Urology	50	31
Dentists and stomatologists	1 108	Primary-care dentistry and special dentistry	1 189	107
Physiotherapists and masseurs	707	Physiotherapists and massage	125	18

Sources: Column 1: CSO (1996a), p. 172, Columns 2 and 3: communication by the Budapest Municip[al] Public Health and Medical Office, 1997.

Notes:

[a] The numbers in this column do not include all the specialists active in Budapest.

[b] Licences were issued under several covers: physician in private practice, health-care entrepreneu[r,] private clinic.

[c] A doctor may work in several clinics, and a clinic may employ several doctors, so that the quotie[nt] of Columns 2 and 1 may show distortions in each direction. Unfortunately, data are only available broken down in Columns 1 and 2. Column 3 would only show the real ratio if all private clinics employ[ed] only one doctor, and all doctors practising privately only worked in one clinic. With dentists the ratio [is] more than one, which means that many dentists work in more than one surgery.

each other how much to give; often they try to outbid each other, to make sure they receive the extra attention they are buying.

The doctors and other health staff have ambivalent feelings about this practice. A relatively small number of them profit greatly by it. Some hospital heads of department are almost feudally possessive about the beds in their wards, waiting for a rake-off from all who occupy them. Undoubtedly, the range of some kinds of provision available is not unconnected with whether the patient pays a gratuity, and if so, how much. Nonetheless, most doctors and other health staff feel that gratuities are an unreliable, unpleasant, and often demeaning way of being compensated for their work. They do not let their relations with patients depend on how much gratuity they pay. However, that does not mean that for many of them this is not an accustomed and indispensable component of their family income.

What direction should the reform take?

I think it is desirable for the private sector to expand. Foreign experience, not just in Europe but in the United States, shows that even in a developed market economy, there remains a high proportion of hospitals and clinics that are publicly owned, or run by non-state, non-profit organisations. Nonetheless, looking at the proportions in Hungary today, there is still room for the private sector to grow very substantially.

There is no need for any uniformly conducted privatisation campaign that follows centrally devised patterns and has a completion date by which the publicly owned organisations have to be transferred to private hands.[26] Institutions based on private ownership, or various combinations of private and public ownership, should be allowed to develop in many different forms, through initiatives from below.[27] Equipment, premises or provisions in public hospitals and clinics could be leased to private health-care businesses. So long as the buyers are professionally and commercially reliable, state-owned

26. My recommendation for the business sphere was always to avoid privatisation campaigns and the imposition of uniform, schematic solutions. Instead I advised a more varied, evolutionary approach to the transformation of ownership relations.

27. Combination of private and public ownership did appear already in Hungary. See Orosz (1995).

organisations could be sold outright to private firms or non-profit institutions. Much wider scope needs to be given for professional groups of doctors or other health staff to establish private firms that provide specific services. It must also become possible for decentralised, independent, for-profit or non-profit insurance institutions to arise, integrating the functions of insurance and primary-care medicine.[28]

It would be desirable for the unfortunate gratuity system to end eventually which would benefit both patients and staff. There is no need for strong administrative bans on gratuities, or for efforts to enforce bans by imposing penalties. Interventions of that kind have been tried in the past, but they have never succeeded. Gratuities need to die out naturally. They will become superfluous once there is organised, institutional auxiliary provision, a fai system of financial rewards for doctors and other health staff, and lega differentiation of earnings.

6. The Interaction of Supply and Demand

It is essential for the expansion of the legal private sector and for the atroph of gratuities to have essential changes in the system of financing, beyond the ones discussed in Sections 3 and 4.

