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Challenge for Effective Health Sector Governance in Hungary: Co-operation between the Medical Profession and Government

by

Pavel Ovseiko

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**Center for Policy Studies
International Policy Fellowships**
(Affiliated with the Open Society Institute and Central European University, Budapest)

Abstract

This paper examines the practices and incentives in the Hungarian health sector that hinder its effectiveness, efficiency and equity along with the issues that clarify the low problem-solving capacity of the health sector governance system. The paper begins with an outline of the major problems facing health sector reform; these problems were inherited from the past and emerged or were aggravated during transition. Then cardinal changes in the health sector brought about by democratisation, liberalisation and decentralisation are discussed. It further focuses on the outlining interests, organisation, and power of the medical profession as one of the key actors in the health policy arena. Finally, the paper makes a suggestion for policy change to minimise the effects of the phenomena that hinder effective, efficient and equitable performance of the health sector (under-the-table payments and adverse incentives) by introducing a system of regulation and policing. In this connection, interaction between the Government and medical profession is analysed. The paper argues that although co-operation between the two actors could contribute towards introduction of the regulation and policing system, it is unlikely that the Government and medical profession would manage to establish a co-operative mode of interaction because their dominant strategies are to compete.

Keywords: Hungary, Health Sector, Transition Reforms, Governance, Medical Profession, Interest formation, Prisoner's Dilemma Game.

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In facing the future we start from the present. To a substantial extent, future choices reflect present judgements of past achievements.

Rose and McAllister, 1986, p.3

The results [of health care reform] is a difficult process of negotiation between key actors as defined by each society's history, traditions and culture.

Saltman, R. and Figueras J,1997

Introduction

Revolutionary transformations in the beginning of the 1990s brought about organisational, financing and technological changes in the Hungarian health sector. Today, the health sector is no longer financed via general taxation and run by the central government; hospitals and doctors can have access to modern management and administration technologies and up-to-date equipment and drugs. These changes, however, led neither to considerable improvements of the health status of the population, nor substantial equity and efficiency gains for the health sector. Today, the public money is often spent on new hospitals and wards even when there is no evidence that they are required, or on expensive equipment and drugs even when their cost-contained counterparts could be employed. The challenge, therefore, is to increase effectiveness and efficiency of the existing health system. This paper addresses one of the fundamental aspects of this challenge—effective health sector governance—i.e. capacity of the Government to implement policies that both effectively and efficiently solve the existing problems (Hay, 2002).

On my analysis, three problems account for the inadequate effectiveness and efficiency of the Hungarian health sector. First, there is a widespread belief that curative health care can retroactively improve health status of the population (Mihályi, 2002). However, achieving and maintaining health is not primarily a matter

of curing illness. In general, curative health care accounts for no more than twenty per cent of factors affecting health status. Along with physical and social environment, life style, in particular, dietary, tobacco, and alcohol habits are the most important exogenous determinants of health. The most significant health gain can, therefore, be achieved by improving environmental, social and economic conditions that influence one's ability to make health-enhancing life-style decisions (Evans, Barer and Marmor, eds., 1994). As such, measures of public health concerning health promotion, hygiene, sanitation, epidemiology, environmental and occupational health and safety should be the baseline measures of health sector reform seeking to significantly improve the health of the population. Inevitably, such reform cannot yield positive results immediately. Health sector reform seeking to substantially improve the health status of the population should put an emphasis on preventive rather than curative measures and it should be carefully planned with a long-term view¹. Second, Hungary inherited from the previous Socialist health system a very strong imbalance between the outpatient and inpatient care in favour of the latter. Inpatient care is costly; therefore, an efficiency gain can be achieved by treating patients (when it is appropriate) in outpatient settings. Finally, rent seeking, free riding and moral hazard behaviour—examples of purposeful abuse of public funds and facilities—from both doctors and patients, hinder efficiency and equity improvements in the health sector². Also, non-purposeful mismanagement accounts for considerable efficiency losses. Thus, through regulation and policing, introduction of incentives for efficient performance, and professional education of hospital managers can both efficiency and equity gains under the existing health sector arrangements be obtained

To simply identify problems and their potential solutions is not enough for successful health sector reform. It is equally important to ensure that the health sector

¹ It is difficult to implement measures of preventive health care not only because of economic and politic challenges for the Government but also because of the moral hazard behaviour on the side of the population. When people know that social health insurance pays for the medical treatment, they do not intentionally damage their health but simply take fewer measures to prevent illness. As a result, they still require medical treatment.

² Often, purposeful abuse of the health care system on the side of patients reflects the problem of dividing health care from both social care for the elderly and social assistance. For example, having no nursing homes or visiting nurses, many elderly patients are forced to seek help in hospitals. Another example, many poor people, especially in impoverished Eastern part of Hungary, use their publicly funded free access to drugs to obtain drugs for their families, relatives in Romania and Ukraine, or to simply sell the drugs in order to make a living (Stubnya, 2003).

governance system can handle the reform. Many well-grounded proposals for reform failed simply because the health sector governance system could neither implement nor sustain the proposed policies. The longer we depart from the time when revolutionary transformations were possible, the more “path dependent” and bounded the development of the health sector has become to incremental improvements (Wilsford, 1994). Finally, radical changes, especially ones that require new institutions, are procedurally expensive. There is, therefore, a glaring need to refrain from dreaming about costly radical changes in favour of figuring out the nuts and bolts of feasible incremental improvements. To put it bluntly, the whole debate on health sector reform should be re-framed in terms of effective health sector governance.

The first step in this direction should be a careful investigation of interest formation in the health sector and how transitional reforms affected the problem-solving capacity of the health sector governance system. Apparently, since 1989, the Hungarian health sector has undergone cardinal changes in three directions: democratisation, liberalisation and decentralisation.

I. Cardinal Changes in the Health Sector Governance System

I.1. Democratisation

Democratisation superimposed on the health sector governance system political competition and uncertainty every four years. For health sector reform, it created the problem of a short time horizon. Theoretically, political competition provides a good opportunity to have a sound health sector reform plan resulted from competition between rival political parties. In practice, however, health care reform never tops the political agenda and competing political parties do not have clear positions regarding fundamental issues of health sector financing and organisation. During an election, the non-incumbent political party often does not develop a plan for health sector reform. Instead, the political party concentrates on issues that can help it win the general election. Thus, when the non-incumbent political party takes office, it does not have a plan for reform. It takes a year for a new government to catch up with work and to implement primary electoral pledges and then another year to develop a vision of health sector reform (Magyar, Cs., 2002). Having two years in office left, the government realises that the last year should be spent on preparation for the new election. Although health care reform never tops the agenda, it is still a very sensitive issue. Superficially, the government avoids any ambitious reforms in the election year. As such, the government has just a year left for the reform. Unfortunately, a year is hardly enough for comprehensive health sector reform to be implemented and to yield obvious positive changes. As such, having a short time horizon, the government wants to minimise or avoid costly and risky reforms. Thus, it focuses on crisis measures, incremental changes and symbolic politics³.

