

Table 6 Investor Ratings of Countries^a

Country	1993 15 Nov.	1994 15 Nov.	1995 15 Nov.	1996 12 Nov.	1997 14 Nov.	1998 12 Nov.
Czech Republic	BBB	BBB	A	A	A	A-
Hungary	BB+	BB+	BB+	BBB-	BBB-	BBB-
Poland	n.a. ^b	n.a.	n.a.	BBB-	BBB-	BBB-
Slovakia	n.a.	BB-	BB-	BBB-	BBB-	BBB-
Slovenia	n.a.	n.a.	n.a.	A	A	A-
Romania	n.a.	n.a.	n.a.	BB-	BB-	BB+
Latvia	n.a.	n.a.	n.a.	n.a.	BBB	A-
Lithuania	n.a.	n.a.	n.a.	n.a.	BBB-	BBB-
Russia	n.a.	n.a.	n.a.	BB-	BB-	CCC
China	BBB	BBB	BBB	BBB	BBB+	BBB+

SOURCE: Standard & Poor's *Rating Handbook* and Standard & Poor's *Global Rating Handbook*, various years.

^a Long-term ratings of sovereign debt in foreign currencies.

^b n.a. = not available.

6 Reforming the Welfare State in Postsocialist Economies

János Kornai

Harvard University and Collegium Budapest

When I was invited to participate in this series on transition, I was not sure whether my proposed topic would really be appropriate. In this paper, I will primarily discuss welfare reform in postsocialist economies. While welfare reform is part of transformation, I do not consider it part of transition. So let me begin by answering the questions of when transition can be considered to be over in general and whether it is over in Hungary specifically. Then I will try to explain the role of welfare reform in the transformation and go on to discuss welfare in detail, with special attention to health care.

Each of us who works in the area has his or her own criteria for determining the end of transition. I have three such criteria, based on the theory I applied in my book, *The Socialist System* (Kornai 1992). When defining socialism, the starting point is not state ownership, central planning, or the communist economy; it is the omnipotent rule of the Communist Party. So the first criterion is that the Communist Party must lose its monopoly power in politics. In that sense, transition in China is definitely not over. One cannot even speak of China as a transition economy because the Communist Party is still in power; rather, China is a reforming communist country. Note that the criterion is not that the country be a democracy, only that the Communist Party not hold a monopoly on political power. The second criterion is that the dominant part of the means of production must be held privately, and the private sector must account for the larger part of gross domestic product (GDP). This private sector does not have to be created exclusively through privatization: it can become dominant through the entry of more and more new firms. Third, the market must be the dominant coordinator of economic activities, alongside various other mecha-

nisms. With these criteria, I aim at a minimum, not at an exhaustive, list.

According to these criteria, the transition from the socialist to the capitalist system in Hungary is basically finished. This conclusion does not mean that there are not any legacies of the former communist system that still need to be transformed; it cannot be stated that everything has been accomplished in all dimensions or that Hungary has a perfect system. There are still many institutions and organizations, as well as attitudes, that must be changed. So transformation is not over, but transition is: the system is now a capitalist one.

Assar Lindbeck, in a recent paper on the Swedish welfare state, refers to Sweden as a country in a mini-transition (Lindbeck 1998). He maintains that the scope as well as the size of the state should be reduced, and most importantly, that the role of the state should be redefined; this is similar to what needs to be done in Hungary. In that sense, one can say that, if Sweden is in transition, Hungary's transition is decidedly not complete, as the reform of the welfare state is still on the agenda. My view, however, is that the reform of the welfare state is part of the ongoing transformation process and that there still are various institutions in need of change in Hungary. Welfare reform is part of the transformation taking place in the postsocialist economies. As the problems in these economies are in some sense similar to those in other countries, from Western Europe through North America to India and China, my suggestions apply to many of the controversies occurring wherever the need for reforming the welfare system is in the forefront of interest.

