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Foundations in the Health Care Sector

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This paper grew out of the analysis of the data of a survey which the Szonda Ipsos Média-, Közvélemény- és Piackutató Intézet (Szonda Ipsos Media, Public Opinion, and Market Research Institute) carried out in spring 1997. The survey was run on a sample of 300 out of the almost 1,500 registered Hungarian health care foundations which were selected proportionally in accordance with their territorial distribution. A questionnaire was sent to all the selected organisations. This questionnaire was interested above all, beyond the foundations' organisational embedding, in their daily activities and in a number of fundamental social characteristics of their decision-making bodies, their personnel, and the beneficiaries of their services. In addition, we endeavoured to obtain a picture of the 'accessibility', decision-making and support mechanisms, and the main features of the financial administration of the foundations. In the course of data processing, it turned out that the results of the survey in many respects point toward some socio-economic problems far beyond the sphere of foundations strictly speaking: they substantially enrich our understanding of the ongoing health care institutional reform in general. This enlarged interpretative potential of the data calls, before we present the main results of the survey, for a brief summary of the most important conclusions of the current debate concerning the transformation of the institutional system in Hungarian health care, and also of the role allotted to non-profit organisations by the adherents of different standpoints. This short overview will later on make it possible for us to

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examine what, from the plans put down on paper, has become reality and what not.

Views on Health Care Reform

Discussions have been ongoing concerning how to implement the changes necessary to the health care system for the last ten years. In approximately 1988–89—after the lively skirmishes of previous years—the medical profession , the health care administration, and the general public reached an 'overall consensus' about the state of affairs: 'traditional' health care was in crisis, and in the interests of the more efficient operation of the health care system, its thoroughgoing transformation was required. Besides the registering of a consensus concerning the fact of the 'crisis', significant differences of opinion remained concerning its precipitating causes and, especially, possible reform solutions. One set of sharply delineated views considered the crisis to be fundamentally *economic and financial in origin*. As a consequence, its adherents took up the cudgels in favour of reform based upon multi-sector ownership, institutional-level financial responsibility, and administrative freedom, as well as dynamic foreign capital investment; as far as accessibility was concerned, however, they insisted on a strengthening of the traditional insurance elements. Others saw the principal causes of the crisis in the *distorted institutional structure* of the health care system, for example, its strongly *hospital-centred* composition. Adherents of this viewpoint expected from the reform process above all development of formerly neglected and underfinanced institutional areas, in the first place the strengthening of the system of general

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practice and of certain out-patient services. This emphasis was reinforced by the decision-making influence of the professional organisations and the institutional associations. Further critics pointed out as the main problem the extremely *uneven development* of health care services. According to their reasoning, in the Hungarian health care system provisions classifiable under organic medicine were too predominant, while huge gaps existed in psychiatric and mental health services, individual forms of alternative health care, and in the fields of prevention and rehabilitation. In respect of both professional and financial programmes, the reform plan which emerged from this evaluation of the situation put the focus on the development of weak areas, and the promotion of greater consonance between needs and supply. Finally, a fourth group of critics put the emphasis on the *chronic underdevelopment of the conditions under which health care services are provided*, and identified as a fundamental condition of internal systemic reform a significantly increased emphasis on the health care sector within the national economy.

All of these commentators on the crisis had something to say about non-profit organisations. The adherents of the first standpoint expected from them, on the one hand, an increase in supply competition within the health care service, while, on the other hand, they expected that, with the appearance of new market-oriented actors, the precarious state of health care finances would be relieved. Critics of the stresses afflicting the institutional system focused their attention primarily upon the appearance of civil interest representation in previously neglected areas and hoped for an increase in their bargaining powers. Those who promised a widening of choice in the health care system took as

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their point of departure the notion that the new non-profit services, as flexible and receptive professional entities, would be suitable for the testing out or extension of new medical–professional ideas which had previously been difficult to introduce. Finally, adherents of the fourth standpoint hoped to obtain from the non-profit format in the first place an improvement of the situation of institutions, the strengthening of the position of the health care system within the public sphere, and more generous budgetary provisions for health care.