Democratisation also enabled the medical profession and other agents of the health sector to influence health policy process. In doing so, they bring in their expertise into health policy-making and legitimise new policies. In helps to avoid costly mistakes

and make new policy sustainable. Whereas various health sector agents can informally influence health policy process, there is a lack of transparent institutions that would facilitate their participation in health policy process. It is important to recognise that democratic participation of health sector agents in health policy process is a powerful instrument of effective governance. When doctors and agents of the health sector alike are placed in a system, which seemed effective and efficient for its designers but not for people actually working in this system, they have two options. One, if the economic benefits of non-compliance are higher than the penalties, the system will not be complied with. Two, if the system does not serve the interests of the parties involved but the penalties for non-compliance are high, they will either covertly game the system, or openly rebel against the system. For success, therefore, of any new health policy, three factors are important:

- transparent democratic participation of the medical profession and other health sector agents in health policy processes;
- scrupulous calculation of costs, benefits, and opportunities that a new policy produces (including benefits from under-the-table payments, opportunities provided by adverse incentives, and other real-world phenomena),
- effective regulation and policing of the health sector.

On the other hand, democratic participation of the health sector agents comes at a high price for public good. Naturally, doctors, pharmaceuticals, commercial providers of health services, and interest groups alike want the public to pay more for health services and drugs. The more affluent members of the public that can afford paying for health care also want to have expensive health services and drugs. In sharp contrast, the general public interest is to have more cost-contained health care services and drugs. As such, in theory, health sector reform represents a political struggle of the public interest represented by the Government against private interests of doctors and the medical industry. In reality, given the practice of rent seeking, the

³ As a solution for the short time horizon problem, Vice-President of the Hungarian Medical Chamber Dr István Szilvási proposes restoration of the monarchy in Hungary. This shows that, values of democracy and effective health sector reform do not necessarily go together. Consequently, survival of democracy in Central and Eastern Europe may be endangered by the inability of democratic governments to solve problems of the health sector.

Government in this struggle may support health sector interest groups. Members of the public who can afford expensive health care are on the side of the health sector interest groups. Naturally, patients who can pay, want to have expensive and high-quality health care immediately instead of the prospect of having cost-contained health care at a later date. It is no surprise that currently, the public interest in the aforementioned struggle seems to be the loser⁴.

Health sector interest groups are financially powerful and politically well connected. Thus, they are successful both in formal negotiations and in clenching shady deals with the Government⁵. Unfortunately, it takes a long time to nurture patient rights groups and other institutions of civil society that could effectively counterbalance the influence of health sector interest groups. Participation, therefore, of health sector interest groups in health policy-making process highlights the problem of having established democratic political institutions that can effectively resist private interests and maximise public good.

1.2. Liberalisation

Liberalisation of the health sector in many cases offered market mechanisms to fix problems of misallocation of funding. For example, under the previous health sector financing system, health sector institutions were funded according to historical data rather than actual demand. Introduction of Diagnosis Related Groups (DRGs) in hospitals and the German point-billing system in outpatient clinics were aimed to establish evidence-based financing. At the same time, liberalisation dramatically reduced the role of the state in the health sector and granted doctors and the medical industry with almost unlimited freedoms to pursue their private interests at the public or the patient's expense. Furthermore, liberalisation made the whole idea of limiting

⁴ The public interest is a loser not only in Hungary. America provides a far more dramatic example of how private interests vested into the health sector counteract reforms. The health care reform of the Clinton administration failed to establish a comprehensive public health care system in the United States, leaving about one fourth of the Americans with a pride for having the most expensive and technologically advanced in the world health system but without health insurance.

individual and corporate maximising behaviour by regulation and policing unpopular. As a result, transitional reforms disabled state regulation and policing of the health sector as well as did not create private mechanisms for regulation and policing such as independent health insurance funds.

Introduction of fee-for-service financing system under the National Health Insurance Fund (NHIF) created incentives for uncontrolled health care spending. The NHIF cannot police activities of doctors and patients by regulating treatment procedures and limiting expenditure on treatment of given conditions. Rather, the NHIF passively pays bills for all the prescribed drugs and treatment including unjustifiably expensive ones. All in all, the state supplies doctors with health care facilities, basic salaries and does not control their professional conduct. Arguably, the fully privatised health care system would be far more efficient. However, *inter alia*, doctors oppose privatisation for the reason that they already run their *de facto* private practices using public facilities without paying for the equipment, office space, auxiliary staff, etc. Also, as their *de facto* private practices are part of the shadow economy, they do not pay taxes.

1.3. Decentralisation

Decentralisation provided the health sector with the utmost stability. Local authorities can guarantee much better than the central government that the health care facilities are maintained and developed properly. Decentralisation, however, also created mechanisms to generate inefficiencies in health sector funding. Apparently, for any given locality, a hospital means security. Thus, local governments want to secure health care facilities that are as good as the best clinics in Budapest, even if there is no justified need for such facilities⁶. Furthermore, health care divisions of local governments still do not possess enough expertise to supervise the decisions of the

⁵ The problem of a short time horizon stimulates politicians to get engaged in shady dealings. Given that politicians are in office for only four years, they are very keen on maximising personal pay-offs from their positions.

⁶ In modern health care, more serious cases should be treated at a higher institutional level. Therefore, it is not only inefficient to have a full range of health care facilities in every locality but also dangerous for patients. In localities where frequencies of certain cases are low, patients should be referred to hospitals where doctors are experienced enough to deal with the cases.

hospital managers who apparently want to have more hospital space, expensive equipment, staff, etc. Altogether, compared to other countries, the Hungarian hospital system is not over-fragmented but it lacks sufficient, for the present degree of decentralisation, planning and co-ordination mechanisms (Kovácsy, 2003). In terms of health sector financing, decentralisation created free riders. Namely, patients from small villages are referred to hospitals of nearby towns and cities. Currently, however, these small villages do not participate in financing the hospitals they refer to (Magyar, L., 2003). Lastly, the local authorities have rights to appoint the hospital management. It politicises the technocratic process of hospital management and creates room for rent-seeking behaviour. By and large, having limited funds for the maintenance of local hospitals and no competence in health sector financing and organisation, for the time being, makes local authorities unable to be active agents of health care reform seeking to bring effectiveness and efficiency changes. Overall, for local authorities, the responsibility for the maintenance of health care facilities is a curse rather than a blessing.

