Hidden in an Envelope:
Gratitude Payments to Medical Doctors in Hungary[1]

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An ethnographer from a faraway land who visited Hungary these days and carried a hidden camera would notice a strange tribal custom when medical doctors and patients meet. The conversation often ends with the patient bringing out a plain envelope and handing it to the doctor with a gratified smile: "Thank you so much, Doctor, for your kind attention," the patient will say. Then the doctor makes a dismissive gesture: "No, I can't accept that." "Oh do, Doctor, I beg of you!" The exchange may, the ritual may take place silently: the patient slips the envelope onto the doctor's desk surreptitiously continue for a while longer, but in the end, the physician pockets the envelope after all. Alternatively, but to a place where it will soon be seen and opened when the patient has gone.

Inside the envelope, there is money, often with a line or two of thanks. The phenomenon of such payments, known in Hungarian as "gratitude money", is the subject of this study.

1. The economic significance of gratitude payments

Some Hungarian physicians conduct regular private practice, in which patients pay for the provisions in the normal way. No one would call these payments gratitude money, even if words of gratitude were spoken.

Most of Hungary's health provisions are offered by institutions in public ownership—hospitals and outpatients' clinics in most cases. The doctors working in these institutions are employed by the hospital or clinic concerned or if formally self-employed, under a contract to them that resembles employment, so that they receive an official salary for their work. Patients are entitled to free medical care by Hungarian law.[2] The expression gratitude money customarily refers to cases where the patient, more or less illegally, gives money to a state-employed doctor for a provision for which the doctor is not entitled to a direct payment, according to the regulations.[3]

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[1] This paper is a reprint of the paper I wrote for the *Festschrift* in honor of George Soros, published by CEU Press, Budapest in 2000. In writing it, I relied extensively on research into the medical gratitude system conducted by TÁRKI, an independent Hungarian social-research institute. This research was directed by the author in conjunction with Dr Géza Bognár MD and the sociologist and economist Róbert Gál. I would like to take this opportunity to express thanks to these two colleagues of mine and to István György Tóth, director of TÁRKI, for their inspiring cooperation. The numerical findings of the research are reported in the studies Bognár, Gál and Kornai (2000a and 2000b), to which I refer in the abbreviated form BGK (2000a and b, respectively).

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[2] In recent years, patients have had to contribute to the cost of certain services, but these co-payments are not great relative to the total cost.

[3] For simplicity's sake, the payments are considered in this study to come from patients, although in many

What is the economic significance of this curious type of payment? Let us look at the question first from the angle of the consumer of medical provisions, the "buyer" in this unusual market transaction.

Gratitude money can be seen as a *wage supplement*. The buyer (the patient) makes a voluntary contribution to the wages that the seller (the hospital or outpatients' clinic) pays to the doctor, thereby raising that employee's total earnings. This concept of gratitude money points to the resemblance it bears to the tips given to waiters, hotel porters or taxi drivers. Employers in such trades calculate in advance that their employees will receive regular tips in addition to wages and set their wages accordingly.

Gratitude money can be seen as a *bribe*. The idea of bribery may remind many Western readers of the scandalous occasions when private firms pay huge sums to civil servants or politicians in return for a fat contract or order. The advantage that the buyer gains here is more paltry: a little extra attention, a move up the queue, a shorter period of waiting, a better bed in a crowded hospital, or simply receiving treatment from a chosen doctor instead of the one assigned.

Now let us look at gratitude money from the "seller's" side. The phenomenon of *rent-seeking* is well known in economics.[4] Typically, providing some service is contingent on a state permit, which makes it scarcer than it would be under balanced market conditions. Those in possession of a permit have a chance of adding a rent to the price they collect from those availing themselves of the service. Ultimately, this rent goes to the bureaucrat who issues the permit or to the provider, or it is shared between them. A good example would be an immediate referral for hospital treatment, with a bed in a single room. The gratitude payment made for the referral to a single hospital room can be classed as a rent pocketed by the treating physician or his or her superior, the senior physician in charge of the ward, or shared between them.

The same example suggests another interpretation as well. The patient is paying an extra fee for immediate referral to a bed in a single hospital room. However, the payment is not going to the owner of the bed, the publicly-owned hospital, but to the doctor, the owner's employee. This *"black" rent* resembles the "black taxis" found in the socialist economy. The drivers of cars belonging to state offices would "taxi" private passengers, but the passenger would pay the driver not the state for the use of state property.