In the wake of these four sets of expectations, we can in theory trace four different paths of development for non-profit institutions in the health care sector. And although the debate has still not been concluded, these expectations began to be accompanied almost immediately by strong reservations. Meanwhile, the non-profit sector began to establish a presence in health care: according to the Central Statistical Office, in 1995, 1,419 registered health care foundations were operating in Hungary. Beyond the fact of their registration, however, we still know little about why, besides the expectations mentioned above, they were really established, the needs of what kinds of professional and social groups they satisfy, and what form of operation keeps them in existence.

The Birth of the Foundations and Their Main Characteristics

It is generally known that one of the most striking phenomena observed in the years immediately after the change of system was the explosion in the number of non-profit organisations: in the most diverse areas of social and economic life, a 'founding fever' gained ground and, one after the other, foundations, associations, and professional and communal societies were established. As a

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result of the regular data-collection activities of the Central Statistical Office, we know that, in the area under consideration in the present essay, the establishment of new organisations peaked as far as foundations are concerned in 1991–92: more than 50 per cent of the 14,216 foundations registered in 1994 came into being during these two years. It is also known from the available data that most foundations have been organised for the purpose of providing or supporting cultural, educational, and social services—in the mid-1990s these three spheres of activity accounted for more than 60 per cent of registered organisations. Health care—so it appears—was not a favourite area for those starting foundations: the 1,265 foundations with a health care profile accounted for 9 per cent of all Hungarian foundations in 1994. The most recent data, however, indicate that we should be cautious before we offer this as a final description of the situation. Things are changing rapidly, and the direction of the change indicates that we are by no means at the end of what we have already called the 'feverish' establishment of health care foundations. From the Central Statistical Office's latest non-profit survey, summarising the situation in 1995, we know that in the course of a single year the number of active foundations rose from 1,265 to 1,419, that is, a rise of 12 per cent in the number of foundations operating in one health care branch or another, while with regard to the sector as a whole there are signs of stabilisation. In respect of the health care sector, therefore, to be more precise we should perhaps talk about delay, gradualness, and caution, rather than about a lack of interest in the sector—looking at the situation after six or seven years, it seems that longer than

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average was required for the slow solution of problems and the acceptance of these foundations as feasible and useful service-providing institutions.

Although for the most part formal and legal considerations are responsible for the fact that only private persons participate in the establishment of individual foundations, or their birth is assisted—fully or partially—by one public health care institution or another , nevertheless, it is to a certain extent surprising that more than two-thirds of health care foundations were brought into being exclusively by civil actors (private persons, entrepreneurs, other foundations, or associations formed by people outside the health care sector). The foundations which they established, however, can scarcely be considered as new, independent organisations: the decisive majority of them are in reality primarily in the service of some 'traditional' health care institution. Our survey indicates that the benefits of these *civil* establishments are enjoyed by two main actors: on the one hand, the 'most traditional' area of medicine, the care of in-patients; on the other hand, alternative medicine, operating in medicine's newest areas—natural remedies, lifestyle, dietary, and psychological guidance beyond the bounds of what doctors have tended to provide in the past, and the ever more fashionable plastic surgery. The almost exclusive beneficiary of *health care institutions and associations* is hospital health care provision: apart from sporadic exceptions, each of the foundations called into being by them was launched for the solution of one or another currently apparently insoluble in-patient problem. What is perhaps more unexpected is that the list of forms of activity supported by the third large circle of founders, *local councils and state institutions* (schools, orphanages), is also headed by the hospitals, and on their

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list of priorities the various public health and health development promoting organisations come only second. All of this means that among those setting up foundations, there is more or less complete agreement: if they want something 'real'—whether it be the general health protection of children or the development of medical treatments demanding the most complex medical intervention—they must seek their backing in the field of in-patient care, in other words, in the segment of the health care system still best able to preserve its institutional stability and high professional standards. The new organisations are growing, not in spite of the old large forms of provision, but under their protective wing.

The fact that health care foundations have still only partly separated from state health-care-providing institutions means, from another point of view, that—independently of the nature of their activities and their 'final user'—every second foundation has some organisation belonging to the 'old' health care system or particular programmes as the beneficiary of its labours. The proportion of those foundations providing exclusively personal services (that is, of those which deal only with activities in prevention or cure) proved to be 39 per cent in our survey. A further 12 per cent of the foundations listed both support for institutions and service-provision for individuals as parts of their orientation.