POINT OF DEPARTURE: PRINCIPLES

Reforming the welfare state is on the political agenda all over the world. For example, there is an ongoing debate over the social security system in the United States. The scope of this paper, however, is limited to the issue of reforming the welfare state in postcommunist countries; that is, the countries that before 1990 were dominated by the Communist Party and operated according to the principles of the communist system, and that are now going through the transformation pro-

cess. Hungary, my native country, is my main example, but many of my observations and recommendations could be applied to other post-communist countries as well.

Some clarification is needed in terminology. The term *welfare program* means something different in the United States than in many other parts of the world, including Europe. In the United States, *welfare* means social assistance to a certain group of people, particularly people in need. I use the term *welfare state* in a much broader sense; it includes state provision of old-age income ("social security" in U.S. parlance),¹ governmental participation in health provision, support for families, children and mothers, the poor, and also the financing of education. All of these belong under the general term *welfare state activities*, on which this paper focuses in general. In addition, specific attention will be given to reform of the health sector.

A typical point of departure for discussions on welfare reform is the financial soundness of the welfare sector. For example, the first argument when discussing social security in America is that the system is not fiscally sustainable. Other arguments are that the tax burden related to the welfare state is too high and that the welfare sector is not efficient and weakens the incentives for saving. These are all economic issues. There are also political considerations. What would the population accept? What is politically feasible?

Economic and political considerations are extremely important. Nevertheless, reforming the welfare sector has a direct impact on people's lives: how citizens relate to the state, how one relates to fellow citizens, and the nature of citizens' responsibility for their own lives. Here, one has to turn to political philosophy and ethics. Such inquiry is not common for economists, even for those who make policy recommendations.

The usual approach is that economists develop propositions that are consistent with economic principles, and then it is the politicians' duty to implement these ideas. Looking into the philosophical and political ramifications of these propositions is regarded as the job of philosophers and political scientists. In response to that approach, I would distinguish two situations: doing positive economic research and thinking about normative questions in order to formulate policy recommendations. When observing the facts and drawing conclusions and generalizations in order to explain various phenomena, ethical

principles can be brushed aside. I would say that 80 percent of my research work has been in positive economics, and in these studies I do not discuss my ethical convictions.

It is quite a different social role, however, if one steps out from the position of an observer and analyst and takes on the responsibility of submitting policy recommendations to the government or to the public. In doing so, the ethical principles behind the suggestions cannot be ignored. There are two tactics economists apply to establish such principles. Many make some tacit or implicit ethical assumptions, leaving them disguised or hidden, so that they are revealed only by careful reading. Others declare openly the ethical principles behind their recommendations.

I am in favor of the latter tactic. There is certainly no consensus about the selection of principles, but being explicit makes one think about them. In the case of some technical issues, one can be technocratic and neutral, but I do not believe that you can make policy recommendations on matters such as welfare state reform without adhering to some basic ethical principles.

I will discuss three of the principles that underly my recommendations.² Principle 1 is respect for individual sovereignty. The individual should be his or her own master and must have the right to choose; however, these rights are coupled with an obligation to take responsibility for one's own life. For an American, that seems an almost self-evident principle, but it is much less trivial, for example, in a Scandinavian country, and even less so in a communist country. The communist system was characterized by a lack of respect for individual sovereignty and by strong limitations on choice; at the same time, the individual was relieved of responsibility for his own life. The state said, "You just work and consume what we give you, and we will care for you and tell you what to do." It was the paternalistic state in its extreme, fully patronizing the individual. Great respect of individual sovereignty represents a radical departure from the ingrained beliefs and attitudes that prevailed under the communist system. The paternalistic features of the system should be reduced, as should the state's intervention in the life of the individual.

Principle 2 is the moral obligation of solidarity. One has an ethical duty to assist his or her fellow citizen if that individual is in trouble or in need of help. This idea can be illustrated by several aspects of wel-

fare state activities, such as pensions or social assistance. I will use the health sector as an example. The solidarity principle requires that one cannot be indifferent to what is happening to the health of others. One cannot indifferently watch while another human being is suffering because of an inability to pay for health services.

