Julia Szalai:

Health and Health Care in Hungary

Many of the publications of the last five-ten years have given dramatic and convincing descriptions of trends of rapid deterioration of the state of health of the Hungarian society. Some of them argued, that dropping health standards, shortening life expectancy, e.t.c. are probably the most crucial among many other important social problems and among several serious warning signs of a deepening social crisis of our time.

A number of other writings have pointed to shocking crisis-phenomena in the circumstances and functioning of the health care system. The impoverishment of its basic mass-services, the unbearable overcrowdedness and poor facilities in nearly all of the hospitals and outpatient--clinics, the chronic shortage of required equipments for relevant medical care e.t.c. cause general dissatisfaction and increasing threat.

The question that has to be examined, whether the processes of rapid deterioration on both sides of health issues /namely on the "demand" and on the "supply" side/ are independent of each other. Or, whether disfunctions of the health service play quite a decisive role in the dramatically negative picture of worsening health standards and their social distribution.

This paper argues in line with the latter explanation. I try to justify below, that the key of the crisis in health care is in its incapability to adjust the system to the changes of health needs in the society. By its incapability, it produces an increasing gap between formal entitlement and meaningful use for efficient cure and care, creating new types of inequalities, confusion and disorder, producing by itself devilish vicious circles of downward social processes. I will argue, that the ultimate causes are rooted in basic power relations of the state socialist society. Therefore the break up of vicious circles requires radical changes in the society in a much broader sense, than just reforms of finance and regulations within "one branch of the national economy".

Some facts about health

The unstoppable deterionation of health of the Hungarian society can be prooved convincingly by a number of facts. The most unquestionable ones are the data on mortality.

As Peter Józan, a leading expert in demography puts it in one of his recent papers[x], the national average

---

x/ Peter Józan: Some Characteristics of the Health Status of the Population in Hungary in the '8o-ies; Manuscript, Budapest, 1988.

rate of mortality of the '8o-ies is below the standard of 1941. In the first two decades of the after-war period Hungary experienced a steady improve of death-rates. The turning point was around the mid-sixties, when the improvement of the yearly average first stopped, and then a gradual increase of the mortality indices has taken place. The national average of 1985 was 34,4 per cent higher, than that of 196o. That means, that the population loss of the eighties is some 45-5o.ooo more year by year, than it was 2o-25 years ago.

Another aspect of mortality is shown in Table 1. As it can be seen, the deterioration of death rates is especially rapid in case of men. The age cohorts at highest risk are those between 35 and 55. The mortality rate of the 45-5o years old men is 2o2 per cent of the relevant rate of 196o; that of the age group 4o-44 is even worse: 219 per cent.

Table 1.

Mortality rates by age and sex

Number of deaths per 1000 inhabitants in the relevant age group

Age	Year					
	196o	1965	197o	1975	198o	1985
			Male			
3o - 34	1,9	2,o	2,o	2,2	2,2	2,8
35 - 39	2,5	2,6	2,9	2,9	3,9	4,4
4o - 44	3,2	3,5	4,3	4,8	6,2	7,o
45 - 49	5,4	5,o	6,2	7,5	9,2	1o,9
5o - 54	8,9	8,6	9,3	1o,9	14,2	15,6
55 - 59	15,6	14,6	15,3	15,4	2o,9	23,1
6o - 64	24,1	24,4	26,o	26,7	3o,o	32,3
All male	1o,7	11,3	12,5	13,3	14,8	15,2
			Female			
3o - 34	1,3	1,o	o,9	o,9	1,o	1,2
35 - 39	1,8	1,5	1,4	1,4	1,7	1,9
4o - 44	2,5	2,3	2,3	2,4	2,8	2,9
45 - 49	4,o	3,5	3,6	3,9	4,4	4,4
5o - 54	5,8	5,2	5,4	6,o	6,4	6,6
55 - 59	9,o	8,7	8,5	8,6	9,8	9,9
6o - 64	15,6	14,3	14,1	14,o	15,3	14,8
All female	9,6	1o,o	1o,8	11,6	12,4	12,6

Source: Demographical Yearbooks, ~~CSO~~ CSO, Budapest

Female mortality rates have started also to increase, though with some "time lag", and with a smaller slope of unquestionable trend of deterioration. The life of women between 4o and 59 is at higher risk nowadays, than it used to be 25 years ago.

It has to be added, that the deterioration of mortality has taken place with a significant increase of inequalities among social groups.

