

Welfare, Choice, and Solidarity in Transition

Reforming the Health Sector in
Eastern Europe

János Kornai and Karen Eggleston



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1

Introduction

The health sector in post-socialist Eastern Europe suffers from a great many serious problems and concerns. The need for radical reforms is generally agreed, but opinions differ on what actually needs to be done, and how and when. Sharp debates take place, sometimes behind closed doors and sometimes in public, within the countries concerned and within the international agencies and academic institutions that are giving advice regarding economic and social transformation.

The authors of this book take positions on the issues being debated. We explain what direction we think the reforms should take and argue our point of view. We do not make detailed recommendations. The emphasis in our remarks is on the desirable features of reform that are common to all the countries examined.

While the book does not avoid taking up a position, it seeks to point to the difficulties that loom in the path of implementing reform. It sets out to identify the trade-offs. It points out what a country will win and lose, and what risks and dangers it will face in taking the approach recommended.

The purpose behind the book is to make recommendations that will facilitate reform. The economic-policy recommendations appear in part II. The preceding part I discusses the points of departure upon which the recommendations are based.

The subject-matter is vast. It is worth establishing first of all

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what criteria the authors used to narrow the scope of inquiry. Although our recommendations may be of broader interest, they are specifically addressed to ten post-socialist countries of Central and Eastern Europe (CEE), namely Albania, Bulgaria, Croatia, the Czech Republic, Hungary, Macedonia, Poland, Romania, Slovakia, and Slovenia. The Yugoslav successor states that have suffered gravely from war, and will continue to suffer for some time, have been omitted. There is no discussion in this book of the Soviet successor states. The ten countries are referred to for brevity's sake as "Eastern Europe," although this is not geographically accurate.

Wherever possible, the tables and examples incorporate the data and experiences of all ten countries. Unfortunately, this could not be done consistently, because abundant data and descriptive materials could be obtained only from some countries and relatively little from others. The largest body of information was available from Hungary, as one of the authors is Hungarian. He was able to gain access to non-public, internal information and the findings of in-depth examinations, and to initiate research into the situation. Nonetheless, the book is not about Hungary or about two or three specific countries, but about Eastern Europe.¹

Health-sector reform has been defined in many different ways. This book takes a relatively narrow interpretation, confined to structural and institutional changes. It does not directly address the otherwise important question of whether the resources available for the health sector are sufficient or lacking. Nor does it discuss how these resources should be allocated among the activities and organizations that promote the improvement of health. The question addressed here is a different one: what economic and political institutions should govern allocation of health-sector resources in Eastern Europe?

¹ The predecessor of this work was Kornai (1998b), which appeared in Hungarian and dealt expressly with the Hungarian health-care reform. Although there is much overlap between the two books, one of the reasons for going beyond the first book was to extend the inquiry beyond Hungary and discuss the reform problems of Eastern Europe comprehensively.

There is hardly an aspect of human life that poses so dramatically as health care the issue of scarcity, a fundamental question of economics. Science and technology are constantly making enormous strides. Even the richest of countries, with the most lavish spending on health care, could effectively use extra dollars or euros to relieve human suffering and save or extend lives. Every spending decision both allocates and excludes. Directly or indirectly, it decides who shall be deprived of certain health-care services. Phrasing the dilemma in this way suffices to show what a weighty question it is. Who is authorized to decide who utilizes resources for health-care purposes, in what quantities, and on what occasions? Should it be patients, doctors,² or the health-sector apparatus? Should it be employers, insurers, or the government and the majority in Parliament? This book considers how that power should be distributed. Its subject is not the allocation of health care, but choosing the political and economic mechanism that will decide that allocation.³

It should be pointed out here that the book employs the expression “welfare sector” as a generic term. It embraces (to name only the more important components) health care, education, pensions, care of children and old people, and social assistance for the needy. One of the central issues in the reform debate is to decide which welfare-sector activities should remain under and which should be removed from state control – in other words, which spheres should be included in the “welfare state.”⁴ Although one division of the welfare sector, health care, is placed to the fore throughout the discussion, some of what is said can be applied to the

² Throughout the book we use “doctor” and “physician” interchangeably and use the broader terms “medical professional” and “provider” to include nurses, physicians’ aides, etc.

