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TOWARDS TO THE MODERN PUBLIC HEALTH CARE SYSTEM IN HUNGARY (1867-1914)

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Abstract in original language
The process of the reform of the public health system was parallel with the general reform of the public administration system in Hungary. After 1875 the new policy of the government tried to reform this base, and launched a systematic codifications-work to press back the municipalities from the local public administration. The act of public health (1876) determined precisely the position of the community in the system of public administration concerning public health.

Key words in original language
Health care systém; Hungary; 1867-1914; reform of administration.

Preface

Although the final steps were made within a few years, the developing of the health-insurance system had taken several years, and the slow process brought very serious problems to solve. In the following pages we will try to expose the most important points of the apparition and transformation of the public health in Hungary between the second half of the 19th century till 1914.

Changes in the financing (1724-1875)

It is admitted that the working of the health system became more and more expensive due to the new technologies, new tools and the high costs of human work. The 19th century, which abounded in inventions in the domain of biology helping the medical sciences, forced the reform of the system of the public health as well.

In the beginning of the period the base of the financing was that everybody paid the bill for themselves, which means that the functioning of the system was maintained by the patients. But what about those who weren't able to pay, and above all in cases (mainly in disasters) which could be dangerous for the community? That is the crucial question, the base on which the system of the modern public health developed.

As it was evident, that the poorest couldn't have remained without medical treatment either, a decree of 1724 ordered that the communities should pay

the bill of the treatment of their poorest inhabitants, in case the poor didn't have any relatives, which could be obliged to pay the bill.[1] This solution equalized the costs between the inhabitants of the community. The next few steps aimed to extend this circle in a geographical way with a certain tax tool: in 1851/52 they created the so called "National Found" system[2], in which the costs of the medical treatments were to pay from a base of an additional tax, and a decree of 1855 prescribed that the medical treatment costs of the poor were to pay from the Found of the country of the Crown, in which the patient was registered. The condition of use of the "free" medical treatment was the production of the certificate of poverty. In this system those hospitals could participate which accomplished some criteria, related mainly to the capacity and the number of the possible forms of treatments. The hospitals which could admit patients not only from community could demand the payment for the poor from the Found.

After the restitution of constitutionalism in Hungary (1867), the new solution with the Act of Communities (1871) went back again to the anterior system, so the communities became responsible for their poor, including the financial responsibility for paying hospital invoices for them.[3] This law tended to give a solution for the problem of the certificate of residence, which could form a base for the free medical treatment as well. Although in the new liberal political climate the right for the free movement was evident, the admission of a poor person to the community could have had hard financial consequences in case of a long medical treatment. That was the main reason for the mainly refusing attitude of the communities towards the small people, namely that the communities tried to refuse, or at least spin out the admission when it was related with a treatment abroad.[4] To summarize the system, the row of the natural/legal persons obliged to pay for a medical treatment: 1) the patient 2) in case of poverty (with certificate drawn up by the authorities of the community) the relatives of the patient (or

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[1] *A magyar korona országainak nemzetközi egészségügye. Az egyes igazgatási tárgyak fejlődésének történetével – hivatalos adatok nyomán.* Közli DR. LINZBAUER XAV. FERENCZ, magy. kir. egyetemi orvoskari tanár. Pest, 1868, Kugler. 34. BÉKÉSY, GÉZA: *A nyilvános betegápolás szabályai*. Budapest, 1902, Országos Központi Községi Nyomda Rt. továbbá 1898/XXI. tc. általános indoklása.