* * *

Below, in order to point out where in the current health sector arrangements inefficiencies arise and how to cope with them, I will consider interests and powers of one of the major players emerged in the health policy arena during transition, i.e. the medical profession. In doing so, I will build my explanations on the assumption of rational maximising behaviour. My explanations will follow the tradition of methodological individualism, viz. explanations will be done in terms of facts about individuals. As individuals have the ability to act in a representative capacity and act as representative of larger units, i.e. the profession, the Government, etc., I will include such composite units in my analysis as well. Furthermore, as individual choices are channelled by institutions, I will incorporate them in my explanations as well. All in all, in order to point out problems of inefficiency in the existing health

sector arrangements and how the current health sector governance system can solve them, I will use tools of actor-centered institutionalism⁷.

⁷ The framework of actor-centered institutionalism developed by Renate Mayntz and Fritz Scharpf (Scharpf, 1997) and adapted for analysis of health sector reform in Eastern Europe by Pavel Ovseiko (2002).

II. Interests and Organisation of the Medical Profession

II.1. *Under-the-table Money*

Despite the public perception of doctors as a special “cast” in society, they are just normal rational human beings. Apart from providing health care for the patients and mastering their profession, the interests of doctors often focus on earning a decent living with less effort. It is true, however, that doctors are special in the sense, that apart from official salaries, they can earn up to 90% of their actual income from unofficial or under-the-table payments⁸. It comes both from the patients and from the medical industry. According to a long tradition, many patients feel almost obliged to offer doctors money or a gift as a kind of tip in gratitude for the service or even as a gesture of social solidarity with doctors who are believed to be underpaid. In the majority of cases, however, under-the-table money is not a tip but rather a bribe or payment for a private service (Kornai, 2000). Patients bribe doctors in hopes of receiving a better prescription, securing more attention, jumping a queue, being referred to a hospital in order not to pay for the prescribed drugs, receiving a sick leave, having a privilege of being treated in a high-profile hospital or being treated by a leading specialist.

Under-the-table money has negative effects on a) equity, b) effectiveness and c) efficiency of the health sector. As far as equity is concerned, under-the-table money discriminates against patients who are unable to offer the money and patients from disadvantaged backgrounds. The latter needs explanation. In fact, doctors perform only part of their duty on the payment basis. In cases where an expertise of highly qualified doctors is needed, a patient in order to get access to such doctors needs to

⁸ Hungarian terms for under-the-table payments are *hálapénz* (gratitude money) and, what is unique for the health sector, *paraszolvencia* (pay on the side). Before the WWII, private doctors charged patients an extra fee (*paraszolvencia*) in order to raise for the so-called “small fund” (*kis kassa*). Recourses from this fund were distributed among young doctors and the auxiliary staff in order to provide them with a material incentive to stay in the profession. It is likely that today in some exceptional departments and clinics under-the-table money is also redistributed. Even if such form of professional solidarity exists among doctors, it is a little consolation for patients to know this. For patients—who used to pay high fees for privately-owned health services many moons ago and continue doing so under the *de jure* publicly-funded health system today—the degree of social solidarity in the today’s health sector is similar to one that was seventy years ago.

belong to particular social groups and networks. If a patient who needs an expertise of a highly qualified doctor belongs to a social network where someone possess information about a highly qualified doctor (e.g. the doctor's friend, colleague or a former patient) then the patient has a chance to negotiate the needed treatment with the doctor on a payment basis. Also, as an informal rule, doctors do not accept money from fellow doctors and members of their families and are willing to prioritise treatment of such patients⁹. Usually, belonging to a right social network is a matter of social and economic status. The status of the medical professionals during the height of Socialism was rather lofty and highly qualified doctors still somehow manage to preserve this status. As such, patients who can offer the doctor a certain amount of money usually belong to the right (in terms of having access to highly qualified doctors) social network.

With regard to effectiveness, under-the-table money creates incentives for doctors not to perform their duties well. Patients who practice gratitude payments may risk their health. The gratitude money creates incentives for doctors to treat the patient as long the patients pay and to prescribe as much expensive drugs and treatments as possible. The doctors, therefore, may continue treatment even if the best interest of the patients is to be referred to another specialist doctor.

The most devastating effect of under-the-table money on the publicly funded health sector is how the efficiency of the health sector performance is hindered. Under-the-table money creates inefficiencies in three directions: i) free riding, ii) moral hazard and iii) shadow economy. First, doctors treat patients privately using public facilities without paying even for amortisation of the public facilities. Secondly, many conditions are “*overcured*” in a way that patients are seen by doctors more often than it is needed¹⁰, expensive treatments are administered when it is unnecessary, and costly brand-name drugs rather than cost-contained generics are prescribed. Together with “*overcuring*”, under-the-table money generates the opposite kind of inefficiencies, i.e. “*undercuring*”. As outpatient care has a low reputation, some

⁹ The same effect of solidarity among doctors is observed in other countries, e.g. USA (Hsieh, 2003)

¹⁰ There is oral evidence that at least 30%-40% of doctor-patient encounters are not justified on medical grounds (Mikó, 2002).

people bribe doctors in primary care in order to receive a referral to the hospital¹¹. As a result, many conditions that could be treated on the level of primary care are treated in the hospital at a much higher cost¹². Lastly, under-the-table money fosters development of the shadow economy because doctors receiving under-the-table money do not pay any taxes.