If ~~we consider~~ a more detailed breakdown of data on the actual activities of the foundations, we can give the above-indicated broad self-classifications more precise content. That is, two-fifths of foundations regard as their main profile the improvement of health care work in traditional institutions, health care

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directed towards certain special groups of illnesses (cancer, illnesses of the heart and the vascular system), and material support for research and the providing of equipment directly related to better medical treatment. Looked at in another way, this means that most health care foundations were called into being not with the intention of reforming the system, but as a result of experience gained over the years of state underfunding and the bad infrastructural provision of health care. If doctors and health care institutions want to prevent an otherwise unavoidable lowering of standards, they must take action, the outcome of which is a new form of service provision on the part of foundations, which does not regard the traditional institutions (above all the hospitals) as 'hiding places' or as 'incubators', but instead has as its main aim the bolstering of precisely these traditional forms and classical medical activities.

In terms of frequency-distribution, this group is followed by that circle of foundations whose bringing into being was motivated primarily by a desire to break away from traditional structures. The organisations belonging to this group see as their main aim the provision of medical and health care services in areas neglected by 'classical' health care. The common characteristic of these areas is that the medical care is inseparable from consideration of the clients' social circumstances, which must be given equal weight with their medical problems as strictly defined. Because of their markedly social orientation, I label what amounts to a little over 25 per cent of all health care foundations as 'health care–social' in orientation, while those belonging to the first and preponderant group can be labelled 'traditional medical treatment providing'

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institutions. The next largest group of health care foundations can be described as 'promoting the interests of the medical profession'.

The aim of the third type of organisation ('promoting the interests of the medical profession') is the preservation of high standard medical care through its key-agent, the doctors. They were brought into being in order to support the further training of doctors, corresponding exchange of working methods with colleagues abroad, and necessary health care research, which, although not directly related to medical care, is necessary for improving the standards of Hungarian medical science. These foundations—which represent 18 per cent of all health care foundations—were brought into being in recognition of the, in the short term, barely remediable dysfunctioning of traditional health care (above all, its serious operational deficiencies and the constant resort to financial 'fire-fighting'). While the client circle of the organisations belonging to the 'health care–social' group is recruited mainly from external actors, the foundations established for the sake of 'promoting the interests of the medical profession' build 'inwards'—at the centre of their interests and activities stands the medical profession.

Besides these three sharply distinguishable types, 'mixed' profile foundations account for around 17 per cent of health care foundations. The activities of such foundations are deliberately diversified. Of their two subgroups, the first (which for the sake of brevity we shall henceforth call the subgroup aimed at 'increasing the presence of traditional forms of medical care'), stands very close to the 'traditional medical treatment providing' group of foundations, but puts greater emphasis than the latter on the treatment of hitherto neglected illnesses,

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while doing more to introduce prevention services into classical medical care and to promote their acceptance within the walls of traditional institutions.

The foundations oriented towards 'the combination of research and social protection', the second subgroup of multi-pillared organisations, also endeavour to promote the treatment and prevention of illnesses on the periphery of classical medicine, but by another route, that of scientific research. In pursuit of this aim they are prepared to enter into open competition with representatives of the 'classical' areas of medical science.

From our survey, it appears that, in the opinion of those who provide the funds necessary for their daily operations, there are two clearly distinguishable groups of tasks to be performed—and which are therefore worth financing—by the health care foundations. One consists of the amelioration of the chronic deficiencies of 'traditional' health care, the reduction of its failures, and the improved coverage of areas it has hitherto neglected—in respect of which above all the state and the general public, and their institutions enjoy priority. The second involves ensuring that the modernisation of Hungarian health care is not brought to a halt—which is a legitimate aim above all in the eyes of foreign donors and the new domestic actors of the modernisation process, capital-rich entrepreneurs and banks.