As an application of solidarity, I formulate a special principle for the health sector, something like a corollary to Principle 2. Equal access to basic health care is a fundamental human right. Two adjectives require some comment. One is "equal." I am not egalitarian in my ethical value system: a strict and consistently egalitarian distribution of income and wealth would be incompatible with Principle 1, as it contradicts the right to individual choice and individual autonomy. However, health deserves special treatment because it is a matter of life and death. People can die if they do not get sufficient health care. Nobel prize-winning economist James Tobin coined the term *specific egalitarianism* regarding basic needs (Tobin 1970). While rejecting egalitarian principles in general, I am ready to accept specific egalitarian principles concerning health.

The second important adjective in my corollary is "basic." I do not suggest equal access to *all* health services; rather, I require only equal access to *basic* health services. I will elaborate upon this concept subsequently, but at this point I only want to emphasize that the corollary implies equal access for everyone to a minimum package.

Principle 1 and Principle 2 are conflicting, and this conflict can be very serious. Therefore, the art of politics is to find an appropriate compromise between these two principles. To do that, certain procedures and institutions are needed, leading to Principle 3, the commitment to democracy and to the transparency of public decision-making processes. Here I will not take positions about whether the total financing that goes to the health sector in, for example, Hungary or Bulgaria or Russia is too much or too little. My concern is not whether health care is overfinanced or underfinanced, which is the main issue in health controversies in Eastern Europe. My question is, who has the right to decide what is too much and what is too little, or more exactly, what institutions and procedures should decide on the magnitude of expenditures on health care.

The answer is not easy, because the players—such as the government, the lawmakers, the doctors, various associations of doctors, cen-

tralized insurance institutions, decentralized insurance companies, hospitals, the patient, the taxpayer, trade unions, and employers' associations—have partly common, partly conflicting interests. However, establishing the right procedures and institutions enables the players to decide both the revenues and expenditures of the health sector. My recommendation is to design or to let evolve institutions that will then make these decisions.

INITIAL CONDITIONS

The initial conditions of reform are complex and I will discuss only two. In Eastern Europe and in the republics of the former Soviet Union, there are universal entitlements. These entitlements generally apply to the welfare sector, and especially to health care. A citizen is entitled by the constitution to free medical service. This entitlement is built into his expectations, and his behavior is based on these expectations. Thus, any reduction in the state's responsibility is perceived as a deprivation, a loss of acquired rights. There are many legal problems and constitutional compromises involved in the reform of such a system.

The initial conditions for the reform differ from country to country, so the reformer's approach should vary as well. In the United States, for example, universal health care is not an acquired right. Even China has abandoned the system of universal entitlements. In rural China, where the majority of the Chinese population lives, state commitments ceased with the collapse of the commune system, and health care has been to a very large extent commercialized and turned over to the market. But for Eastern Europe, entitlements are still part of the law, and most medical services are still provided free of charge.

Another condition that must be taken into account is a deep dissatisfaction of the population with health care. People are not terribly grateful for the fact that medical service is free because they take this for granted, but they are very angry if the quality of medical service is poor. They compare it to the standards of countries like Austria, Germany, or France. Today, Eastern Europeans travel widely; they have relatives in other countries, and so they have clear notions of the qual-

ity of health service in Western Europe. They find it unfair that living in Hungary, or in Bulgaria or Romania, means that one does not get the same health care that a German or a Belgian would get.

There is a rather clear relationship between GDP and the share of health expenditure in GDP, and it is also established that this share grows as GDP grows. Richer nations spend a larger part of their GDP on health. One can draw a regression line based on data from countries around the world to show this relationship and see that Hungary is above the regression line (World Bank 1993). In an earlier paper (Kornai 1997a), I call Hungary a premature welfare state, because its spending on welfare activities far exceeds what is justified by its level of development. In the 1980s, for example, Hungary was much less advanced than the Scandinavian countries, but the Hungarian ratio of welfare expenditures to GDP reached that of Scandinavia.