First of all, social class differentials have to be mentioned here. The increase of male mortality-rates between 197o and 198o was produced exclusively by blue collars. During those ten years the risk of death was modestly decreasing for white collars, while its increase was sharp among workers.

Regional and territorial differences have been also increasing. Men born in Budapest in 1982 have a chance of living their life two and a half years longer, than those born in small villages in the countryside. Men living in the upper class area of the capital /2nd district/ have a mortality rate similar to the national average of West-Germany in the eighties, while those living in the slum area of the centre /7th district/ have one that equals to the relevant index of Syria.x/

x/ See Peter Józan, ibid.

Similar threatening trends can be described also in case of infant mortality. While the national average of the yearly rate has been reduced significantly between 1965 and 198o /from the index of 38,8 deaths per 1000 lively births to 23,2/, the improvement has not continued during the last years: the yearly average rate is around 2o.o nowadays. However, even the process of 15 years of improvement has not been without contradictions: the reduction of the average infant mortality rate was accompanied by a significant increase of inequalities among the lower and upper social groups, the latter gaining much, the former gaining nothing from the development. The stagnation of national improvement did not lead to a stagnation of the differentiation-process: inequalities between the social edges have not stopped to increase. /See Table 2./

Other measures of poor health can also be justified. Hungary is on the top of the European rank order in the ratio of alcoholism.

Recent morbidity surveys show a steady increase of neurosis and mental disorder among schoolchildren.

Symptoms of serious health problems caused directly by the damages of the environment /e.g. pneumonial diseases, high rate of chronic bronchitis, asthma e.t.c./ have been registered recently.

Table 2.

Infant mortality per 1000 births according to the level of schooling of the mother 1965-1985

Year	Level of schooling					
	< 8 classes	8 classes	9-12 classes	13 classes or more	Average	Ratio of inequality between the group with highes vs. lowest schooling
1965	42,5	39,3	31,6	26,9	38,8	1,6
198o	42,o	25,o	18,o	16,2	23,2	2,6
1985	38,2	21,7	17,9	12,9	2o,4	3,o

Source: Demographical Yearbooks, CSO, Budapest

The framework of the present paper does not permit to enumerate and analize all the signs and symptoms of a critical stage of the health of society. But the above facts, hopefully, indicate convincingly the gravity of the problem.

Facts and tendencies in the health care system

Let me now turn to the "supply-side", namely to the short description of the present state and constraints of the health service system. Here a brief history has to be given, to make the contradictions and vicious circles bounding the it more understandable.

Priorities and constraints

The present tensions and inner structural problems of the functioning of the Hungarian health care system remain inexplicable without taking into account the broader context of economic and social policy of the last four decades.

The establishment of a socialist society was based on two main ideological assumptions. The first was faith in the efficiency of a centralized and planned system, not only in economic, but also in social terms. The second was trust in the centralized state control of all the processes of production and distribution, resulting in a high degree of social equality. It was thought that overall direct planning, on the basis of state-ownership of the means of production, can totally substitute the regulative role of the market. The elimination of market forces

would produce a formerly unknown rate of economic growth, since the new system would avoid the 'needless wastages' stemming from the post festam adjustments of market economies. It has to be added that any type of classical social policy seemed to be unnecessary on these grounds, since faith in general wealth and equality made it unnecessary to operate any institutions of defense or correction. Instead, social policy became an in-built and inseparable part of the functioning of political, ideological and economic life. The mere declaration of rights and entitlements seemed to be an automatic guarantee for reaching the socio-political aim of equality of access and disposal.

The rapid legal extension of rights was based on the outstanding role of work. Most entitlements were defined on the basis of gainful employment in stateowned spheres of the national economy. Gainful employment was the main ground and almost the only stipulation of entitlements. It seemed selfevident that all provisions would be equally available among those employed. Therefore the basic needs of life, housing, health care, education, the partial care for children, were met by universal benefits and programs provided by the state in the form of free or highly subsidized services. Since the means and control over the processes of production, of redistribution,

and partially even of consumption, were in the same central hand, it seemed logical that guarantees over equal shares were automatically provided. That solution seemed to be the most efficient way to fight poverty, while universalism among those employed served as a great incentive for work.