As far as forms of support are concerned, our data show that the health care foundations' continuous operations are built mainly upon the acquisition of various monetary donations (since establishment, 85 per cent of them have received some kind of monetary support), although in most cases (56 per cent of organisations) their material resources are supplemented by various

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contributions in kind, services, and/or voluntary work. Of course, whether a foundation is able to utilise different forms of support apart from money depends partly on its operational profile: voluntary help can clearly be more effectively used in respect of consultation or in the exercising of physically handicapped children than in medical research work or in evaluating experimental data. And the situation is similar in respect of contributions in kind in the form of either services or goods. These profile-dependent characteristics can also explain why the proportion of foundations which receive only monetary support is highest (88–100 per cent) in the three foundation-types which pursue the most classical medical aims, while in making good use of voluntary work—even under conditions of no complementary financial support at all—the two social foundation-types were the most adept.

The forint value of the support received is of course very variable: the order of magnitude varies between a few thousand and several hundred million forints. As may be seen in Table 2 in the Appendix, in 1996 donors gave, on average, around 4.5 million forints to health care foundations, but this average figure masks a considerable spread. The foundations 'promoting the interests of the medical profession' can enjoy around double this sum (average donations of 8.2 million forints), while those organisations which have oriented themselves toward the least accepted combination of activities by attempting to integrate new areas of medicine in traditional health care can expect only one-tenth of it (on average 550 thousand forints). The donors' rather diverse priorities may be clearly seen in the size of the sums received from them by the different foundation-types. The public donates a great deal for the solution of social–

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health care tasks, but very little for the, in the short term, less visible and more intensive aims to which the foundations 'promoting the interests of the medical profession' attach their flag. State actors above all urge the improvement of traditional health care—even if more budgetary resources are not made available they endeavour, by means of sums awarded on a tender basis to foundations established in their sphere and one-off donations of support, to slow down the further exhaustion and lowering of standards in state hospitals and surgeries. The 'results-orientation' and modernising bent of market actors, however, clearly entails that their significant, multi-million-forint support will go above all to the 'research-oriented–experimenting' foundations 'promoting the interests of the medical profession', although—if with more modest sums—they are also to be found among those which finance the organisations established in the bosom of the large health care institutions, above all those involved in the acquisition of technical equipment.

We can measure the social acceptance and surprisingly rapid institutionalisation of the health care foundations not only in terms of their sponsors, but also in terms of the variety and extent of the areas supported by them. Taking as a basis a single year, 1996, 60 per cent of them offered monetary or contribution-in-kind support, and some kind of service to other organisations or private persons. The 'league table' of beneficiaries is headed by the general public (private persons received support from 38 per cent of health care foundations in 1996), followed by state institutions (28 per cent), then other non-profit organisations (14 per cent of health care foundations supported or provided services for them). The proportion of foundations which provide

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donations or services to private market actors is insignificant: a total of only 2 per cent. The health care foundations are much more target-oriented in respect of the provision of donations and services than in their acquisition: diverse kinds of actors are offered support very rarely—such foundations (which are otherwise the sphere's most capital-rich organisations) account for 5 per cent of the total. In their service-providing-donating orientation—to a certain extent contrary to what we would expect—foundation-groups brought into being for different reasons show considerable uniformity: 30–48 per cent of their beneficiaries are private persons, and—partly overlapping with them—30–42 per cent are state institutions. The fact that in the 'output' of the health care foundations the grants and services offered to the general public and to state institutions represent such an overwhelming proportion indicates the new foundations' basic common function: however diverse their philosophies may be, however diverse the concrete tasks for which they were brought into being, they agree on the fact that their primary task today is to check the dangerous lowering of standards of 'traditional' health care and to promote better health care provision for the general public.

Decision-Making Mechanisms

The appearance of foundations in the health care system—as in other areas—has resulted in the fact that a set of relations which was formerly characterised by informality has been brought to the surface and has been diverted onto more regulated paths. This is an important development in itself, which, whatever happens, brings with it a diminution of the importance of the patriarchal

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subordination–superordination so characteristic of organisational relations in Hungarian society—although particularly in the health care system—in recent decades. Although hierarchical relationships have by no means disappeared, the space in which they operate and their exclusivity are certainly being narrowed by the appearance alongside them and the institutionalisation of contractual relations grounded upon new principles and specified agreements, and the equality of the partners. The question now is whether, alongside the more formalised system of contacts *between* foundations, the internal operations of foundations and the relationships they have built up with those seeking their services have been put onto a more institutionalised track.