Also, under-the-table money paid by pharmaceutical companies, producers of medical equipment, and providers of commercial health services gives another instance of moral hazard and free riding behaviour as well as fostering the shadow economy. In order to sell more drugs, pharmaceutical companies pay doctors up to ten percent of the cost of the prescribed drugs, offer gifts, or invite doctors to “conferences” in exotic places (Magyar, Cs., 2002)¹³. Given that pharmacies are privatised, it is in their interests to sell to pharmaceutical companies the information on actual prescriptions. As Hungarian doctors are well trained, and that currently nobody apart from them controls their activities, pharmaceutical companies have a vested interest in commissioning medical studies and experiments on new drugs and treatment procedures in Hungary. As expected, payments for such medical studies go directly to the commissioned doctors (Pásztélyi, 2002). Despite the fact that the doctors use public facilities and put at risk the health of the human subjects involved in the studies, neither the public, nor the human subjects receive any financial compensation. Even if doctors were willing to pay the hospital or human subjects, they could not do so officially as the sphere of medical studies is not precisely regulated. In order to boost sales, producers of medical equipment provide doctors in managerial positions, who can negotiate purchasing of the equipment on behalf of the

¹¹ The phenomenon of bribing a doctor in order to be treated in the hospital is observed mainly in Budapest and a few other big cities with well-known hospitals. In small towns and the rural area, it is usually rather expensive to travel to big cities and to pay gratitude money at the rate of big cities. However, considerations of receiving free drugs and maybe even food provide a rationale for the dwellers of small towns and the rural area to bribe doctors in order to be treated in a local.

¹² The difference between the cost of the same procedures in outpatient care and inpatient care can be up to ten times higher in inpatient care.

¹³ These practices of pharmaceutical companies are not special to Hungary. They are well-known phenomena in Western Europe and America. Clearly, they were imported to Hungary by overseas pharmaceuticals. We can only guess whether it was a naiveté or purposeful ignorance of the policy-makers that prevented them from passing a law banning doctors from accepting gifts from pharmaceutical companies. It was only in 2000 when the Government introduced such a law.

public hospitals, with a premium of a deal (*ibid.*)¹⁴. As a result, instead of increasing utilisation rates of the existing equipment and purchasing only needed and cost-contained equipment, hospitals have incentives to purchase new expensive equipment¹⁵. For example, in the 1990s purchases of expensive specialised equipment such as CT scanners and MRI systems increased dramatically, whereas almost no funds were left to replace and upgrade conventional cost-contained X-ray machines (Mihályi and Petru, 1999). Commercial providers of health services also supply doctors with incentives to refer the patients to them¹⁶.

Not all doctors earn under-the-table money. Earning under-the-table money is a matter of belonging to certain medical specialties, having a high professional reputation and a managerial position. Some doctors do not accept under-the-table money, as they believe it is unethical. Apparently, the overwhelming majority of doctors are against under-the-table money because of ethical, professional or economic considerations¹⁷. The majority of doctors, however, who can earn under-the-table money, do so. This phenomenon is difficult to root out for the following reason. The current health care system does not allocate to doctors the appropriate salaries for the doctors' unique qualifications, skills, and training would suggest. Official salaries of doctors in Hungary are equal to salaries of other public sector employees but are lower than wages in the industry. It goes without saying that salaries of doctors are dramatically lower than incomes of bankers, businessmen, and

¹⁴ It is not rare that the cost of such equipment in Hungary is higher than in Western Europe or Northern America.

¹⁵ Utilisation rates of medical equipment in Hungary are lower than it could be justified. For example, in 1998, the Hungarian Audit Commission together with the British Audit Commission made a survey on the instrument utilisation rates in the laboratory and imaging services. It appeared that in certain areas of laboratory medicine instruments utilisation rates were up to twenty times lower than they should be. This can be explained by both low actual utilisation rates and "private" use of the public instruments by doctors (Mikó, 2002).

¹⁶ Historically, the majority of legal commercial services were created by high-positioned doctors themselves or with their assistance by their close associates, members of the family, etc. Therefore, on the local level, referral to such services may be a matter of family, collegial or patron-client relations between doctors. On the National level, when politically influential doctors created whole new branches of commercial health services (e.g. high-tech diagnostics and dialysis), they ensured that their services had high reimbursement rates from the National Health Insurance Fund. Due to the enhanced lobby force of the producers of high-tech equipment and providers of high-tech commercial services, NHIF's reimbursement rates for the usage of such equipments are extraordinary high.

¹⁷ Economic considerations are based on high transaction costs of dealing with under-the-table money as the latter takes time that doctors could devote to their patients. Doctors believe that their knowledge and skills to cure patients should be officially paid better than their entrepreneurial and cashier skills to deal with under-the-table money.

other winners of transitional reforms alike. It is impossible to find a reason why highly educated and hard-working doctors should not compete for high salaries with other professions. Therefore, as a result of maximising behaviour, choosing between earning only mediocre official salaries and securing a decent income via shady dealings with patients and the medical industry, many doctors opt for the latter option.

The phenomenon of under-the table payments deserves an economic and also sociological consideration. Apart from constituting a part of a doctors' income, under-the-table payments is the backbone of the medical profession, in a way that it sustains and promotes the *status quo* of the medical profession. In the next section of the paper, I will consider implications of under-the-table payments on organisation and development of the medical profession.

II.2. Gerontocratic Hierarchy

Organisation of the medical profession in Hungary is extremely hierarchical¹⁸. The more experienced a doctor is, the more he or she can earn from patients. Also, given that currently doctors, not managers run hospitals, the more experienced a doctor is, the more managerial power and access to public money he or she has. Senior doctors, therefore, control most of under-the-table money and younger doctors wait in line for their time. Furthermore, the lion's share of under-the-table money is based in the most prestigious hospitals in the most affluent regions of Hungary. Thus, under-the-table money is an incentive for doctors to excel in the profession and to move to the best hospitals. As such, under-the-table money promotes a meritocratic hierarchy in the medical profession. When newly qualified doctors enter the profession, they earn low official salaries and have a little chance of receiving under-the-table money. The more they excel in the profession, however, the better the chance they have of

¹⁸ The hierarchical system of the medical profession can roughly be compared with the hierarchical system in the compulsory army service. In the compulsory army, everybody is against the situation when novices are abused by seniors but when the novices who were abused become seniors, they take advantage of their senior position (Kovácsy, 2003).

receiving under-the-table money. The longer they are in the profession, the more vehement they feel against any reforms aimed to reduce their chance of securing a high income via earning under-the-table money. The calculation that turns middle-aged doctors into supporters of under-the-table money is simple: despite earning low salaries now, they are gradually getting closer to the time when they can earn a great deal of under-the-table money.