Nevertheless, Hungarians were and are dissatisfied. They do not accept the idea that Hungary's GDP is smaller than that of more developed countries and that therefore health expenditures should be smaller, too. They feel, quite understandably, that a suffering Hungarian deserves the same treatment as a suffering Austrian or German. So, while there is free allocation of health services, and total health spending is proportional to the resources, people are not happy. This situation is partly due to the illusion that health care is free: individuals are not aware of the fact that it is they, not the state, who pays for it.

What can be done under these circumstances? In a recent book, I outline my recommendations for reform of the health care system in Hungary.³ I will present a few ideas from this proposal, which will be organized in two sections. First, I will discuss the demand side, that is, the financing of the health sector; then I will turn to the supply side, the delivery of health care.

THE FINANCING OF HEALTH CARE

First, let us consider the financing of the *minimum basic package*. If we accept the principle that every citizen should have equal access to basic health provision, the guarantor must be the state. There are sev-

eral possible institutional arrangements; I will consider two, which I will designate A and B.

In arrangement A, the state determines by law a basic package of health insurance that is mandatory (such as the required insurance for automobiles, which can be exceeded by voluntary insurance). Citizens may buy this package in a decentralized insurance market. They are free to choose the insurance company, but they must buy the coverage. If certain people are unable to afford it, the state steps in and pays their mandatory insurance, in accord with the solidarity principle. Those who want to do so can buy additional health insurance, as is consistent with the principle of individual sovereignty. If one is ready to pay more, he or she can buy better health service.

In arrangement B, centralized financing for basic health service is retained, resulting in a kind of national health service (sometimes called a single-payer system) based on taxation. Basic health care is financed by the state budget. This system does not exclude the provision of health service on a voluntary basis, which can be provided in a decentralized fashion.

Arrangement A allows for more freedom of choice and more respect for sovereign decisions, while it ensures, through application of the solidarity principle, equal access to all, including the poor. It also has certain disadvantages, such as higher transaction costs. In addition to these factors, the time sequence of reforms must be considered.

I recommend a two-phase reform process. The first step should be the introduction of arrangement B, because it builds on the initial conditions. That achieved, a gradual move to arrangement A, the more decentralized approach, could follow, provided there is sufficient popular support for such a move. The main reason for suggesting this incremental strategy is that I oppose any suggestion that would create an institutional vacuum. Private insurance policies offered by insurance companies, the institutional framework for decentralized private health insurance, appropriate legal regulation, and well-functioning supervisory authorities still do not exist in the field of health care. One cannot have trust in something one does not know. Consequently, people do not have confidence in private insurance. Listening to a valid explanation is not enough; what really changes people's minds is practical experience.

An illustration is provided by pension reform in Hungary (an area where the Hungarian transformation is greatly ahead of that of other postsocialist countries). The first, preparatory step was the introduction of voluntary pension schemes at the beginning of the 1990s to supplement compulsory contributions paid into the central pension fund. A host of privately managed, decentralized pension funds of all sizes sprang up within a short while. These made good use of investment possibilities offered by the market, and their managers gained expertise in financial operations. Also, the funds operated under strict legal supervision. The first decentralized pension funds started to produce handsome returns for members. This evolution also provided some practical experience for the population and created confidence. Thus, when the new, more radical multipillar pension system was introduced in 1997, which shifted a significant part of compulsory contributions into private, decentralized pension funds and insurance companies, people knew what the privatization of the pension system was about.