At the same time, it also legitimized the relatively low level of wages and salaries. The new principles of regulating personal disposable incomes were formulated according to a new logic. In theory, incomes in cash no longer had to cover all the needs of the individual and the family, since many basic elements of consumption were now taken out of the financial sphere of the exchange of goods and money. In reality, the emerging gap between income and the national product served as the main resource for that forced accumulation of capital regarded as a prerequisite of rapid structural change in the economy. The direct connection between low wages, the entitlements of gainful employment and standard of living provided the strongest motive for accepting any kind of employment. The economic and social goal of full employment was thus not only an aim but a means of extensive industrialization, in a situation where the resources of labor intesive capital investments were poor.

It can therefore be seen, that the two basic goals of rapid growth and social quality assured by declaring universal access to state-offered benefits in kind for those employed, have involved all those contradictions and tensions, characterized by a widening gap between rights in theory and the conditions of their practical realization. Health care is not the only, though one of basic spheres, showing such contradictions.

Shortages and methods for 'substituting spendings' in health care

Services in medical care have been functioning under double pressure. On the one hand, the rapidly expanding number of those taking up employment has led to a huge rise in the rates of those entitled to receive all the services and benefits of social insurance. The rate of coverage was around 3o% in the late thirties, and increased to 56% in the fifties, reaching a rate of 9o% in the early sixties. On the other hand, the services had to meet the extended mass of previously unsatisfied needs, without requiring great resources for investment and operation. The network of the services, the material basis of cure and care,had been developed in the first three decades of

the century; it was adequate in quality and in quantity for a much smaller population. The number of hospitals was more or less in accordance with the structure and needs of the thirties, when general and massive poverty of the greater part of society was an automatic obstacle, hindering the articulation of their medical needs. The abolition of financial barriers opened the door for the previously excluded strata, and their severe needs had somehow to be met.

The double pressure of expanded needs with relatively reduced resources led to a shortage-economy in health care. The share of the whole of the state health service was and remained around 3% of the national income, while in all those countries where free universal medical care was introduced, the share had been steadily inceasing, reaching 7-12% in the seventies.

The overall and unquestionable priority given to the economy in national spending, and the double pressure on the health care system has meant a continuous adaptation to the scarcity of resources, leading to a great variety of methods of 'substitution". In other words, the priorities of the economic policy had to be accepted in all those other spheres, such as health care that were now "gift of the state". Since there have not been state-independent institutions which could fight both to reach and maintain

high standards in various fields of social policy, the "gift", so it turned out, could be reduced in size whenever necessary. State-expenditures on health, education and social security thus became and remained a residual part of the state-budget, and the priorities given to the economic sphere have remained unchanged.

Let me give some examples of the strategies have been used to meet the challenge posed by this double pressure in a situation of chronic scarcity in health care.

The main form of substitution of investments was an extensive and rapid increase of manpower. The number of doctors employed has been the most rapidly increasing element of the system, preceding in rates of expansion any other parts and factors of provision in medical care. Hungary has one of the highest ratios of medical staff to population in Europe /see Tables 3/.

Regarding the very low level of doctors' salaries, the extension of services via the rapid increase of the labor force was an economically rational strategy. It was also efficient in professional terms /though only for a short period/. Since the structure of morbidity was that of a relatively poor country the most frequent diseases were tuberculosis and different kinds of severe epidemics - both the direct consequences of under-nutrition and a very low standard of public hygiene. In consequence,

Tablw 3.

Some indicators of provision in health care

Year	Number of doctors	Rate of increase /1955=1oo/	Number of medical districts	Rate of increase /1955=1oo/	Number of daily consulting hours delivered in out--patients clinics	Rate of increase /1955=1oo/	Number of hospital beds	Rate of increase /1955=1oo/
1955	14.153	1oo	2872	1oo	17.427	1oo	64.55o	1oo
196o	15.698	111	3o76	1o7	18.996	1o9	72.351	112
1965	19.521	138	3349	117	25.618	147	79.2o1	123
197o	23.524	166	3646	127	3o.712	176	85.768	133
1975	27.o55	191	38o1	132	34.984	2o1	9o.18o	14o
198o	3o.842	218	4o5o	141	37.o71[x]	213	95.539	148
1985	33.516	237	4276	149	38.925[xx]	223	1oo.348	159

Source: The Present Situation in Health Care, 1981 /Egészségügyi helyzet, 1981/, CSO, Budapest, 1983

x/ Because of re-organization of the publication of statistical information on that type of service, the latest comparative data refer to 1979.

xx/ Estimation after adjusting the datum to the above basis, to help the relevant comparison.

the mere creation of a medical sérvice could raise standards, without requiring great investments and expensive techniques. In the long run, however, the structural discrepancy between manpower, and space and means became a bridle of relevant care.