There are both positive and negative effects of under-the-table money on the development of the medical profession. On the positive side, one may argue that under-the-table money supplements official salaries and, by doing so, keeps doctors in the profession. The medical profession during Socialism enjoyed a rather high status. Furthermore, there was no great variation in salaries and wages between various professions. One commentator put it this way: “everybody was underpaid and so were doctors, money did not count that much” (Magyar, Cs., 2002). The prestige of the medical profession and personal interests to pursue a medical career were the primary factors influencing people’s decision to enter the medical profession (Szilvási, 2003). On the other hand, senior doctors earned under-the-table money from patients during Socialism as well. As such, doctors were less “underpaid” than people in other professions. During transition, the gaps in income between different professions became dramatic. The publicly funded medical profession found itself amongst the losers of transition. In the 1990s, competition to enter the medical profession decreased dramatically. A prospect of earning a decent living via under-the-table money, therefore, may provide mid-career doctors with a rationale not to leave the profession. At the same time, for young people considering a medical career, the prospect of earning a decent income via under-the-table payments is probably not a significant factor in favour of deciding on a medical career. Indeed, it is risky to invest six to ten years in medical education and then wait ten to 15 years until they can earn under-the-table money in order to catch up with their peers who took more lucrative careers.

Whereas the positive effects of under-the-table payments on the development of the medical profession are dubious, there are unquestionable negative effects. One, under-the-table money provokes in the profession the gerontocratic crisis. A meritocratic

hierarchy in the medical profession is also a gerontocratic hierarchy. Thus, it prevents young talented and ambitious people from pursuing a medical career¹⁹. In order to secure under-the-table money a senior doctor needs to treat patients himself. Therefore, young doctors neither have enough experience in medical practice nor receive under-the-table money. Instead, young doctors mainly do paperwork for senior doctors. As such, many young doctors choose not to waste their time in waiting for their turn to practice medicine and to earn a decent living. Following this logic, in the 1990s, many young qualified doctors (30-40 years old) left the profession (Stubnya, 2003). Some of them moved into new commercial health services such as diagnostics and dialysis, medical industry, sales and marketing of medical equipment and pharmaceuticals. Others went to work abroad or left the medical profession altogether. Another negative effect of under-the-table money on development of the medical profession is caused by uneven distribution of under-the-table money among medical specialties. Some of them are thriving, e.g. gynaecology when others are dying out, e.g. radiology. Also, under-the-table money often determines the abilities of medical specialties to lobby their specific interests. More affluent specialties can lobby their interests better both on the level of the medical profession and on the level of policy-making. This inevitably sparks conflicts between different medical specialties and fragmentises the medical profession.

II.3. Adverse Incentives

Under-the-table money and organisation of the medical profession, itself, are not the only negative factors, but also the way the Government finances and organises the health sector are contributing towards growing inefficiencies in the health sector. Hungary inherited from the Socialist times a very strong imbalance between the outpatient and inpatient care in favour of the latter one. Inpatient care is more

¹⁹ As noted earlier, one should not exclude a possibility of that in some exceptional departments and clinics under-the-table payments are to a certain degree redistributed among young doctors and the auxiliary staff. However, it should be put bluntly that the lion's share of under-the-table money goes to senior doctors.

expensive and therefore a high efficiency gain can be achieved by treating patients where it is appropriate outside hospitals. There was a strong drive in the late 1980s and early 1990s to create a strong and independent system of general practitioners (GPs) who were supposed to act as gatekeepers. Although such a system was created, GPs do not act as gatekeepers. On the contrary, they send patients directly to higher levels of the health system (Kovácsy, 2003). GPs are paid according to the quantity of patients they serve (capitation), rather than their actual performance. The incentive for GPs, therefore, is to have healthy people but not problematic ones. Official salaries of GPs are rather high compared to official salaries of doctors in clinics. GPs can also earn under-the-table money from pharmaceuticals for prescribing their drugs. Still, GPs have a poor chance to secure under-the-table money from patients. In total, instead of providing a definitive treatment, GPs have incentives to quickly prescribe drugs that are promoted by the pharmaceutical industry and then to refer problematic patients to specialised clinics in order to minimise the workload.

On the contrary, in the specialised clinics the incentive for doctors is to keep the patients. Official salaries of doctors in such clinics are performance based. Doctors, therefore, have incentives to prescribe as many expensive examinations and treatments as possible in order to secure higher official salaries²⁰. Also, doctors in specialised clinics have a far better chance to earn under-the-table money from the patient than do the GPs. From the patient's perspective, they are also interested in being treated in hospitals as they do not need to pay anything for the prescribed drugs and they believe that treatment in the hospital is much better than in a GP's practice or outpatient clinic (Kovácsy, 2003). Historically, two-thirds of the outpatient clinics are affiliated with inpatient clinics (hospitals) and have a common management. Given the fact that the cost of inpatient care is up to ten times higher than the cost of the similar outpatient care, the common management creates demand for inpatient services (*ibid.*). When a patient comes to an outpatient clinic, the incentive for the

²⁰ Performance-based calculation of salaries of doctors created the problem of uneven payments in different medical specialties. Some of them benefit from such payments but some other loose. The problem creates the implication that in the long run the losing specialties can disappear (Szilvási, 2003). Therefore, re-establishment of salaries based on working hours can be a solution to this problem (Dózsa, 2003). Generally, the performance-based system of payment is not a problem, but rather inability of the Government to take all factors into consideration and to make correct calculations create the problem.

management is not to provide a definitive care on the spot but rather to perform a full range of available tests and examinations and then to refer the patient to the hospital. Often, inpatient and outpatient doctors are the same people. There are anecdotal examples when doctors in outpatient clinics referred their patients to themselves in hospitals (*ibid.*). Admittedly, hospital care presents a doctor with a better chance to secure under-the-table money from the patient. Therefore, in a situation when inpatient and outpatient doctors are the same people, a choice of the doctor to refer the patient to the hospital may be affected by the doctor's expectation of under-the-table money from the patient.

III. Dark Power of the Medical Profession

In the 1990s, the Hungarian Medical Chamber and Colleges of medical specialties were re-established (or established from scratch). These organisations were envisioned to be the self-governing bodies of the medical profession in the area of ethical and professional conduct as well as to represent and promote the health policy-making interests of the medical profession and its specialties. Currently, however, the actual function of these organisations is better thought of as one of trade unions (Kovácsy, 2003). They are primarily engaged in the debate with the Government on salaries, wages, and cost of services. Given the hierarchical organisation of the medical profession, the medical professional organisations tend to represent the interests and the vision of the top of the hierarchy. Since the establishment of the medical profession enjoyed far better opportunities for development of the profession in the past it, therefore, argues for a greater role of the state in the health sector in terms of funding. At the same time, senior doctors are keen on preserving the current situation where they have managerial power to use public funds on behalf of their hospitals and public facilities for treating patients privately. As reforms are usually damaging for the establishment of the medical profession, the Chamber and Colleges are keen on preserving the *status quo* in the health sector by opposing Governmental initiatives. On the one hand, such opposition can be beneficial for public good, as badly planned reforms have a chance to be stopped. On the other hand, progressive reforms are also likely to be blocked.