These four interpretations of gratitude money are closely allied. One type of phenomenon can shade into or coincide with another. They certainly have one important feature in common: gratitude payments are earnings that are concealed. The recipients avoid paying tax and other compulsory deductions (such as social-insurance contributions) on them. The secrecy may apply not only to those who receive the gratitude payments, but to those who make them, who are ashamed to be seeking advantages in such a way. Concealment is also encouraged because the transaction is illegal, although it is not an offence punished in practice. Neither has anyone ever been prosecuted for accepting gratitude money or the associated tax evasion. Since the law is not applied in this area, perhaps it would be more appropriate to describe such transactions as semi-legal.

2. The extent of gratitude payments

Since gratitude payments are concealed transactions, there are obviously no accurate statistics about their incidence or volume, based on direct observation. Nonetheless, there are ways of

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cases they may be made by a relative on the patient's behalf.

[4] See Buchanan et al. (1980), Krueger (1974) and Tullock (1967).

gaining a numerical picture of the gratitude-money syndrome. As mentioned in Note 1, the author was involved in designing a broad survey taken in 1998 by TÁRKI, in which two samples were asked for information about gratitude payments in a detailed oral interview. One sample of about 1400 persons represented the adult Hungarian population, while the other, of about 1000 persons, represented the medical profession. This empirical research is the main source to which the following refers.

The extent of gratitude payments is shown in *Table 1*. The sample of the public was asked whether it is customary to pay gratitude money for 14 medical acts taken as examples. The majority of the respondents answered in the affirmative for eight of the 14 acts. Even for a simple injection, every third patient makes a gratitude payment.

It is worth noting that the incidence data estimated by doctors are lower than the estimates by the public. Respondents were asked, "How many patients out of ten give gratitude money to an obstetrician, in your opinion?" The average of the responses from the public was 9.2 and of those from the medical sample 8.5. The difference was greatest in the case of a district pediatrician: 6.5 according to the public and 4.6 according to the medical sample[5] (BGK 2000b, Table 4 on p. 301). The doctors were also asked what percentage of certain types of doctors accept gratitude money. The averages of the responses were 94.4 per cent for obstetricians and gynecologists, and 89.9 per cent for surgeons. The lowest percentage was 78.5 per cent for psychiatrists (BGK 2000b, Table 6 on p. 305).

An attempt was made to arrive at a numerical estimate of the proportion of Hungarian doctors' total earnings that gratitude payments represent. Here just the result is given. Taking net official income (after the deduction of tax and compulsory contributions) and gratitude money together to equal 100, only 38 per cent consists of official income and 62 per cent of gratitude money (BGK 2000b, p. 312).

The gratitude-money phenomenon is not confined to Hungary. According to expert opinion, semi-legal payments to doctors are widespread in Romania and Poland as well, and it seems likely that they are made in other post-socialist countries as well. Research in Poland found that the gratitude money paid in 1994 about equalled the amount that doctors were receiving in official net income (Berman 1998). This is an extremely high proportion, although it is still less than has been found in Hungary. Without any national pride, it can be said that the gratitude-money syndrome, as a sickness of the health-care system, occurs to the most serious extent and exhibits the most acute symptoms in Hungary. The conclusions in the rest of the study are based throughout on the experiences in Hungary.

3. The motives behind the spread of gratitude payments

The rather pompous expression *paraszolvencia*, now a synonym for gratitude money current among Hungarian doctors, dates back to the period before the Second World War. However, *paraszolvencia* at that time had a different meaning from the one it acquired later. Senior doctors would put an appreciable proportion of the indeed high fees they received from private practice into what was known as a petty-cash fund. This they distributed from time to time among the subordinate doctors and assistance working for them. It was a redistribution of fees from *private* medical provision. It differed from the gratitude money of the socialist

[5] We were careful not to put the question to the doctors in the form, "How often do you personally receive gratitude money and how much?" We were afraid that medical respondents would decline to answer and lose their confidence in us. Instead, we asked, "In your opinion, how often on average do doctors (or doctors in a specific field) receive gratitude money and how much?"

and post-socialist periods in having no connection with free provision funded out of the public purse.[6]

Gratitude payments in today's sense began to spread when the provision and financing of health care were completely nationalized after the introduction of the socialist economic system. In the initial, Stalinist period, when the dictatorship was at its most brutal and repressive, greater risks attached to making, and still more receiving illegal payments, which kept gratitude money within relatively narrow bounds.