Other methods of organization and re-definition for the substitution of investments were also used. A campaign to organize a network of services on the district level took place in the fifties. The required number of district doctors was delivered by extended university courses, while the employment of doctors was centrally directed by massive administrative regulations, hindering their free movement. Consulting rooms were constructed from what was available without requiring too much expense. Empty flats and offices were altered and "re-defined" for the new purposes.

The picture was somewhat different in the case of hospitals, though it followed the same logic. The main method of expanding their capacity was a cramming of hospital-beds into all available corners and space, including the consulting rooms of doctors. True, these transitory actions were thought to be provisional, but it gave birth to new shortages, requiring the prolongation and stabilization of an unintended second-best solution. Meanwhile, the program of building new hospitals was postponed for decades.

The number of in-patient institutions is less today than it was in the thirties, many of the small local hospitals have been closed down because of "unecomomical operation". No new buildings were established until the mid-sixties.

The cramming of beds has led to an extra overuse of hospitals. The shortage of space required by technical and medical norms for adequate cure is estimated at 500,000 m^2, i.e. 25% of existing space. Needless to say, the long-run postponement of investments in new hospitals has produced a deterioration of standards of cure, the shortage of funds has resulted in an overall scarcity of elementary equipments, and made it necessary to close additional parts of hospitals in the last decade which had become physically dangerous.

The main form of "substitution for spending" in health care was the creation of a new network of out-patient clinics. Different in form from their Western counterparts, these clinics operate separately from the in-patient institutions. The network was expanded in the sixties. The underlying rationale was to provide some kind of specialized professional medical service in a much cheaper way than in the hospitals. It is important to note that district doctors offer only a general practice, their role is to provide preventive medicine, to decide over sick-leave, to direct the patient toward the relevant specialized

service according to his/her medical needs. Because of the overburdened and overused hospitals, the latter task should have been executed by the out-patient institutions, but without the relevant background for in-patient care, they became attached to the district services rather than to the hospitals. The number of cases referred to these out-patient clinics has been increasing steadily, whilst it has not resulted in the desired relief of in-patient institutions. The striving to keep up with needs has followed the above way of development: consulting hours have been multiplied and "defined" without concomitant investments in space or equipment, leading to a high degree of overcrowding.

This general and ever-increasing shortage, and the overuse of all institutions within the system, has provoked a series of administrative regulations on the part of the health care authorities. They have tried to control the moves and to ease the situation by determining deserving and non-deserving cases. All these efforts, however, were ineffective since the real structural causes of the tensions remained untouched. The widening gap between medical needs and the means for satisfying them have concluded in a spiral of stadily growing number of visits. The 12o million cases per year, some 12-15 visits per inhabitant per year cover a great deal of unmet needs.

But the increasing overburden and the above tensions have not been the only outcome. More important is that, as a natural consequence of the constraints, any priorities given within the structure cause heavy inequalities. Shortage in itself produces and increases inequalities of access. The more powerful groups within society try to "escape" and to secure for themselves a better standard of medical care, and these processes lead to a great differentation of the quality of services. The separated hospitals and outpatient clinics of the top-bureaucracy of the state is one example. But significant regional and territorial inequalities can also be registered.

Thus the present functioning of the system and the chronic shortage of elementary material prerequisites provided a great "competition for resources" The result of the frequently hidden competition follows the lines of morbidity. Naturally, the overall shortage is not the only "responsible" factor for inequalities of access. But it increases all those inequalities that come from the systematic social differences of the standards and ways of life, and hinders the advance towards the original goals of universalism and equality of opportunity.

Here are some concrete examples.

District medical service has been defined as an element of the basic provisions that have to be available

for everybody in his/her home. In reality, the shortages of resources and available manpower have led to growing territorial inequalities even in that very elementary type of services. Some regions of the country suffer a high ratio of "empty districts", i.e. where one doctor has to render a service for some 5-6ooo people /the average rate for district doctors is 25oo inhabitants/. Needless to say, the high rate of lo% of empty districts is characteristic for the poorest parts of the country.

Another aspect of unequal access to relevant care can be measured by inequalities in spendings on basic medical services. In 1981 I was able to analyze the budgetary spendings at the local level in four counties. It was found that there were 1:2o differences in per capita annual expenditure on district services between small villages and highly industrialized large cities. In other words, the quality, the quantity and the standard of basic medical care available to various groups of society showed a high and negative flexibility of "norms".