Despite the fact that the Chamber and Colleges are the most outspoken representatives of the medical profession, they are not only the places where the power of the medical profession lives. Apart from the Colleges, there are National Institutes of medical specialties. The National Institutes may compete with the Colleges as directors of the Institutes are appointed by the Government. If the Government is not happy with a College's position on a certain issue, it may turn for support to the National Institute of the respective medical specialty. In many cases, however, leaders of Colleges and Institutes are the same people. At any rate, the Chamber, Colleges, and National Institutes have no legal veto-power to participate in health policy-making. Their positions are translated into policies only if the Government desires it. Otherwise,

organisations of the medical profession have no other choice but to lobby informally. There are two important points to note about the organisations under consideration. One, the medical profession is ridden with conflicts between various specialties as well as with personal conflicts between leaders. Therefore, these organisations do not have the utmost degree of positive or negative solidarity. Yet, there are influential figures in the medical profession outside these organisations. In other words, the power and interests of the medical profession are not always consolidated and institutionalised.

As mentioned earlier, the medical profession has no formal veto-power to influence health policy-making. The medical profession, however, has a number of informal veto mechanisms. First, as it applies to the health sector financing and organisation, the politicians, the public, as well as the majority of doctors are considered “the lay people” (Mikó, 2002). It makes it easy for doctors engaged in the politics to influence the public and politicians on the issue of health sector reform: the doctors do need to manipulate the lay people’s opinion; they simply create it (*ibid.*). It goes without saying that even if younger doctors disagree with more senior doctors, the former do not have a voice in the professional organisations. Second, one should not underestimate the power of the fourth estate. When politicians disagree with the medical profession, it can use the mass media to influence politicians. Given that health care reform is a salient issue, the Government tries to avoid any criticism in the mass media. Third, Hungary is a small country where the majority of mighty politicians, influential journalists, and politically active doctors live in Budapest. It is even possible to guess in what exactly districts of Budapest they live and in what baths they bathe (Adam, 2002). Also, politically influential doctors are coming from the best hospitals and they are considered to be the top cream of the medical profession. There is a good chance that they know the political and mass media elite as their patients. Knowing each other helps to develop trust and common interests. It is likely that being part and parcel of the elite social network allows doctors to also use the network to influence the opinion of the network’s other members. Being immersed in the elite social network and having trust and reciprocal relationships with other members of the network helps the medical profession to lobby its interests. Many important decisions, therefore, in the health sector are facilitated by informal communication. One disenchanted commentator noticed that for successful lobbying

the most important thing is to know personally a decision-maker and his telephone number (Dózsa, 2003). Fourth, although medical professional organisations are originally meant to regulate professional conduct, their actual function is that of a trade union. Similar to trade unions, in order to achieve their goals medical professional organisations can warn the Government of serious industrial actions or even civil disturbances²¹. Fifth, in Hungary, the administrative elite dealing with the health sector was traditionally educated as doctors. In the former times, the Ministry of Health even employed practising doctors on a part-time basis. In the present times, there are examples when leaders of the medical profession became leaders of the Ministry of Health. As such, when the Ministry of Health is actually the Ministry of the Medical Profession, one should not exclude a certain degree of solidarity between doctors in state administrative positions and doctors in leading professional organisations. Once again, Hungary is a small country; it has only four medical universities (Dózsa, 2003). As such, doctors in administrative positions and leaders of the medical profession have the opportunity to know each other from their student years. Last, it is in interest of both the medical profession and the medical industry to benefit from public money. Therefore, one should not dismiss the idea that the medical industry financially backs the medical profession when the latter lobbies for their common interests. Altogether, similar to the situation when part of the income of doctors comes from shady dealings with the patients and medical industry, the sources of the political power of the medical profession are also rather “dark” (Kovácsy, 2003).

²¹ Although medical professional organisations sometimes successfully use this strategy in negotiations with the Government, it is difficult to imagine that they actually can organise industrial action.

IV. Games the Medical Profession and Government Play

In order to conceptualise the challenge for effective governance currently faced by the health sector, I will use game theory. Although the word 'game' suggests light situations and peaceful behaviour of the players, in fact, game theory is usually applied to rather serious situations. For example, it proved to be helpful for planning military operations of the Allied Forces during the World War II. Currently, it is used in politics and economics to model interactions, which apart from leaving room for co-operation or mutually beneficial actions involve strong conflicts of interests and competition. In a nutshell, a game is an interaction between two or more actors, where each player tries to optimise his pay-off and makes his decision separately from another player but anticipating his decision. There are two types of games. One, a zero-sum game, or a game of competition, assumes that the amount of winnable resources is limited. It means that a gain of one player is always a loss of another player. Competition is, therefore, a dominant strategy for the players²². Two, a non-zero-sum game, or a game of co-operation, assumes that the amount of winnable resources is infinite, i.e. the gain of one player does not necessarily equal to the other player's loss. As such, in a non-zero-sum game, competition is not necessarily a dominant strategy because co-operation can yield better pay-offs for the players.

Does health sector reform potentially represent a game of competition or a game of co-operation? In order to gain insights into this question, let us consider interests of two major players: the medical profession and Government. In their game, funding and organisation of the health sector is at stake. For the Government, it is crucial to deliver health services to the population in accordance with the Constitution. At the same time, given that public funds are scarce and that the Government is under monetarist pressures, it is problematic for the Government to increase public expenditure on the health sector. The same applies to organisation of the health sector, viz. the Government is under the neo-liberal pressure to organise the health sector in a way that reduces public expenditure and increases involvement of the private sector. In sum, although the Government is under soft budgetary constraints and neo-liberal

pressures, it has a Constitutional responsibility to deliver health services to the population. Thus, the Government has a limited room for manoeuvre to escape this pressure in order to fulfil its Constitutional responsibility. In doing so, it can secure a better opportunity to be re-elected. For the medical profession it is important to cure people, advance medical knowledge and skills and to have ensured that medical professionals are employed and earn a decent living. In the long run, provider privatisation of the health sector may better maximise interests of the medical profession. However, transition to a new health system will burden the elite of the medical profession with transaction costs. For the current elite of the medical profession it is important to preserve its power to use public funds and facilities as well as the autonomy of the profession. Consequently, the medical profession is also open to a trade-off. Altogether, health sector reform can be thought of as a non-zero-sum game with the result that co-operation between players can yield for them better pay-offs.