The phenomenon of gratitude money really began to flourish in the Kádárite period of "soft" dictatorship. What induced patients to resort, voluntarily, to a procedure that was unpleasant and costly for them?

The Kádár period brought some loosening of the command economy and attempts to introduce "market-socialist" ideas into industry, agriculture and commerce. The same did not apply to the health system, where the system of bureaucratic allocation remained unchanged. Patients who submitted themselves to the rules did not have any real choices. Administrative regulations decided which doctor they consulted when they were ill: the "district physician" for their place of residence. That doctor prescribed the treatment or referred them on to a specialist or a hospital. There they were passed from hand to hand in a similar way, and in each case the patients had to submit. Gratitude payments alleviated their defenselessness to some extent: it bought them a little freedom. It could influence which doctor treated them, how attentively they were nursed, what tests were done on them, and so on. In a distorted way, it slipped a little of the market into a realm of bureaucratic constraints.

The doctors' motives were similar. The centralized command economy strictly controlled wages in every branch of the economy, including the health system. The supply and demand for highly qualified work had little effect on relative wages, since the centralized command economy also disabled the labor market. Wages in health care were set according to the importance that the central decision-makers attached to its activity, compared with other sectors. Medical work, like most intellectual activity, received little financial reward, so that doctors' pay hardly exceeded the average pay for employees. However, doctors could soar above that depressed standard of living through the gratitude money they were given.

Through this concealed market, patients and doctors, as buyers and sellers, became accomplices in breaking the regulations of the state. Unauthorized transactions took place and the flows of money were concealed from the tax authorities.

Of course, the financial and health authorities were not stupid. They knew very well that gratitude payments were being made, but they tolerated this happening over a wide area. They saw it as a cheaper solution than raising doctors' official pay. Furthermore, there was a political gain to be made. It reduced the tensions in society to some extent. Perhaps citizens would grumble less if they felt they could purchase a little privilege with their money. So the state leadership connived with those who cheated the state, in what became a general characteristic of society in the Kádár period.

The same kind of connivance with those who infringed the rules allowed semi-legal, concealed, informal economic transactions to develop in every sector of the economy, as the "second economy" or "shadow economy".[7] Gratitude money is the specific manifestation of the informal economy found in the health sector.

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[6] See Ádám (1986), p. 57. This book gives an excellent account of the history of gratitude payments in Hungary.

[7] This behaviour is known in English-speaking countries as moonlighting.

The most important works about the second economy in the Kádár period are Gábor (1979), Gábor and Galasi (1985), Ékes (1993) and Dallago (1992). The latest studies of the hidden economy in post-socialist

The Kádár period ended in 1989, when the change of system began. This covered the political sphere, where a one-party system gave way to a multi-party system and dictatorship to democratic government based on free parliamentary elections. Within a few years, the change of system had extended to the narrowly defined business sphere (industry, agriculture, transport, commerce etc.) as well, as private ownership and market coordination became dominant. Despite all these changes, the phenomenon of gratitude payments obstinately survived and perhaps even expanded, appearing in even more perverse forms than it had before the change of system.

The survival of gratitude money is connected with the fact that the health sector belatedly began to undergo in the 1990s a process of reform of the kind that the business sphere of the economy had undergone in the Kádár period.[8] The changes display a strong ambiguity: bureaucratic and market coordination, and public and private ownership, combine in a sometimes healthy and sometimes distorted way. Gratitude money fits into this ambiguous environment.

To take one form as an example, many more doctors have a legal private practice these days, while remaining as full-time employees of the state health organization. Many of them keep up a private clinic for the purpose, in their homes or elsewhere. A patient calling at a doctor's private clinic is given a preliminary examination, or may simply have a conversation with the doctor. The patient is charged for this private provision. Then the sequence of events becomes more problematic, legally and economically. The same doctor goes on to treat the same patient in the state hospital where he or she works, as his "own" patient, but of course on state premises, using state equipment. The doctor does not pay any fee to the state for using its capital assets or for the work done for the patient by colleagues and subordinates. How can the payment this patient has made to the doctor be classified? Nominally, it is nothing other than the market price of a private provision. In fact, much of it is a tacit form of gratitude money, for "extra attention" to a favored patient, given by a doctor in state employ. All four explanations of gratitude money given in Section 1 apply here. The inclusion of a private practice, or the fact that the patient pays the money openly in the private clinic instead of tucking it into the doctor's pocket in the hospital corridor, makes the transaction easier. Whatever kind of inspection is attempted, it is legally impossible to say where the regular market price of a provision ends and the gratitude money begins.