[2] cs.kir. BM 1852/33.009, magy. kir. udv. kancellária 1863/3244 – MOL K150-1867-17-IV-12-3833

[3] 1871/XVIII.tc. 22§ g

[4] We have to point out, that the general rules of registration weren't clear enough, and there were several opaque points in the serial of decrees, which aimed to give a solution. The position of women, children and domestic servants remained a vexed question, and therefore the misarranged system became a standing resource of hard financial problems for the communities and hospitals as well. – to the question: FELSZEGHY, BÉLA: *A községi illetőség*, Beszterce, é.n., Csallner Károly. PETRÓK, GYULA: *Illetőség, elhagyottá nyilvánítás, közsegélyezés*. Kaposvár, 1909, Szabó Lipót ny. POMOGYI, LÁSZLÓ: *Szegényügy és községi illetőség a polgári Magyarországon.* Budapest, 2001, Osiris. VITA, EMIL: *A községi illetőség.* MJÉ, 1912. szept., 36. füzet. A községek lépéseihez példa: *Polgármesteri jelentés Karczag rendezett tanácsú város 1900. évi közigazgatási állapotáról*. Karczag, 1902, Sződi S. ny.

association, charity organization and employer) 3) the community (with right of recourse) 4) the municipality.

There remained the question of the patients treated in Austria. Till 1807, the bill of the poor hospitalized in Austria was automatically paid from the fundus confraternitatum, so from the found which was created by Joseph II. from the properties of some orders. In 1807, as the capital dwindled away, it was necessary to have a special permission for the payment. From 1810 there were the Hungarian municipalities that paid for the poor, and between 1814 and 1855 the whole system was based on mutuality, which means that every country paid for the hospitalization in its territory. From 1855 it became the state which paid for its own citizens.[5] This system was adopted by the poor decree of 1872, and got only slightly modified by the further decrees, which aimed to make the process of payment precise.[6] Concerning the other countries, the fate of the bill of medical treatment depended eventually on the existence of international treaties or conventions. Several government of the German Alliance concluded treaty to resolve the same problem, and Austria joined it in 1853. In 1867 Austria concluded a treaty with some cantons of Switzerland, and in the 60s and 90s with Italy. With France and England there was only an accord concerning mutual hospitalization of insane patients, and with the United States, Serbia, Rumania and Turkey no treaties existed.[7]

The malfunction of the financing-system

The result of this system wasn't splendid at all. The different parts of the public health system belonged mainly to the communities and municipalities, which meant that even the so called "public" hospitals worked above all with the subsidies of the owner, so the community or municipality and the income from the patients. The erroneous system of the 70s' created an unmanageable quantity of cases of contested registration. The situation was aggravated by the beginning of mass internal migration, which led to a considerable surplus in Budapest and in the developing cities of the country and to a shortage in workers and tax-payers on the confines of Hungary. Due to the ambiguity of the rules of residence and registration into the community in several cases in which the facts weren't evident, the Home Office which was competent to make a decision, made a conclusion favourable to Budapest, or to the developing community in which the poor settled to find a job.[8] The strategy of the patients was absolutely

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[5] 855/6382 (márc. 6.) cs.kir. BM

[6] BM 1872/8803, BM 1872/23.144, BM 1876/51.661, BM 1880/12.012

[7] A Budai Cs. Kir. Helytartóság 1854. évi jan. hó 14-i 537. sz. rendelete, 1897/XV. tc., LINZBAUER, 1868, GRÓSZ LIPÓT, 1869

[8] MOL K150-1653-1888-IV-23-6987

comprehensible. As Budapest had the largest capacity in medical treatment, the countryside-workers in need of hospitalization chose the capital in which they had better chances to have an adequate treatment as in their provenance. As a result, the municipalities and communities – according to the law of 1875[9] – had to pay considerable amounts of medical treatment for the workers who didn't obtain normal residence in the capital and remained pro forma registered in the provenance-community.