In this area our data point to the existence of a disordered situation. Although substantive steps have been taken in the direction of institutionalisation, a great deal of power is still being exerted to keep the new organisations running along the tracks of traditions taken over from the 'old' health care system.

This is bolstered above all by the conspicuous absence of transparent regulations. As already mentioned, around 60 per cent of health care foundations offer some form of support or service to 'external' actors. Looking at the matter more closely, however, it turns out that around 6–8 per cent of them have at most done this only occasionally since they came into being: on the basis of their typical operations they should rather be classified as 'self-consumers'. As a result, of barely half of health care foundations is it worth our while asking the question: If and when they provide support, in accordance with what principles and distribution mechanisms do they do so? The answer to this question suggested by the data is that these mechanisms are invariably governed

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by personal considerations. Half of the foundations which provide support more or less regularly decide whether to accept or reject applications, dispensing with all formalities, on the basis of existing relations and anticipated reciprocity. Putting out to tender is very rare: among the 300 foundations ~~questioned~~ investigated, only one in seven had ever advertised in respect of targeted support or a programme to be financed by them.

The distinctive mark of tradition can also be discerned in the adjudication system. In total, 27 per cent of foundations had established some clear rules to regulate their decision-making procedure; a further 10 per cent of them only examined whether an application meets certain formal criteria; while only 10 per cent make their decisions in a transparent fashion. Although they more or less regularly award support, this is always done on an *ad hoc* basis, governed primarily by personal inclination. It is surprising—and again an indication of the power and general validity of their practised routines and old habits—that the health care foundations barely differ, in accordance with their profile, in respect of their procedures. Whether we look at their social–health care programmes which target the general public or at their desire to improve institutional conditions, there is a general lack of ~~worked out~~ elaborated application and decision-making mechanisms providing access to 'outsiders'. The picture is at best modulated by size of capital: the richer and larger a foundation is, the more likely it is to utilise some kind of controllable tender-application and distribution system in the disbursement of its support.

The personal 'intimacy' which pervades the functioning of these foundations above all provides security. And although it may be that the circle of those who

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are aware even of the existence of particular foundations is quite narrow—as a result, their disappearance or bankruptcy also goes unnoticed—nevertheless, the safety yielded by these 'cushioned' relationships appears substantially greater and more manageable than the impersonal and incomparably wider radius characteristic of advertising in the press. The decisive majority of foundations make no effort to place advertisements in the various local and/or national press organs, and in this way to make their existence known. So it appears that, in their own eyes, the majority of foundations are still not strong or stable enough, nor sufficiently experienced to advertise, as 'true' entrepreneurs, their formation and services. They were brought into being not with a big programme of expansion in mind, but with a view to self-protection. In keeping with this programme of self-protection, however, is the fact that those who know about them and who require their services learn about their existence through personal channels.

Given the extent to which the personal element permeates everything, it is scarcely surprising that we hear about the support activities of health care foundations only in very rare cases: in total, only 9 per cent of them had ever published in the press a list of those supported by them. 'Outward going' monetary expenditure, grants, and services are not viewed as true *foundation-type allocations*, but as necessary contributions to the activities of one or another 'known' organisation, hospital, patients' club, or self-help group which the foundation in question regards as important and legitimate. As a result, it is surprisingly rare—in total, in only one-third of cases—that the uses to which support is put are investigated. The aims—once they are accepted—are taken to

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speak for themselves, and, given the deficiencies and constraints which bisect the health care system from top to bottom, the view is that support is almost impossible to 'squander'.

On this basis, it is not surprising that, although the foundations without exception meet the legal stipulation that boards of trustees be established for decision-making purposes, these boards of trustees usually have nothing to make a decision about. If 'outward going' support is rare, and if there are no clarified principles, auditing routines, and rendering of accounts, then the function of these respectable bodies can scarcely be to guarantee democratic decision-making. We must seek their role elsewhere: less in the regulation of distribution and support than in the protection of the foundation's very existence. This protection is, however, twofold: on the one hand, relations which help to secure the position of the foundation, and on the other hand, the provision of the money needed for primary operations and survival. As far as the first sphere of action is concerned, everything seems to indicate that the members of boards of trustees see themselves above all as high-ranking 'diplomats': who, other than the members of the board of trustees, could 'link up' the foundation with the mother-hospital, and have access to local mayors, know 'important' people, and appear sufficiently important to other people? It therefore rests with them to cultivate the necessary connections, to create the external 'image' of the new organisation, and to have its usefulness accepted and its security guaranteed. Because of this, the putting together of a board of trustees requires careful work. And the more 'specialised' the organisation, the more important it is for it to be accepted and safely 'bedded down' in its

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environment, and the more indispensable it is that substantial financial resources be acquired for its operations.