One of the keys to success for the reform is to apply the principle of *secto neutrality*. This, in Hungarian economic parlance, means the following:

Buyers, even if they are buying with state funds, should not make thei purchases dependent on whether the seller belongs to the state sector or th private sector. The period of market socialism was remarkable for a failure t apply this principle. When a state-owned enterprise or a state authority bough inputs, it had to obtain them from state-owned enterprises wherever possible This was either laid down as a rule, or if not, it was imposed on senior state sector officials by the official climate of opinion. A private firm or self-employed supplier could only be considered if there was no state suppl

28. These could resemble in their operational sphere and regulations the HMO or othe 'managed health care' organisations found in the United States. See Feldstein (1994).

available. This pampered and gave privileges to the state sector, and held back the development of the private sector. Remember that the input requirements of state-owned firms formed the overwhelming majority of aggregate demand at that time. This situation has remained to this day, not in the economy as a whole, but in the health sector. The publicly funded social-insurance system is not impartial about whether to buy from the state or the private sector. It discriminates against the latter. To some extent it is forced to do so by the current regulations, and to some extent it shows bias voluntarily, so to speak, because its managers know this is what is expected of them. So the public spirit of the socialist period (priority for state ownership) lives on in the health sector.

Let us take dentistry as an example. The social-insurance system pays fees to the dentists in state clinics for their work according to a set price schedule. Patients entitled to it according to the regulations receive the treatment free or against a co-payment. Let us suppose that a private dentist will charge a higher fee for some treatment than the social-insurance system is paying for the compensation of doctor employed by the state. At present, if patients covered by social insurance go to a more expensive, private dentist instead, the social-insurance system does not even pay the part of the bill it would have paid if treatment had taken place in a state clinic. This is a typical infringement of the principle of sector neutrality. It gives patients a strong financial incentive not to go to a private dentist, which restricts his or her potential earnings.

Nonetheless, many patients go to private dentists, because they hope for better treatment and they can still afford the cost. On the other hand, most patients would not have a stomach operation in a private hospital and pay the full price of it if the social-insurance system would pay for the operation in a state hospital.[29] So without demand generated by the social-insurance system, the supply offered by private hospitals does not extend to treatment that the social-insurance system finances in the state sector (and only in the state sector). This prevents the development of the private sector, which would be incapable

29. It is another matter that the patient receiving the 'free' operation in the state hospital gives a gratuity to the surgeon as a precaution.

of surviving if all its income came *only* from the patients' pocket (directly, c
through private medical insurance).

Applying the principle of sector neutrality will mean that treatment
financed out of public funds, according to a clear price schedule, regardless c
the ownership form of the provider. That will be the minimum compensatio
a fair price for giving the treatment in a reliable, professionally correct way, t
an *average* standard. The reform will allow provider and patient to agree, withi
legal bounds, that the latter pay an *extra fee* for treatment, if the provider cal
for it and the patient feels it is worthwhile. That will not deprive either side c
the sum financed from public funds.

It will give an enormous boost to expansion of the private sector if secto
neutrality becomes general. Healthy competition will develop betwee
organisations offering the same types of provision, irrespective of the
ownership form. Such competition will leave patients less defenceless an
encourage higher quality and greater efficiency.

At the same time, the changes proposed will drive out gratuities. On the or
hand, patients will feel they now have a real chance to buy above-averag
treatment for extra money. On the other, the pay of doctors and nursing sta
will become legally differentiated. Pay differences will emerge, not only betwee
public and private health care, but within publicly owned organisations as we
This will contribute to the simultaneous assertion of principle 2 (public fundir
of basic care to an average standard) and principle 1 (the sovereign right fo
individuals to buy treatment they judge to be better than average).

One of the foundations of economics is that supply creates demand ar
demand supply. The present situation is one in which both private supply ar
private demand are very limited, which reciprocally restricts their expansio
Sector neutrality will allow this vicious circle to be broken. If demand expan
rapidly, it will become worthwhile creating private supply for treatment that h
hitherto been a monopoly of state organisations. This wider supply will provic
an attractive field for private medical insurers as well. So far there has bee
nothing to finance with private insurance. In this way there can develop
'virtuous circle', in which extra demand promotes extra supply, which furth
enhances private demand, and so on.