In game theory, the problem of co-operation is usually analysed by means of the prisoner's dilemma game. It goes as follows. Two suspects in a crime are put into separate cells. They can either confess or deny the allegation. If they both confess, each will be sentenced to three years. If only one of them confesses, the other will be freed and be used as a witness against the other, who will receive a sentence of ten years. If neither confesses, they will both be charged with a minor offence and jailed for a year. Obviously, a dominant strategy for each prisoner is to confess. As such, trying to maximise their pay-offs separately and, in doing so, competing against each other, together they will produce a sub-optimal outcome. In order to minimise the total punishment for the system consisting of the two prisoners, the prisoners need not to pursue their dominant strategies but to find a synergy to accept a common strategy of rejecting the allegation. When they manage to co-operate in denying the allegation, they both can produce a more optimal outcome of the game. The unique equilibrium of this game—viz. situation when no player can gain from unilaterally switching to another strategy—highlights the principle of sub-optimisation. The latter is the

²² A dominant strategy is one that "dominates" all other strategies in a player's strategy set in a way that it yields a better pay-off than any other strategy.

situation when optimisation of outcomes for every subsystem does not optimise the outcome for the system as a whole.

I argue that the prisoners' dilemma game illustrates the structure of interaction between the medical profession and the Government. In order to optimise performance of the health sector, the medical profession and the Government need to co-operate. Below, I will consider two problems causing inefficiency in the current health sector arrangements and suggest how co-operation between the medical profession and Government can tackle these problems. The latter are under-the-table money and adverse incentives. It is extremely difficult to root them out, as they both result from maximising behaviour of patients, doctors, and the medical industry. In order to root the problems of under-the-table money and adverse incentives one can either change the incentive system or find unexploited options to eliminate these problems within the existing health sector arrangements. It is difficult and expensive to change health sector arrangements. Thus, it is preferable first to try to find unexploited options for efficient performance of the existing health sector arrangements. I would like to put forward an argument that such an option is presented by an effective system of regulation and policing²³. The latter, in terms of a policy action, means to have established and enforced standards of care that patients should receive as well as cost-contained and effective treatment procedures that doctors should follow.

The phenomena of under-the-table money and adverse incentives deserve two considerations. One, such phenomena exist because the medical professionals have low official salaries. Under the current economic and politic circumstances, the publicly funded health sector is a curse for the Government, which is obviously under the monetarist pressure to reduce public expenditure²⁴. The Government, therefore, cannot afford financing the health sector on a sufficient level. In the Socialist times,

²³ Regulation and policing is important for effective performance of any type of health sector arrangements. For example, it is true that, in the private health care system patients do not have a rationale to bribe doctors. In order to get a better treatment patients simply need to officially pay more. However, the medical industry and providers of health services still have a rationale to pay doctors for prescribing their drugs and treatments. Therefore, an effective system of regulation and policing is important even for any type of health sector arrangements.

²⁴ The 50% increase of salaries in the health sector made by the current Government was severely criticised by the IMF.

the health sector was never financed sufficiently²⁵. There is limited evidence that the Socialist Government took into consideration the existence of the under-the-table money phenomenon and set salaries and wages in the health sector lower than it should be, allowing the patients to “top up” salaries of doctors and wages of the auxiliary staff. It is plausible to think that facing the problem of suppressing public expenditure, post-Socialist governments consciously or unconsciously continued the practice of their Socialist predecessors. Also, post-Socialist governments deliberately did not create any formal channels for the medical profession to influence policy-making. Indeed, to have a powerful policy actor advocating increasing public health sector expenditure and scrutinising governmental policies was not in interests of any Government. As such, the phenomena of under-the-table money and adverse incentives are consequences of the Government’s inability (or unwillingness) to address the problem of a) low salaries in the health sector and b) exclusion of the medical profession from policy making²⁶. As a reaction to this, the medical profession defends the practice of under-the-table money and takes advantage of adverse incentives²⁷.

Another consideration of the phenomena of under-the-table money and adverse incentives is based on the analysis of interests of the medical profession. Clearly, if under-the-table money constitutes up to 90% of a doctor’s income, even a three-time increase of his official salary will not create a rationale for him to abstain from accepting under-the-table money. In a similar vein, if a doctor has a material incentive to prescribe expensive drugs, he will do so. When accepting under-the-table money or prescribing more expensive than necessary drugs, a doctor weighs the costs and benefits of his action and if benefits exceed costs, he takes the action. There are costs of violating one’s ethical code and being caught. If a chance of being caught is low and penalties for the prescription do not exist or are smaller than the benefits, the doctor will find a way to proceed with the prescription. If the doctor does not find the

²⁵The health sector was considered to belong to the non-productive sector of the economy. As the aim of the Socialist economy was increased production, the health sector lacked a sufficient financing.

²⁶ This way of reasoning reflects the ideology of the Hungarian Ministry of Health (MoH) led by Dr. István Mikola. Namely, MoH argued that under-the-table money was not a disease but rather a symptom. This approach was in sharp contrast with the predeceasing approach according to which under-the-table money was viewed as a disease.

cost of violating his ethical code high, he will proceed with the prescription. In the current situation when there is a lack of order and policing in the health sector, a simple increase of doctors' salaries will not eliminate the problems of under-the-table money and adverse incentives. Thus, an effective system of regulation and policing is needed.

In the analysis of the above problems, it is difficult to identify a party, which is primarily responsible for their very existence. These problems result from interaction between the Government and the medical profession. The strategy of the Government to accuse the medical profession in corruption is aimed to manipulate the public opinion. The public knows about corruption in the health sector much more than about corruption and incompetence in the Government simply because the public deals with doctors more often than with politicians. Similarly, attempts of the medical profession to preserve the publicly funded health system are not simply an altruistic enterprise. The well being of the current elite of the medical profession depends on the preservation of the publicly funded health system. In the game the medical profession and Government play, the current situation—which is characterised by the existence of the phenomena of under-the-table money, adverse incentives, and dark power of the medical profession exist—represents an equilibrium. The latter is a situation when no player can gain from unilaterally switching to another strategy. The Government's dominant strategy is to accuse the medical profession of being corrupted and to make doctors responsible for the problems of health services. As a result, it does not need to increase public health spending in order to fulfil its constitutional responsibility. For the medical profession, the current situation is also acceptable as it allows to senior doctors (who politically represent the medical profession) to earn high incomes and to preserve their positions on top of the medical hierarchy. Obviously, such an equilibrium is suboptimal.