4. The economic consequences

Gratitude money has several harmful effects from the economic point of view.

The incentive effect. Patients, in their own way, are giving the doctor a financial incentive. They hope this will encourage the doctor to give them privileged treatment. However, the chance of the incentive being effective is not great, for several reasons.

The doctor is bound by professional standards. These preclude making the care given to patients dependent on the size of a gratitude payment. One of the questions put to the physicians in the survey was, "What percentage of doctors, in your opinion, do their duty only

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Hungary are Mária Rédei Keszthelyi *et. al.* (1999) and Havasi and Schumann (1999).

Turning to the size of the post-socialist informal economy, several authors have tried to give a comparative quantitative estimate for several countries. The most reliable results have come from the investigation by Mária Lackó (1999). These suggest that the output of the informal, officially unrecorded economy in 1997 added 25.5% to the officially recorded GDP in 1997. Another quantitative comparison is described in a study by Friedman *et al.* (1999).

[8] For more detail, see the author's book on the Eastern European health-care reform (Kornai and Egglestone, 2000).

for the money?" The average of the responses was 9.1 per cent (BGK 2000b, Table 9 on p. 306).[9]

There is confusion about what the customary "price" in gratitude money is for various medical actions. According to the survey, only about a third of patients have previous information about what it is customary to pay (BGK 2000b, Table 15 on p. 316). That is one of the drawbacks of a quasi-market transaction, which does not take place under transparent circumstances. The patient may have "underpaid" and the doctor be disappointed, or he or she may have "overpaid", so that the same incentive effect could have been obtained at less financial sacrifice.

According to Walrasian theory, a process of groping *(tâtonnement)* takes place on a normal market—repeated collisions between supply and demand prices lead ultimately to an equilibrium price that harmonizes supply and demand. On the kind of concealed market in which gratitude payments are made, the lack of transparency means that the process fails to converge on an equilibrium price. Instead, the "buyers" bid each other up, sending the price higher and higher. Once the price has risen, a new patient immediately feels called upon to give what the others usually do. Ultimately, the price can only go up and never down.

Furthermore, gratitude money is not the only incentive force in this distorted coordination mechanism. At least as weighty a consideration is the patient's connections with the medical network, power position and prestige, the extent to which a doctor can expect reciprocal favors from the patient or the patient's circle, even the degree to which the patient is to be feared. The doctors' views on this are shown in *Table 2*. The two incentives (gratitude money and connections) work together, which in itself means it is problematic to decide what role to ascribe to gratitude money in this complex of effects.

Patients are unable to judge what contribution various people make to their treatment. According to *Table 3*, the size of the gratitude payment tends to depend on the "assertiveness" and the grade of the doctor, rather than the actual performance or the degree of experience. The bluntness of gratitude money as an instrument is also apparent in its uneven distribution between medical fields. The most gratitude money goes to those whose contribution is most felt by the patient: the obstetrician at childbirth or the surgeon directing to the operation. Yet the correctness of the diagnosis may depend largely on how conscientiously those working in the laboratory or on the X-ray or other diagnostic appliances do their tasks. The lives of patients undergoing surgery are not only in the hands of surgeons, but of their assistants and the anesthetists.[10] Nonetheless, the latter fall outside the sphere of gratitude payments. Gratitude money, which is based on superficial impressions, makes an extremely clumsy means of giving incentives.

The distributive effect. Another damaging economic effect of gratitude payments is an added distortion introduced into a distribution of income and expenditure that already contains many injustices. Many poor or even destitute patients feel they have to give gratitude money. The gratitude "price" of a child birth averages HUF 19,000–23,000 (BGK 2000b, Table 10 on p. 307), while the net monthly average earnings by employees in the survey year was HUF 45,162 (KSH 1999, p. 93). This is an enormous burden on a lower-income family.

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[9] In 1998, the Central Statistical Office asked a representative population sample of 2500 to what extent they agreed with the following statement: "There are circumstances in which tips have to be given, like it or not." There was complete agreement by 59.6% of the respondents and strong rejection by 9.5%. The rest agreed with the statement to some extent (Havasi and Schumann, 1999, p. 953).