Based on what has been said, it is possible to refine the statement at the end of Section 4. Sector-neutral financing makes it all the more possible for the country's total health expenditure to reflect the sovereign choices of the community of citizens, not the preferences of politicians in charge of central planning. It is not just that the community of citizens will decide, through the political process, how much health care to finance out of their taxes, apart from the sums covered by private sources. It also means that citizens can choose how much of this tax-derived public money earmarked for health care to spend in the state sector and how much in the private sector. This enhanced opportunity to choose may induce the community of citizens, through the political process, to express changes in their preferences and devote more (or less) to financing health care through the tax system.

To conclude the discussion of demand and supply, let me return to the first question in the introduction, about who is authorised to take the decisions relating to health care. Transforming the ownership relations on the supply side, placing material incentives on a sound basis, and stimulating market forces will all help to give both to patients and to doctors and other health staff a more active, effective role in making specific health-care decisions.

Let me say here that restrictions of space prevent me from discussing in this study several other essential aspects of the reform. These include the following:

- What changes should be made in the province and responsibilities of central and local government in financing health care, exercising financial and professional supervision over it, and in the distribution of property rights?
- How should the settlement between the health-care provider and the financing institution take place? To what extent should there be a 'fee-for-service' proportionate to the treatment given or a 'capitation' calculation proportionate to the number of patients treated? To what extent should it be possible to tie down a certain provider's capacity in advance by contract, and so on?[30] The various methods of calculation produce quite different sets of favourable and unfavourable incentive effects. These questions certainly need

30. A comprehensive review of this sphere of problems can be found in Newhouse (1996).

clarifying, whatever the outcome with the financing institutions (tax, private insurance) and with the property relations discussed in detail in this study.

7. Concluding Remarks: What Support and What Resistance to Expect

The reform, which my book explores in more detail and of which this study presents a few of the main ideas, does not entail radical financial restriction or spending cuts at the expense of patients. It does not promise rapid results, but it can bring a lasting improvement in the medium and long term. It can distribute the tax burden more equitably. It may also reduce the tax rates, improve incentives, and develop competition within the health sector that encourages more efficient provision. There is no obvious reason why the reform should attract appreciable resistance. It could count on broad, mass support.

In reality, however, the reception for the future reform is unlikely to be so enthusiastic. For one thing, there will be some who are temporary or permanent losers by the transformation. For another, many who will not lose, or may actually gain, will be afraid of the change because they judge their interests mistakenly, or because they fear change as such.

The medical profession will presumably be divided in its reactions. There will be a direct loss to only two, partly overlapping groups. One consists of those whose position gains them more in gratuities than they would obtain by legal means through professional competition among doctors. The other consists of those who owe their present position of authority mainly to the bureaucracy and would find themselves relegated in a more market-oriented health sector. In fact the majority of doctors would gain by the changes. The greater the extent to which market forces apply in a country, the higher the medical profession rises on the earnings list. (See Tables 2 and 3.) The reform will mean that doctors who have hitherto received humiliatingly low wages can receive higher earnings by open, honest means. Their independence and opportunities for initiative and enterprise will increase.

The general public will be affected by the changes in two capacities. As *patients*, the one real change for the worse will be that they have to make a greater co-payment for many treatments and medicines that come within the

Table 2 *Physicians' Incomes in Germany*

Basis for comparison	Average income of physicians compared to average income of other groups of earners (per cent)	
	1989 (Federal Germany)	1992 (United Germany)
All earners	313	404
Civil servants	296	382
Architects	214	163
Lawyers	140	144

Source: The table was compiled by Roland Habich (German Institute of Economic Research, Berlin) on the basis of official German income-tax statistics.

Table 3 *Physicians' Income by Selected Specialities in the United States in Comparison with Average Incomes, 1993*

Speciality	Average income = 100
Average income of physicians	496
Primary care	350
General surgery	716
Anaesthesiology	701
Radiology	763
	Average income of those with university degree = 100
Average income of physicians	286

Sources: The data on average incomes used as the basis for comparison come from the U.S. Bureau of the Census (1996), p. 462, and on medical specialties from the Physician Payment Review Commission (1996), pp. 307-320, and were collected by Karen Eggleston.
Note: Those included in the table hold university degrees not higher than Bachelor's degrees.

sphere of basic provision. Political wisdom would suggest that this extra load be placed on the shoulders of the public gradually, in line with the general rise in real earnings and the improvement of health-care services. On the other hand, patients will experience several favourable changes: greater freedom of choice, a more open and transparent payment system, a lessening of their defencelessness, and eventually, an improvement in quality.