The question is, in light of this, what kinds of factors should a circumspect 'personnel policy' take into account?

Our survey data show that the older health care foundations see national acceptance as a guarantee of their protection: they expect to obtain this above all from the male members of their boards of trustees who occupy important state positions. In contrast, new foundations established in the last two years have followed a different policy: above all, they see as their task the protection of the interests of those in the profession and the effective organisation of one or another service.

Our data show that extremely diverse strategies are employed for elections to boards of trustees. There are particularly marked differences in relation to an organisation's profile of activities. As may be seen in Table 3 in the Appendix, the foundations set up to protect the interests of the medical profession are very much 'masculine' organisations—more precisely, organisations of male doctors. The closedness of the profession is in nothing else so apparent as it is in the efforts of the doctors' 'own' foundations to defend the esteem of the profession by means of high-level research, regular study-trips abroad, and exchange of working methods. These aims sit very well with the fact that not only representatives of the medical profession , but also nationally famous and very influential personalities are most prevalent in the organisations in this group. Similarly, primarily men—and among them above all doctors—wish to protect traditional medicine: they are in the majority in around three-quarters of the

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foundations in this group. Since these foundations are more closely linked than any others to the recipient hospital or surgery—most were brought into being in order to supplement funding, and they define their role as keeping traditional health care on its feet—in addition to the presence on boards of trustees of hospital directors and head doctors, it is important for them to win over influential members of local and county councils, and of national professional bodies. Members of the two subgroups of 'mixed' foundations can certainly find themselves in a difficult position when they have to think about the 'most effective' composition of a board of trustees. The data suggest that they try to found the 'personnel' strategies of these multi-profile organisations on a number of pillars. The socially-oriented group puts much stress on the presence on boards of trustees of local and national 'potentates'; at the same time, the two 'classical' medical foundation-groups are more open to women, those without a university degree, and persons from outside the medical profession. The foundations 'aiming at strengthening the position of traditional medical care' are more concerned than anyone else that members of their boards of trustees have a higher education, though they also consider it important to invite nationally well-known and influential people, while they are fairly open to women and to participants from outside the medical profession. Finally, the 'health care–social foundations' peripheral status in the medical world means that of all the organisations this is the group in which boards of trustees with a majority of health care professionals are most rare and female dominance is most frequent.

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Looking at these markedly divergent 'personnel policies' from the point of view of their function and 'meaning', data analysis shows that there is no general recipe for a good strategy: one type of board of trustees is required if the main aim is to increase financial resources, and another if the principal requirement is to ensure the material assets and working conditions of everyday operations. And although we might think that with an increase in the size of the board of trustees—that is, with the election of board members capable of providing various resources, goods, and funds—benefits will also increase, the situation is not so simple. The size of the board of trustees does not have a direct effect on either the amount of available support or on the formation of everyday operational conditions. It is the board's opinion-makers—in accordance with their social position—who really influence the course of events.

The amount of obtainable financial support is influenced above all by three factors: men, those with a higher education, and the density of the board representation of local leaders. If the latter consider the foundation as 'theirs', as one might expect, they do a lot for it: expansion of their influence can mean funding increases of millions of forints. The dominance on a board of trustees of local leaders and well-known persons is important in respect not only of money, but also of infrastructural provision. As the data in Table 4 in the Appendix show, for the basic operations of new independent organisations this is a more significant consideration than any other. Finally, a strategy markedly different to the election to the board of trustees of a local leader is required if the foundation's services are expressly labour-intensive, and if, for the provision of the necessary workers, it is vitally important that a significant part of their

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activities are carried out by voluntary workers. Such foundations are effective if women are in the majority on their governing body, particularly women recruited from the middle ranks of the health care system.