[10] Interestingly, anaesthetists in the United States are among the best paid medical professions, while in Hungary, they are paid no more than the average for doctors and receive no gratitude money.

The survey does not support the optimistic supposition that wealthier patients are more likely to make gratitude payments than poorer ones. In a regression analysis explaining the frequency and incidence of gratitude payments, the variable representing income did not prove significant (BGK 2000a, p. 25).

Health-care expenditures impinge on people's lives unexpectedly and unpredictably. A patient may pass from being healthy to being seriously ill in a matter of moments. This certainly places a great financial burden on the patient and the family, especially if the patient pursues paid activity that has to be suspended or reduced for a longer or shorter time. As a consequence, medical care is among the classic fields of insurance, both as social insurance covering large groups of the public and as private, commercial insurance. Gratitude payments fall outside the sphere of institutional insurance. The extremely large, unexpected costs of an illness cannot be turned into a regularly paid premium of a supportable size. Individuals or families are obliged to make gratitude payments when the illness has already placed them in a worse financial situation.

5. The disruptive moral effect

Many doctors are aware of how unfairly the costs of illness become distributed among patients through the system of gratitude money. The survey showed that more than half of doctors consider case by case whether to accept a gratitude payment (BGK 2000b, Table 9 on op. 306). One criterion is the patient's financial situation, although the doctor too may be in need of the money. Doctors may accept gratitude money from wealthier patients, but not from poorer ones. It is good to know that many doctors score well on this moral test. But what sort of system is it that sets a test of this kind to its doctors, day after day? Along with the difficulties of making professional decisions, they have to deal with many psychologically demanding ethical problems in any case, when they weigh risks and face the many dilemmas to do with prolonging life and the quality of life. How can it be permissible to burden them also with problems of assessing their patients' financial means and promoting an equitable distribution of income?

The mechanism of gratitude money spreads moral disruption, whose effects become more harmful as the phenomenon spreads and becomes more deeply rooted. It institutionalizes falsehood. The official rhetoric, under the socialist system and in the self-promotion of the "social market economy", states that citizens have a right to free health care, while everyone knows that most patients are taking gratitude money out of their pockets and putting it in a plain envelope for the doctor. The rhetoric states that everyone shall have equal access to health-care provisions, while everyone knows that people are trying to buy themselves unequal access more favorable to themselves.

The survey sought to probe into the judgement of gratitude money, among the public and among the medical profession. Nine strong statements were formulated. Respondents were asked to express a view each, using a four-point scale: 1 for complete agreement, 2 for stronger agreement than disagreement, 3 for stronger disagreement than agreement, and 4 for complete disagreement. The distribution of the responses, which appears in *Table 4*, reflects plainly the moral discomfiture. In the bottom row, only 37 per cent of the public and only 29 per cent of the doctors were prepared to admit that there is a moral problem involved here. The others dismissed the idea. The strong statement that accepting gratitude money is morally reprehensible is accepted by only a tenth of the doctors. Indeed only a third of the public identify with it wholly or partly.

Karl Popper (1962) contrasted the “closed” and the “open” types of society, giving several criteria for distinguishing them. Although it does not feature on Popper’s list of distinguishing marks, there might be arguments for including “openness” in the sense of transparency. The gratitude-money phenomenon is alien to a truly “open society”. It riddles the society with hidden, secret relations. It is impossible to fathom, under these circumstances, what the relationship between doctor and patient is. Is the doctor serving the patient as an agent of the caring state? Or the doctor and the patient accomplices in cheating the state? Does the seller stand in a money-goods relation to the buyer?

What is the relationship of the patient who makes a gratitude payment to the other patients? Is it one of solidarity, or are the secretive envelopes intended to ensure that he or she can cut in before the others?

Contemporary sociology and economics pay great attention to the problem of social confidence. The weaker it becomes, the more needful it is to govern personal interactions by legal prescriptions and economic incentives. Gratitude money undermines social confidence, day after day. *Table 4* shows that more than a third of respondents sense this confidence-destroying effect.

6. Why is the system of gratitude money so firmly rooted?

The gratitude-money phenomenon is economically and morally damaging. So why does it survive so obstinately?

The answer according to the first approach is that society has fallen into a trap. Economists are aware of many states of equilibrium that are sub-optimal or even expressly harmful to the long-term interests of most of those involved, but maintain a kind of balance among the interactive participants. A harmful equilibrium may be stable, so that it recovers from slight oscillations. The gratitude-money syndrome seems to be one of these. There are strong vested interests in retaining it.