I argue that an effective system of regulation and policing, which includes standards of care for patients and treatment procedures for doctors, can optimise performance of the existing health sector arrangements. The Government can no longer control the

²⁷ For example, the Medical Ethical Code endorsed by the Hungarian Medical Chamber allows doctors to take under-the-table money paid by patients if it is paid in gratitude after receiving treatment.

medical profession. Thus, in order to establish and enforce a set of cost-contained and effective treatment procedures, which doctors should follow, and penalties for deviation from these procedures as well as a system of enforcement, the Government needs the co-operation of the medical profession. For the medical profession, there is no rationale to regulate and restrict its activities as long as such measures neither ensure high incomes for doctors, nor contribute towards development of the profession. As such, to gain co-operation of the medical profession, the Government needs to increase official salaries in the health sector. If doctors had high official incomes, they would be interested in excluding from their profession colleagues who are incompetent and/or violate professional norms and procedures. Still, one should not exclude a possibility of a negative solidarity among doctors, i.e. doctors may defend their incompetent and corrupt colleagues. The medical profession, therefore, should delegate to the state a certain amount of regulation and policing functions. In return, the state should delegate to the medical profession a certain power to officially participate in health policy making in order to negotiate with the state salaries of doctors, costs, and content of the medical procedures, organisational reforms, etc²⁸.

²⁸ Currently, professional organisations of the medical profession also perform a role of trade unions. If the EU's push towards strengthening a tripartite dialogue in accession countries succeeds, one can expect that the professional organisations of the medical profession will lose the necessity to play the role of trade unions and trade unions of the medical profession will fully take their role to negotiate with the Government issues of salaries, working conditions, etc.

Conclusion

In the prisoner's dilemma game, despite the fact that co-operation is beneficial for both players, it is irrational. The expectation of a player who considers taking a co-operative strategy that his counterpart will not reciprocate but rather cheat him determines that both players stick to a competitive strategy. A great deal of trust between the players is needed in order to allow them to abandon their rational strategies of competition and to "irrationally" choose a co-operative strategy. This trust can be generated between the Government and medical profession's representative only through personal relationship building. If leaders of the medical profession and Government somehow manage to achieve this, then they can agree upon an unbiased framework that would facilitate participation of the medical profession in health policy-making with a view to creating an effective system of regulation and policing or any other improvement in the health sector.

Theoretically, participation of the medical profession in health policy process is not desirable for the Government because the medical profession for different reasons can lobby against any reforms, including progressive ones. Also, participation of the medical profession in the policy process burdens the Government with high transaction costs in terms of time needed to introduce reforms and resources spent on negotiations. If the Government knows what course of action to take to bring effectiveness, efficiency, and equity improvements into the health sector, then to take a unilateral action is more preferable for the Government than to first seek endorsement of the medical profession for this course of action. In practice, however, a history of transitional reforms shows that the Government usually does not know what course of action is beneficial for the health sector. Thus, one should assume that to bring substantial improvements to the health sector by the Government's unilateral action is hardly possible. At the same time, if the medical profession could officially scrutinise and veto governmental reforms, many mistakes could be avoided. Furthermore, unilateral actions of the Government are subject to illegitimate beliefs on the side of the medical profession. When doctors, as any other human beings, are put in a system which they do not approve or which work against their interests, they will rebel against the system and game it. Therefore, in order to have an effective,

efficient and equitable health system, the Government needs to introduce reforms in co-operation with the medical profession. For the Government, it is a difficult and in a way, irrational decision to delegate some of its power in the health sector to the medical profession. However, if the Government manages to do so, the current public health system will have a chance for a more effective, efficient, and equitable performance²⁹. However, I am sceptical that the Government will follow this course of action. As such, below, I will sketch out most likely scenarios for health sector reform in Hungary.

In order to be elected, the Government plays a two-level game: one with the general public and another one with the elite. As far as the general public is concerned, during the election campaign, the current governing party (MSZP) pledged to reform the health sector. Furthermore, when taking office, the new Government dubbed itself “the health Government”. As such, it is obviously under the pressure to implement some reforms, at least, on the level of symbolic politics. The Government has already increased salaries in the health sector by 50%³⁰. It means that in terms of symbolic politics the Government has already made an effort to reform the health sector. The fact that this effort will not yield any substantial improvements in terms of effectiveness and efficiency of the health sector performance can be blamed on corruption in the medical profession. Therefore, if the Government is successful in the game with the elite, it can limit its efforts in health sector reform to symbolic politics and still have a chance to be re-elected.

As far as the elite is concerned, the Government should bring benefits to the elite if it wants to keep office. On the face of it, the Government should not proceed with any reforms that violate the interests of the elite of the medical profession. In other words, it is important for the Government to preserve the status quo in the health sector. As such, it is unlikely that the Government will proceed with any organisational reforms

²⁹ Obviously, giving away part of power in the health sector to the medical profession will complicate and slow down policy-making process. Therefore, improvements to the health sector will come in a piecemeal manner.

³⁰ It is a rather symbolic measure as the medical profession argues that a sufficient level for an increase of salaries should be 250%-300%.

such as state-sponsored privatisation as it happened with GPs³¹. On the other hand, the elite of the medical profession has neither financial resources on its own, nor official political power to veto decisions of the Government. For the latter, provider privatisation involving real money is very tempting. In the long run, new owners of health sector facilities will become royal supporters of the party that allowed privatisation. In a short run, privatisation will bring funds to the state budget, party coffers and, last but not least, to decision-makers in the Government. Consequently, if the Government invites private investors with big money, such as the medical industry to participate in privatisation of the health sector, costs of losing support of the medical profession and even electorate will be compensated by benefits from privatisation. If the worst scenario happens and privatisation results in a crisis in the health sector, the governing party will lose the next election. However, the politicians in office who support the interests of the private investors with big money will have a chance to earn more than their political careers can pay off in many years to come. Also, they will have a chance to create a solid financial base for themselves or their party colleagues to run for office in the following election.

³¹ GPs were made to privatise their practices and as they did not have money to do so, the Government itself financed GPs.

List of Interviews³²

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Sandor, Judit (30.07.02) [Central European University], personal interview.

³² Given that up to date publications on the subject of this paper are scarce, the paper is mainly based on a series of exploratory interviews. People who made a significant contribution and who did not prefer to remain anonymous are listed.

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