³ The expression “political and economic mechanism” is used in the sense in which it was applied in the debates on socialism. It covers a specific configuration of property rights, decision-making spheres, incentives, and forms of coordination.

⁴ As the description shows, the expression “welfare state” appears in this book in its European sense. This differs from American parlance, where the definition of “welfare” is narrowed down to social assistance.

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welfare sector as a whole, or to other branches of it besides health care.

It emerges from what has been said already that the book is not confined to the economics of health care. Indeed, it is not simply concerned with some important economic aspects of the welfare sector, because it goes beyond the borders of economics. This is an interdisciplinary study centered on the ethical and political–philosophical aspects of reform. It sets out to analyze not only the economic context of the issue, but its social and political environment as well.

For whom is the book intended? It mainly addresses two groups. One consists of those with an interest in the post-socialist transition in Eastern Europe. This interest may not be confined to the health sector; it may extend to the reform of other sectors. This group may find it instructive to consider the changes in the health sector, since these raise several problems common to changes in other areas. The other target group of readers consists of those concerned with health-care reform, whether in Eastern Europe or elsewhere. Although the changes in Eastern Europe have several specific features and the book's recommendations do not aspire to universal validity, the line of argument may yield more general lessons, valid beyond the bounds of Eastern Europe.

The authors would like the book to be comprehensible not just to health economists, but to a broader readership that includes politicians, legislators, party officials, civil servants, doctors, academic economists, political scientists, and press and media journalists. We must apologize to specialists in the field for having to stop and explain some concepts and connections with which they may be already familiar.

We want to measure the book's success not simply by approval from our academic colleagues (welcome though that would be), but by whether it manages, even indirectly, to exercise some influence on the course of events. This aspiration explains why the book is a hybrid. It is not a pamphlet written by politicians and PR people; it is much longer than

that in any case. It is apparent that it is written by academics, but it is not an academic monograph, because the emphasis is on recommendations for reform.

The book is the work of two authors. János Kornai has specialized in conducting research on the problems of Eastern Europe. He has spent decades studying the socialist system and reforms of it – and, in the last decade, the transformation that followed the collapse of socialism. It seemed that the experience of his earlier research could be applied to this new field. Where the reform of the socialist health-care sector had yet to take place, a fragment of socialism had survived in the midst of a capitalist market economy.⁵ The main features and concomitants of socialism appear clearly: bureaucratic overcentralization, the absence of price signals or distortion of prices, chronic shortage, queuing and forced substitution, and the “black” economy. Where reform gets under way, the questions that immediately arise are familiar to all who took part in and analyzed the earlier debates about market socialism. Can market coordination be introduced while state ownership remains? How far should centralization or decentralization be allowed to go? What function do prices have, and what cost elements should be covered by revenue from sales? Is it possible to harden the budget constraint and impose financial discipline if that inevitably brings losses and hardship for the public? Regrettably, participants in the world-wide debate on health care have not drawn on the intellectual resources of the debates about socialism. They feel that every question and every answer has to be discovered anew. Perhaps this book can help to alleviate this shortcoming, by trying to import into the lively and varied polemic on health care such experiences and ideas, which are sinking into oblivion. Here in the introduction it is

⁵ When public ownership and administrative allocation still characterized the welfare sector in Israel, one economist asked the ironic question (paraphrasing the debate between Trotsky and Stalin): “Can socialism be built in half a country?”

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enough simply to mention this connection, to which the discussion will return on several occasions.