Before analyzing these conserving forces, it is worth considering what structure the health system would have if there were no gratitude money. Rather than taking an abstract system, let us look at three structures that function without it (OECD 1993 and 1994, Saltman and Figueras 1997, Fuchs 1996, and Newhouse 1996). One is Britain, which has a strongly centralized, nationalized system, in which the state pays the National Health Service doctors respectable salaries out of taxpayers’ money. They do not receive gratitude payments. Another is Germany, where the core of the health sector is provided by a social-insurance system grounded on traditions dating back to Bismarck. There is periodic wage bargaining between the medical associations and the health-care funds, leading to agreement on medical pay. This turns out to be three or four times average earnings, not 1.3–1.5 times as in Eastern Europe. There is no gratitude money. Finally, there is the United States’ system, where most of the financing comes through decentralized, private insurers. This market form provides doctors with high earnings, as open, commercial income. There is no system of gratitude payments.

This study is not intended to take sides on the question of which example or combination of these examples Hungary might follow. What is common to all three structures is their *transparency*. If the health sector is financed out of taxation, taxpayers can see how much they are taxed and on what legal basis. If there is a market-based structure in which the financing comes from insurance premiums, the insured can see what premium they will have to pay for what cover.

It would be naive to expect Hungarian society to stand up and sing in unison, like the cast of the *Hair*, "Let the sun shine in!" Far from it. There are strong vested interests in maintaining the opaqueness. Many prefer a situation in which they can conceal from others the advantages they have gained.

The medical profession is divided, for some are receiving a lot of the gratitude money and some little or none at all. Let us assume that gratitude payments are abolished in a way that provides enough compensation to maintain *average* medical earnings. Even then there would be winners and losers, and the distribution would depend on the extent to which the compensation was proportionate to the official salaries so far. The gains and losses would be widely dispersed. Furthermore, many of the probable losers who receive large amounts of gratitude money at present would be among those in the main positions of power and influence, although the two spheres would not entirely coincide.

The medical profession is not only divided, but ambivalent on the question of eliminating gratitude money. On the one hand, there are doctors, even among those who win by the present arrangements, who find the system problematic and demeaning. According to Table 4, the vast majority of doctors share this feeling. On the other hand, even doctors who initially shrank from accepting gratitude money have built these payments into their household earnings and could not do without them. They have calmed their consciences over the moral objections by arguing, in the words of one of the statements featuring in Table 4, "Until the state pays doctors properly, doctors can justifiably accept gratitude money." The survey showed that 82 per cent of doctors fully or partly identified with this view and that two-thirds of the public accepted it more or less.

That leads to the other group with an interest: the general public, the actual or potential patients. People regard the gratitude-payment mechanism as a burden, but at least they know it to some extent. They feel (rightly or in some illusory sense) that this is an expenditure over which they have direct control. Many people see the connection with a doctor they have built by paying him gratitude money as an important investment, since it makes it possible for them to continue to rely on him.

A sizeable proportion of the population is averse to change, because the alternatives to the present system are not clear. Will people have to make higher taxes and health contributions so that doctors can legally receive higher pay? Will this extra deduction be voted for in Parliament? Or would the public be willing to take out voluntary private insurance to finance the higher earnings of doctors? In another survey taken by TÁRKI, people were asked if they would be willing to take out auxiliary, private medical insurance. The response was affirmative from 48.7 per cent of the respondents (unconditionally, or with certain conditions attached), while 41.6 per cent clearly rejected the idea.[11] The second group may well be large enough to block any change.

The question of change would depend primarily on the political sphere. The progress and specific outcome of the reform does not depend on rational arguments. It depends on the "political economy" of the process and the power relations among political parties, parliamentary blocs and political pressure groups and lobbies. It is precisely the politicians who appear to be shrinking from the transparent solutions. It is easy to talk of the need for health reform in general terms, when addressing political rallies or parliamentary debates. The phrase has never been absent from the arsenal of slogans among government or opposition parties. It is another matter to know which party will dare to address the matter outright and when, saying who is to pay for a radical increase in the *legal* pay of doctors and how. For that

[11] This research was headed by the author and István György Tóth. For the numerical findings, see Janky and Tóth (1999). The proportions quoted in the text appear on p. 64 of the report.

is ultimately the question. Gratitude money cannot be abolished with the stroke of a pen, by passing a law or issuing a directive. The concealed, semi-legal gratitude payments have to be *replaced* by extra legal, taxable earnings. Ultimately, politicians will have to decide how and when the trade-off should be. Is there to be a drastic rise in the social-insurance contributions for health care? Should some other kinds of tax be raised and the extra revenue diverted to raising the pay of doctors employed in publicly owned institutions? Should more be spent for this purpose from existing revenues, while reducing other types of expenditure?