Facts and Suppositions: Has the Effectiveness of Health Care Increased?

To our initial question concerning whether, with the appearance of foundations, the health care system has been improved, the available facts do not allow us to give an unambiguous answer. Taking the four directions of reform outlined in the introduction in turn, we can briefly sum up as follows:

In respect of administrative 'rationality' it is certainly a positive outcome that the previous informal 'background economy' of the health care system has been brought out into the open, with its own independent organisational framework and 'face'. At the same time, organisational separation is disordered and just getting started—the majority of new foundations 'suck in' a great deal from the recipient institutions for the sake of their existence and operations, while supporting them with many assets, services, and a significant part of their financial resources. Through administrative symbiosis, however, it is not possible to know in more detail 'what and how much?' in respect of individual institutions—in this way the essential conditions of rational economic behaviour (above all the unambiguous accounting of assets and expenditure) cannot be further realised.

The development of healthy competition has been genuinely helped by the alternative job opportunities provided by the foundations. Although those working in the health care services of the foundations for the time being are

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only rather loosely linked to the new organisations, nevertheless, by means of the foundations, alternative mobility paths are opening up before them. This opening up will probably stimulate the operations even of the traditional institutions—because sooner or later the new institutions will become their true professional rivals. At the same time, the complex intertwining of old and new organisations has a retarding effect, as a consequence of which their mutual defencelessness still appears more dominant than the competition between them.

The appearance of foundations has done little to protect the interests of workers in the health care system, or so it would seem. The proliferation of new organisations has resulted rather in the weakening of common interest representation than in its strengthening. At the same time, the diffusion of foundations has probably done a lot for the protection of the interests of individuals—above all through the more varied opportunities available in terms of mobility paths and employment.

Finally, it is also difficult to form a clear view of whether the spread of foundations has brought more resources into the health care system. Taking into account only raw figures, the answer is of course simple: the around 9–10 billion forints which have come to the new institutions represent a clear surplus to the sector. However, as it turned out: the actual mobilisation of these financial resources relies on a complicated and opaque system of mutual funding (‘reciprocity’), and on the effective exploitation of the buildings, infrastructure, and services of ‘old’ institutions by the internally emerging ‘new’ foundations. From the viewpoint of the organisations in question, comparison of

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'pluses' and 'minuses' is almost impossible. The picture is clearer in relation to personal incomes: through the increase in work opportunities, the foundations provide significant surplus-incomes to ever widening circles of doctors and other health care professionals.

The true gain, however, cannot be measured in money, although its 'resource value' is significant. The gain in question is the modernisation potential which, despite all their dissimilarities and developments, and their embryonic condition, the foundations have created in the course of the last few years. Being more flexible and more mobile than their 'older' colleagues, they have promoted the appearance of new treatment and service sectors, the accumulation of significant modern professional knowledge, the introduction of modern equipment, and the creation of openings in the administration and organisation of the health care system which 'yesterday' were still closed and rigid. And although the full utilisation of this modernisation potential is still hampered by many factors, nevertheless, we must say that the emergence of health care foundations constitutes one of the most important preconditions of the transformation of Hungarian health care.

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Appendix

Table 1 *Foundations Established before 1995 and a Breakdown of Health Care Foundations by Year of Registration (%)*

Year of registration	Total foundations*	Health care foundations
before 1990	2.8	7.7
1990	10.3	9.2
1991	30.4	21.8
1992	24.8	23.0
1993	15.3	19.9
1994	16.4	18.4
Total	100.0	100.0

* Total number of foundations in Hungary on the basis of the Central Statistical Office's 1994 non-profit survey (KSH [Central Statistical Office], *Nonprofit szervezetek Magyarországon, 1994* [Non-profit organisations in Hungary, 1994], Budapest, 1996).
Note: Even in 1995–96 the 'establishment fever' did not diminish: according to our survey, a further 14 per cent of health care foundations operating today came into being in the last two years.