Inequalities of access to basic medical services have been additionally increased by the side-effects of the development policy on settlements of the last decade. A new strategy was declared in 1971, which created 11 "classes" of different types of settlements each playing a different sort of role in rendering services for the inhabitants of

the surrounding area. This classification has meant a great deal of inequality in the redistribution of funds between grades within the hieararchy, and a formerly unseen rate of concentration of resources followed the administrative declarations. For example, the number of so-called "attached" villages has increased. In these, all independent local services and institutions, even agricultural firms and local district doctors have been shut down. The doctors have moved generally to the central village of the "branch of villages" under the same local administration. The inhabitants in the "attached" villages can in theory go to the center to get their basic service, but in practice they are often left without any types of care. /The doctor visits the "attached" villages every second week, and the consultations take place in unsatisfactory conditions, since the old consulting rooms have been closed down./

This administrative concentration had had the following effect on the social processes. The better-off strate have left these "dead" villages, so that the situation has become even worse: old people and the worst-off groups of unskilled, poor families are those whose medical needs are generally the highest, but for whom provision is the poorest.

Taking one example of a county with an "average" situtation regarding its indices of medical care /Zala/, of its 261 villages only 71 had a district doctor in the locality itself in 198o.

Concentration was even more intensive regarding the "mose expensive" forms of medical care, in the network of in- and out-patient clinics. The two latter types of institutions exist nowadays almost exclusively in towns and cities; the inhabitants of the villages can approach them with a prescription given by their district doctor. Considering the shortage of places and the poor conditions, the concentration of services means the practical exclusion of many groups in need. A number of resent investigations of social determinants in using various medical services have led to the parallel conclusion, that the take-up in higher grades of the health care system declines with the distance from the urban centers.

The significantly liberated and easier conditions for the movement of the doctors from one place to the other has led to a concentration of personnel. Thus, the distribution of inhabitants according to the size of the settlement and that of the doctors shows an opening scissor /Table 4/.

Table 4.

Differences of the distribution of inhabitans and doctors, according to the size of the settlement

Size of the settlement /number of inhabitants/	Number of settlements in the relevant size-group /1978/	Percentage of inhabitants in the relevant size-group /country=1oo/ /1978/	Percentage of doctors in the relevant /size-group /country=1oo/ /1978/
1ooo	15o3	6,4	o,8
1ooo-1999	799	9,8	2,6
2ooo-2999	323	7,o	2,1
3ooo-4999	253	8,8	2,7
5ooo-9999	149	9,9	4,5
1o,ooo-19,999	73	1o,o	7,2
2o,ooo-29,999	21	5,3	6,1
3o,ooo-49,999	20	8,o	1o,6
5o,ooo-99,999	19	6,5	9,1
1oo,ooo and over Budapest /capital/	1	19,6	37,9

Source: Network of Settlements, Vol.4 /Településhálózat IV/. CSO, Budapest, 198o

The relations of the social structure follow and strengthen the above described territorial inequalities of access. Those in the better socio-economic position live in places with a better infrastructure. But if not, they

are the only group that can overcome the disadvanteges of the residential hierarchy. The process of social concentration produced a multiplicating of disadvanteges on the other end of the scàle:those, who live in poorer surroundings are generally poor themselves, in terms of personal standards of living, too. And although their medical needs might generally be higher because of less opportunity for prevention and for saving their health, their access to realize them is generally much less. The outcome is a clear hierarchy of access to the higher grades of the medical care system, especially to hospitals.

Consequences and the ways to overcome them

It is obvious, that there cannot be drawn a direct equation between the state of health and the state of health care of a given society. Health care is just one of those networks of defense, that societies create to protect the life of their members. No matter, how wide or narrow is the concept of "health" in a society, it is evident, that the task of the medical care systems is to offer services in case of ill-health to stop deterioration via curing and caring those, who are sick. Other than health risks of life should be met by different systems. So, for example, protection should be offered for security of

work, environment, financial stability e.t.c., that are obvious tasks of separate systems of social policy outside health care.

But that statement does not imply, that health care has no social policy implications. Even the most professionalized and specialized way of curing, focussing its activity to one organ, inevitably affects the person as a unity with all of his relationships. Therefore social and social policy implications are always there in an overt or covert form.