No one in Hungarian public life has yet made a clear, numerical proposal. The government parties have not made a commitment and the opposition parties have not promised to do anything specific if they come to power.

If the political sphere does not prepare to replace gratitude money by fiscal means, there is no other way left than to legalize the market transactions. A way has to be found to finance the increase in legal medical pay through private insurance under commercial conditions. This will not only have to be permitted, it will have to be admitted to the public that the change will increase the inequality of access to health provisions. It will not be possible to take this course while blandly talking of equal access and stirring up feeling against the market and the profit motive.

The political moves required to replace gratitude money are certainly unpleasant ones. For the time being, politicians prefer the twilight zone in which gratitude payments remain, in which mutually inconsistent statements, promises and arguments can coexist.

If the distorted gratitude-money system had never emerged in Hungary and other Eastern European countries in the first place, it would now be easier to arrive without it at a more favorable combination of public and private ownership, and bureaucratic and market coordination. As people say ironically, it would have been better to have started from somewhere else. However, that is the initial situation. The habits and the economic and moral consequences of the gratitude-money system have penetrated deep into every participant in the Hungarian health system.

I cannot make a forecast, only outline a scenario. Perhaps the strongest hope is that the private sector will spread on the supply side of the health service. Private enterprise, by its nature, adjusts to the situation on the labor market, and so it will offer steadily higher wages to its employees than the public sector has. To be able to finance this, it will press for the appearance of private insurers and impartial treatment for all sectors from the social-insurance system. In other words, it will insist that the social-insurance system be willing to finance all providers on equal terms, irrespective of whether they are publicly or privately owned. These developments will also force an increase in the legal medical pay in the public sector as well, to prevent a flight of the best doctors to the private sector. So earnings will steadily rise and gradually supplant the semi-legal gratitude money. That in turn will make alterations in the household budget, to extents that vary for different families and individuals.[12] This may take place without any great upheavals, provided the transition coincides with a general, steady rise in real incomes.

[12] If one of the main sources for the increase in medical earnings became voluntary private insurance, this would make the financial burdens on a family easier in a year when a member fell ill. However, the premiums would also have to be paid at other times, when no member happened to be ill. On the other hand, the long-term cost of private medical insurance may be greater or it may be less than the long-term cost of making gratitude payments. They will probably be greater, (i) because the extra pay, however generated, will affect all doctors, not just those receiving gratitude money, which increases the costs that private insurers have to meet, (ii) private insurers may allow cross-subsidy of the relatively sick by the relatively healthy, and (iii) private insurance will be costlier to administer than gratitude money.

This scenario fits into the Hungarian tradition of gradual transformation. It does not call for a brave stand by politicians. They will simply need to be willing to accept an organic growth of the private sector in the health-care system and provide for periodic codification of *de facto* institutional changes that have occurred. Of course the long, slow, painful period of transformation could be radically shortened by a charismatic reforming government prepared to let society out of the trap rapidly, even at the price of initial unpopularity.

However, let me repeat that this is not a forecast. It is not possible to guarantee that there will either be a slow, gradual transformation or a bold breakthrough. There are traps from which societies do not succeed in escaping for long, long periods of history.

7. Gratitude money as an emblem of the post-socialist transformation

Gratitude payments in the health sector are an important problem. Their survival or elimination affects the life of almost every Hungarian citizen. However, its significance goes beyond this, which is one reason why it is worth examining closely. It is symbolic of the remnants of a closed and opaque society' or new variants of this in Hungarian society. It represents, in an extreme and blatant form, a twilight in which public affairs are hidden from the public, personal relations are sullied, mutual confidence is undermined, the state is outwitted by collusion, moral values are impaired, and plain, honest speaking is absent.

The incidence and size of gratitude payments and the progress made with eliminating them can serve as a yardstick. They make a good proxy for where the health reform stands. More importantly still, they indicate where Hungary stands with the structural transformation and moral purging of its society and its political sphere.