Table 2 *The Average Value of Support Obtained by Differently-Profiled Health Care Foundations in 1996 ('000 HUF)*

Type of Foundation Supported						
Provider of support	**'promoting the interests of the medical profession'**	**'traditional medical care'**	**"health care–social**	**'social–research'**	**'increasing the presence of traditional forms of medical care'**	**Average**
General public	62	114	558	115	231	219
State actor	45	1 902	529	863	87	1 526
Market actor	1 763	1 378	561	449	132	1 089
Hungarian/ foreign non-profit	6 314	220	2 810	328	104	1 678
Total	8 184	3 614	4 458	1 755	554	4 512

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Table 3 *Some Characteristics of the Boards of Trustees of Health Care Foundations by the Foundation's Range of Activities*

The percentage of foundations on whose board of trustees					
Groups by activities	**men are in the majority**	**the proportion of those with a university degree is at least two-thirds**	**the proportion of local leading personalities is at least 25%**	**the proportion of nationally known personalities is at least 40%**	**the proportion of health care professionals is at least two-thirds**
'promoting the interests of the medical profession'	70	77	12	33	81
'traditional medical care'	73	75	28	25	63
'health care–social'	45	67	20	22	20
'social–research'	62	65	27	27	42
'increasing the presence of traditional forms of medical care'	50	94	12	25	38

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Average	62	73	21	24	48

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Table 4 *Effect of the Composition of the Board of Trustees on a Number of Operational Conditions of Foundations*

Compositional characteristics of the board of trustees	***Annual average financial support ('000 HUF)***	***Percentage of those which are well equipped****	***Number of working hours completed by voluntary workers each month***
Women in the majority	931	13	189
Men in the majority	6 694	16	64
Proportion of those with university degrees less than two-thirds	880	16	127
Proportion of those with university degrees at least two-thirds	5 892	12	102
Proportion of local leading personalities at most 25%	2 816	12	120
Proportion of local leading personalities at least 25%	11 255	23	61
Proportion of nationally known personalities at most 40%	5 395	15	114
Proportion of nationally known personalities at least 40%	2 382	15	98
Proportion of health care workers less than two-thirds	5 443	18	126
Proportion of health			

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care workers at least two-thirds	3 715	12	91

* By "well-equipped" we mean that the foundation has at least three of the following: own telephone/fax line, copy-machine, computer, or vehicle.

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Table 5 *Structure of Foundations' 1994 and Health Care Foundations' 1996 Income, by Source (%)*

Source	***Foundations****	***Health care foundations***
State support	*29.7*	*11.8*
of which: non-normative support	26.7	3.6
Private support	*33.2*	*57.7*
of which: support from companies	11.5	29.3
support from the general public	5.2	18.3
Income from basic activities	*6.5*	*2.6*
Income from economic activities	*27.4*	*20.5*
Other income	*3.2*	*7.4*
Total income	*100.0*	*100.0*
Average income of individual foundations ('000 HUF)	*6 293***	*6 617*

* All Hungarian foundations—on the basis of the Central Statistical Office's 1994 non-profit survey (Central Statistical Office, *Nonprofit Organisations in Hungary, 1994*, Budapest, 1996).

** Corrected for rises in the rate of inflation between the two surveys.

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Table 6 *Some Characteristics of the Management of the Health Care Foundations by Sphere of Activities and Size of Annual Income*

	Type of foundation by activity					***Income of the foundation in 1996***	
Characteristics	'promoting the interests of the medical profession'	'traditional medical care'	'health care–social'	'social–research'	'increasing the presence of traditional forms of medical care'**	max. 200 000 HUF	**min. 1 million HUF**
1996 total income*	15 954	3 919	7 315	2 605	779	57***	24 157
1996 total expenditure*	2 472	2 836	5 770	1 566	330	123	10 651
Income components (%):							
state support	5	8	14	15	20	11	12
private support	54	63	57	56	58	57	58
profits	30	22	16	16	15	24	21
Expenditure components (%):							
personnel	12	14	10	12	5	12	16
material costs (%)	15	27	30	24	37	34	23
support paid out (%)	48	31	28	29	38	19	45
Payment for one working hour of voluntary work (HUF)	162	789	296	538	23	32	1067

* '000 HUF.

** Because of the very small ? **elemszám**, and because of the inadequate publication of data particularly frequent in the group, we can use the data in this column only with considerable reservations.

*** Together with 58 organisations which had no income at all in the given year.

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