A similar attitude is required when decentralizing health insurance: rushing ahead may create serious troubles, as, for example, in the Czech Republic (World Health Organization 1997). There, some insurance companies promised too much in order to lure people into private plans and then refused to pay for certain medical activities; the doctors went on strike because they did not get paid. That is the reason why I do not suggest an early deadline for reaching arrangement A. I recommend starting with arrangement B and progressing gradually. Experience will tell when the time has come to introduce legislation to allow a basic health care package to be bought from licensed health insurance companies that have proved to be reliable. The second phase requires experience, appropriate legislation, regulatory mechanisms, and an elaboration of the ways and means of assisting the needy. Success requires an evolutionary, gradualist approach in this context.

The next issue involves defining what I consider to be "basic." If asked, a physician would say that any reasonable medical intervention is basic. As long as an additional dollar spent on health has positive marginal utility, a doctor is inclined to call it basic. Yet, there is no country in the world, not even the richest, that could increase medical expenditures to the level where the marginal utility of one additional dollar is zero. If tomorrow the United States were to spend three times as much as it does now (13–14 percent of GDP), a doctor could still

certainly propose one more activity, operation, screening, or preventative method that would contribute to the improvement of health. It is very difficult for doctors to acknowledge the facts of scarcity and ultimate resource constraints.

Let us confine the discussion at this point to arrangement B, that is, financing the provision of basic health care out of tax revenues. There are two genuinely effective constraints. The first involves how much a country can afford to spend on basic health care at its level of development. The second concerns how much the community is willing to pay for this particular expenditure, that is, for the provision of basic health care for all citizens. This decision is not a medical one in the domain of public finance. It must go through the constitutional channel of political decision making, and thus it should be determined by the legislature.

Lawmakers, of course, need support from their constituencies. They can get support in this case only if ordinary citizens have a better understanding of the relationship between state spending and taxes. Let me repeat that Hungarians think health care is free, and they find it unsatisfactory. They are not aware that they pay for it in many ways, including taxes and various compulsory co-payments. Dissatisfaction makes them ask for greater health expenditures without understanding that this commitment requires more revenues and thus higher taxes. Their discontent is created by deception and is futile. Consequently, I advocate more transparency in financing matters.

There are several practical ways to make financing more transparent. My example is Hungary, but some other Central and Eastern European countries with similar institutional conditions have the same problems.

1. In Europe—not only in Hungary but in many Western European countries—the term social *insurance* is often used. In the Hungarian case, I think this usage is wrong and deceiving. What the employer and employee pay for the services provided by social insurance is far from being an insurance premium; it is first of all a redistributive tax. In the case of a true insurance policy bought and sold on the market, an equal premium is paid by the rich and the poor customer alike for the identical policy sold by the same insurance company. In con-

trast, in the so-called social insurance programs, people with higher incomes contribute more.

2. It is disturbing and confusing that the health tax, or contribution as it is now called, is split into two parts, one paid by the employer and the other by the employee. In fact, both parts are components of the total wage bill, the total compensation for work. The situation would be different if employers could choose from different levels of health contributions, including the zero option. In Hungary, however, the contribution paid by employers is calculated according to uniform and mandatory rates. The system would be much more understandable, without putting any additional tax burden on people, if salaries were summed so as to include the employer's contribution for health insurance and then, out of this gross amount, the contribution were deducted as a tax. That would make it clear to employees how much they pay for the health service. Tax withholding should be the responsibility of employers as part of their managerial and accounting obligation. The present "employer's contribution," with the employer paying the employee's insurance, is deceptive.
3. The introduction of an earmarked health care tax would also improve transparency. Empirical observations show that people are more willing to pay certain taxes if they know exactly what the taxes are being collected for (Haynes and Florestano 1994). As an advocate for specific egalitarianism, I call for a redistributive tax for health care, but one that is designated for this purpose. I am certain that people would be more willing to accept a tax that is spent on others' health than on just anything. It is clear that this only means relabeling initially, but it could help people—patient and doctor alike—to understand that the health tax they pay must cover basic health service for everyone.
4. Currently, the distribution of the tax burden is rather unfair. Taxes collected from employees pay the larger part of the revenues to the social insurance fund. There are millions of free