The changes will also affect citizens as *taxpayers*. It will certainly be an advantage here if the situation becomes more transparent. This will also give citizens a clearer sense of how much they pay personally for health-care purposes and how much they receive in provision.[31] There will be some people who achieve a positive balance, because they have paid relatively little, but a lot has been spent on them and their dependants. There will be some who feel they are on the losing side, as insured persons (because luckily they are healthy) and/or as taxpayers (because they pay tax on a high income.)

Up to now, the main cost of financing basic health provision has been borne by wage and salary-earners. (See Table 4.) The greater the success in altering the proportions of the tax load and widening the tax base–one of the reform's tasks–the more today's free-riders' can be drawn in as taxpayers. This brings up one of the well-known problems of political economy: the relation between the distribution of the tax burden and the political voting preferences of citizens. Today, the load of health-care expenditure is unfairly distributed. Altering that

Table 4 *Distribution of health-care provision in kind financed by social insurance and social insurance contributions in 1995*

Categories of insured	Average per capita expenditure (HUF)	Proportion of the population (per cent)	Proportion of the provision (per cent)	Proportion of financing (per cent)
Old-age pensioners[a]	51 350	23.2	44.8	21.3
Employed	20 708	31.1	24.3	68.0
Self-employed	20 708	7.5	5.9	3.3
Unemployed	18 474	2.2	1.6	1.7
Other[b]	17 300	36.0	23.4	5.7

Source: World Bank (1997).
Notes:

[a] Contributions of pensioners were not deducted from pensions, but paid by the pension insurance system out of its budget, in proportion to the pensions. As the study relates, this arrangement ended in 1997.

[b] All those insured as dependants of the insured, whose contributions are paid by the budget.

distribution and imposing tax on hitherto untaxed income will gain the reform friends and enemies in parliament. The resistance is likely to be lessened because many of those who oppose redistributive taxation in general are more prepared to accept a specific egalitarianism in health care. They will endorse this more easily if it can be guaranteed that the extra tax they pay will be used exclusively for ensuring that everyone has equal access to minimum, basic health-care provision.

That leads to consideration of another question. How are the proposals outlined likely to be received in the political sphere? Transparency will be attractive to those advancing a clear, open health-care and taxation programme, and repellent to those wanting to avoid taking a clear position and continue to side-step the sensitive questions of taxation and spending. The constitutional solutions proposed will be attractive to those who want to set the main figures for public spending by parliamentary means. They will be repugnant to trade unions and employers' federations whose representatives have so far had special powers over decisions on health-care finances, which they would lose under the reform. Finally, the position taken by politicians will depend on the social groups on which they build their support and on the set of values they put before their voters. The more they identify with the postulates put plainly at the beginning of the study, the more prepared they will be to support the reform. If they profess principles strongly opposed to those postulates (for instance, an extreme individualist, or on the other hand, an extreme collectivist position), they will also reject strongly the practical proposals as well.

The reform outlined here should certainly be introduced gradually. As I mentioned earlier, there has to be time for the new institutions required to develop. There has to be time for people to adapt. A further argument for a gradual approach could be added here. There has to be time for the people concerned to comprehend the changes and how they affect their interests. Having said that, I would risk the following statement. Once the misgivings and anxieties have been dissolved and the effects of the changes have been presented objectively, the majority of the public will come out in support of the reforms.

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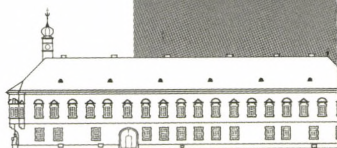

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