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Table 1. The frequency of gratitude payments for various kinds of medical intervention, in the opinion of the public (in per cent of those who named a figure higher than zero)

Question: "*In your opinion, how much gratitude money is it customary to give for the following health-care provisions?")*	Answer
For an X-ray examination.	8
If a doctor takes the patient's blood pressure.	12
If a doctor gives an injection.	31
For radiotherapy treatment.	35
To a physiotherapist, per treatment.	48
For a routine gynecological examination at a specialist clinic.	48
For a therapeutic massage.	51
To a pediatrician who makes a house call to give a compulsory inoculations.	51
To a pediatrician or family doctor who regularly visits the patient at home.	75
For a tonsillectomy.	77
If a duty doctor makes a house call at night.	86
To a surgeon performing an appendectomy or gall-bladder surgery	87
To an obstetrician for a child birth.	92
To the head surgeon conducting a heart operation.	92

Note: For instance, figure 8 in the first row means that 92 per cent of respondents think nothing need be given for an X-ray examination and only 8 per cent that some payment should be made. The proportions ignore the "don't know" responses.
Source: BGK 2000b, Table 3 on p. 300.

Table 2. Opinions on the usefulness of gratitude money and connections (Responses as a percentage of the sample of the public)

Question: *"In your opinion, which achieves more: gratitude money or connections?"*	Answer
Gratitude money.	19
Personal connections.	41
They achieve the same.	35
Neither achieves anything.	5
Total	100

Source: BGK 2000b, Table 17 on p. 317.

Table 3. The factors influencing the size of gratitude payments, by medical specialty ("In your opinion, what decides whether a doctor receives more or less gratitude money?" The relative frequencies with which factors are cited)

Factor/Informant	Family doctor	Pediatrician	Medical specialist	Surgeon	Psychiatrist	Total
Specialty	85.3	87.6	89.1	82.9	91.6	86.8
Rank	66.1	72.6	79.3	84.9	80.4	75.6
Reputation	68.3	70.0	77.2	84.4	67.3	74.0
Length of service	19.8	24.7	28.7	27.1	14.9	23.6
Whether able to decide on referral	24.7	53.4	50.0	42.2	44.9	45.3
Assertiveness	53.3	60.3	50.4	55.3	49.5	53.0
Performance	35.3	28.8	36.9	33.2	32.7	34.6
Other responses	3.3	2.7	2.5	4.5	0.0	2.9

Note: Question put only to the doctors' sample.
Source: BGK 2000b, Table 8 on p. 306

Table 4 Opinions on medical gratitude money, among doctors and among the public

Opinion	Wholly agree	Partly agree	Wholly disagree	Partly disagree
Giving gratitude money reassures patients, because they feel they are buying extra attention.	19.4	44.2	19.5	16.9
Physicians	26.1	28.4	19.8	25.7
Public				
Gratitude money makes no difference.				
Physicians	32.0	17.6	23.7	26.7
Public	14.4	17.1	30.0	38.5
Gratitude money erodes the confidence essential in the doctor-patient relationship.	17.8	17.6	31.9	32.7
Physicians	15.1	21.7	33.2	30.1
Public				
Gratitude money is a necessary evil.				
Physicians	58.0	22.2	9.8	10.1
Public	52.3	30.1	9.2	8.4
So long as the state does not pay them properly, doctors have a right to accept gratitude money.	54.4	27.5	11.0	7.1
Physicians	39.1	28.4	17.5	15.0
Public				
It is morally reprehensible for doctors to accept gratitude money.				
Physicians	3.6	7.5	29.4	59.6
Public	16.6	17.7	33.3	32.4
Gratitude money is unpleasant and demeaning to both doctors and patients.				
Physicians	68.0	21.8	7.1	3.1
Public	30.0	32.4	22.6	15.0
The existence of gratitude money shows that society considers doctors to be underpaid.	72.6	17.5	6.7	3.2
Physicians	41.6	28.1	17.0	13.3
Public				
Gratitude money is not a moral issue.				
Physicians	42.2	29.1	18.1	10.7
Public	33.5	29.3	19.4	17.8

Note: The average values are the arithmetical means of the values obtained on a four-point scale (wholly agree=4, tend to agree= 3, tend not to agree=2, wholly disagree=1).
Source: BGK 2000b, Table 1 on p. 295.