So the question that can be raised is as follows: How far does the present Hungarian health care system meet its inevitable social policy tasks and implications? Does it concentrate its protection to those in greater needs? Or, all of its energies are put into the everyday fight against the inner constraints and troubles of the system itself, hindering the efforts to turn to the challenges coming from needs of the public.

The above mentioned examples of growing inequalities imply the negative answer for the question. In addition to them, I would like to quote here some results of a survey, that has been the only one until now to search the direct interrelationships between health needs and the delivery of health services.

The survey was done in a Western, quite underdeveloped county of Hungary.[x/] The fundamental tool of the research was a detailed questionnaire on life history, present life and working conditions, personal report on history of health and take-up of health care. In addition, the general practicioners reported the health status of all the respondents in a separate questionnaire. The two-way approach to measure health made it passible to analyze answers for the question raised above.

Let me quote here one set of the results, convincingly showing, that prevention and protection is concentrated on those social groups, that have more chance to defend themselves in a broader sense. While efficient help is missing or is offered just in cases of extra risk for those, who are in grater need.

x/ The survey "Life history, way of life and health" was done between 1977 and 1979. It was based on a representative sample of the adult population of Zala county. The research was directed by Ágnes Losonczi. Participating researchers were: László Antal, Péter Makara and the author of the present paper.

Table 5.

Opportunities to get to higher and more specified grades of the health care system, in case of different health needs, according to the living standard of the household and to the type of settlement

	The health status of the respondent								
	Is good			He/she had already serious health problems, that causes ill-health from time to time			Chronically ill		
	1	2	3	1	2	3	1	2	3
Poor	72	28	loo	51	49	loo	34	66	loo
Rural dwellers, living on decent level	64	36	loo	38	62	loo	31	69	loo
Well -off rural dwellers	73	27	loo	44	56	loo	33	67	loo
Urban dwellers, living on decent level	47	53	loo	13	87	loo	17	83	loo
Well-off urban dwellers	39	61	loo	25	75	loo	18	82	loo

1= No take-up or max. local G.P.

2= Take-up of specified health care

3= Together

Table 5. shows, that even better-off rural dwellers have marked disadvantages in getting to the relevant grade ot the health care system in time. Territorial differences hinder the access: One third of those chronically ill rural respondents, who had no financial problems, did not get further, than the local medical centre. /And we have seen earlier, that most of these services are very poor in their facilities and quality, being unable to cure effectively the slowly progrediating disease./ On the other hand, four fifth of urban dwellers - independently of their material capacity to "buy" extra help - have access to a greater diversity of specialized and relevant services. Therefore the chances for prevention and protection differ greatly. As a consequence, the scissor of social inequalities opens through the life history of accummulating unmet health needs on the one hand and more or less adequate cure and care on the other.

The above described disfunctions, the general disratisfaction and the rapidly increasing problems of general health standards have become issues in political discourses.

Two official proposals are on the agende nowadays.

One is argueing for introducing some selectivity to the system by marketizing its services. The basic argument is a quasi-economical one, namely, that at the present stage

the country cannot efford free of charge medical care to everybody. It should be offered only to those, who are in need. However, marketization of the services without any changes in the way, how they are produced, distributed and controlled, means only "priceing out" of great masses. It would lead just to the exclusion of remarkable social groups. True, a superficial balance of demand and supply can be created by these means. But I doubt, it could lead elsewhere than an even more rapid increase of inequalities of both, access and health standards.

Other proposals aim at changing individual life styles. The argument is, that people should give up their unhealthy behaviour, should smoke and drink less, should re-structure their consumption, should take part more intensively in sporting e.t.c. The individualization of responsibility seems to help those in power to get rid of their tasks and obligations in a true and deeply rooted re-structuring of the whole of the health care system.

Both of the proposals are short-sighted and defensive. In addition, both of them leave untouched the core of diseases of the system, i.e. its basic power-relations and all the consequences of chronic shortages and inequalities. There are no signs of real commitment to more radical changes nowadays.

The author thinks /although the detailed arguments could be presented in another paper/, that the only way out could be based on redistributing power and control in and above health care. A publicly controlled, independent social security system could be the potential fundament and general framework of a genuine reform of social policy and health care. /The two spheres cannot be separated from each other./ The crucial point here is, that the independent social security /based on an electorial procedure to arrive to a meaningful representation of various social groups/ could be the way of creating an organ of efficient social self-defense, instead of the present system serving the reproduction of a centrally organized "dictatorship over needs".