The other author, Karen Eggleston, is a health economist. She completed her studies recently, in which she gained an insight into the modern literature on health care and had an opportunity to acquaint herself with various conflicting views. Her own research has mainly been concerned with the incentives influencing health care. In writing this book, she was also able to make use of experience she gained while studying the health sector in China.

We hope that our two bodies of knowledge and experience will produce a special blend that helps to enrich the literature on health-care reform.

The use of the first person plural in many places in this book is designed to express the personal, individual character of the proposal, not the originality of the idea behind it. Our assertions rest on our own assessment of the situation and reflect our own system of values. Reform proposals often result from committee work, so that the final text reflects a compromise between the views of committee members. This applies still more at a later stage, when the reform is being enacted by Parliament. By then, it embodies numerous compromises struck during the political process of legislation, and various concessions made by the experts who drafted the bill and the politicians who voted for it. We do not belong to the health-sector bureaucracy, nor are we invited experts of a political party or members of Parliament. That means we can express our opinions without making compromises for the sake of agreement. We realize that if there turn out to be people in the government or the administrative system in any of the Eastern European countries who agree with our proposals, they will probably have to make concessions on some issues, against their better judgment, to ensure practical implementation. We think the established division of labor means it is their job, not ours, to make those concessions. Let them decide, according to their feelings of political respon-

sibility and their ethical notions, how far those concessions should go. We have a different job, because we, members of the academic community, have different opportunities open to us. We want to utilize the advantages we gain from that division of labor, in being able to express our views consistently, as our convictions dictate.

Finally, let us say something about the tone of the book.⁶ We sense deeply what health and illness mean to everyone, which we have learned from our own experiences in life. There were two occasions when the first author lay in a ten-bed ward of a Budapest hospital after a serious operation, and was able to study the socialist health sector closely. On one occasion he was taken to a private clinic in Geneva after a road accident. Although he was in great pain, they did not set about treating him until it became clear who was going to pay. There he learned to his cost what a “pure market” entailed. Personal experience, of course, is not even the most important aspect. We have sensed several times the anxiety, fear and pain of our relatives in times of illness and defenselessness. During such illnesses, and sad to say, after a good many deaths, we have often asked ourselves: was everything possible done to cure the patients and save their lives? To what extent could the state of the health sector be blamed for their suffering, or, in the worst case, death? We feel this empathy not only for family and friends, but also for all our fellow human beings. Even so, our aim when writing this book has not been to seize every chance to write a heartrending description of present conditions, or pin blame on society, governments, or politicians. Precisely because the situation is dramatic in many respects, the best way to help

⁶ The problem of terminology in this book should be mentioned here. Each country in Eastern Europe has its own terms for the various health-sector institutions and the various components of the economic and political mechanism. Simply to translate these literally into English would lead to terminological confusion. Moreover, the terminology in the English-speaking countries is not uniform either. To avoid ambiguity, this book consistently uses the expressions current in the United States.

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is not to dramatize and work up people's passions, but to think the tasks out, calmly and dispassionately. Figuratively speaking, our ideal is not a doctor who bursts into tears on seeing how ill the patient is, but one who reassures the patient and family and soberly considers what remedy or treatment will be of most avail.

The book is the end product of a long process of research. The work of János Kornai, the first author, took place under the auspices of Collegium Budapest, Institute for Advanced Study. He received financial support from the Hungarian National Scientific Research Foundation (OTKA T 018280 and T 30080), from the Hungarian Ministry of Finance, and from the European Commission DG Research INCO Programme, which supports the "Institution-Building" Project of Collegium Budapest. He wishes to express his gratitude to them all.

János Kornai has given several lectures on the subject-matter of the book, including at the Washington conference of the National Academy of Science, Harvard University, the World Bank, the Berlin Wissenschaftskolleg, and the Hungarian Medical Association. The debates following these lectures provided much inspiration for his work. Part of the book constituted the Federico Caffè Lecture he gave in Rome; this gave us the honor of having this book published in the Caffè Lecture series.

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