Shortly after the law came into force, it became clear that each part of the system was adverse party and they had a stake in not to cooperate with each other. The fundamental interest of the communities and municipalities dictated that they try to avoid the payment for the poor as far as possible: so the costs should be born by the relatives of the patient and if it wasn't possible, they tried to shift the obligation on another municipality, although it is worth to noting that in certain cases the community drew up the certificate of poverty – out of charity – even if the poor didn't accomplish all the criteria to obtain the document.[10] This situation contributed to the phenomenon of the imperfect filling of the information-sheet which caused a chaotic plight in the central administration, because all the parties – except the Home Office – were interested in the failed process of the ascertainment of state of registry, because in this case it was the state which was obliged to pay for the medical treatment of the poor. In this system it was the hospitals which could never receive their money on time, so in consequence even the policy of the owner of the institution – which aimed to spare money – caused serious financial difficulties to the hospitals.[11] Finally, even the hospitals made several mistakes in the process of admission. It occurred repeatedly that the hospitals filled in the admission-sheet only after the beginning of the medical treatment, and it resulted from this that if the state of provenance of the patient wasn't clear enough, the ambiguity could contribute to the felonious slowness of the finishing of the process.[12]

The growing administrative problems of the system of 1875, and the growing financial difficulties in the budget forced the government to rethink the possibilities of modifying the system. As the reform of the whole administrative system was – due to political reasons - practically impossible, and because the competence of the municipalities remained a touchy point, the government which aimed in a fashion to put under control the local administration decided to progress only step by step to avoid the larger

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[9] 1875/III. tc.

[10] THIM, JÓZSEF: *A szegény betegek gyógyításáról*. Gyógyászat 1896, jan. 12. 24-25.

[11] MOL K150-86-1870-IV-9-5304, MOL K150-179-1872-IV-9-332-38482

[12] BM 1885/8989 (márc. 3.)

political difficulties.[13] This rather general political intention met the professional point of views of the experts of the public health system who already pointed out all the faults of the existing system to the political and the medical circles as well.[14]

The situation was given for the government: the system of the institution was financed supposedly by the communities and municipalities, and they decided in all the questions concerning its work. After a careful examination of the real financial situation of these legal persons, we could observe that it was eventually the state which maintained the whole system through the municipalities.

To have a better approach, it is absolutely necessary to have a look at the system of taxation at this time. In accordance with the laws of 1870s', the costs of the public health system were to finance from the "domiciliary-tax" in the municipalities (counties), from supplement-tax in the communities (cities), and from community-tax in the villages.[15] There was a considerable difference between the financial possibilities of the municipalities (counties) and the other legal persons (cities and villages), namely during the preparation-works of the budget of 1868, the Ministry of Finance blocked the introduction of the taxation based on "domiciliary -tax" with a decree and accomplished a budget with the system of subsidies, which replaced the "domiciliary"-tax annually.[16] The argument for this solution was that the municipalities effect tasks which form the tasks of the state anyhow and it is the municipality which accomplishes them instead of the direct state work. The municipalities lost their position concerning the taxation, added to which that the government created an institution for the execution of the taxation even on that level.[17] After a series of restructurating of the levy and reorganization of the administration of the municipalities, they had to retire from the administration of their own budget. As the municipalities didn't

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[13] KOZÁRI, MÓNIKA: *Tisza Kálmán és kormányzati rendszere*. Budapest, 2003, Napvilág., WLASSICS, GYULA: *Önkormányzat és felügyeleti jog.* Különlenyomat a „Jogállam" XIII. évfolyamának 1. füzetéből., Bp, 1914, 9.

[14] DUBAY, MIKLÓS, DR.: *A közegészségügyi törvényjavaslathoz.* Bp, 1876, Franklin., CSATÁRY, LAJOS: *A közegészségügy államosítása, tekintettel a közigazgatási reformra*. Egészség, 1889/6, 271-276.

[15] 1870/XLII. tc. 11§, 13.§, 1872/XXXVI. tc. 10§, 1871/XVIII. tc. 121.§, 119-120§

[16] SZITA, JÁNOS: Tolna vármegye költségvetési gazdálkodása a dualizmus első éveiben (1867-1870). In: *Tanulmányok Tolna megye történetéből V.* Szekszárd, 1974, 319-342., a kérdéshez továbbá ld.: STIPTA, ISTVÁN: Megyei elképzelések a törvényhatóságok rendezéséről. In: *Jogtörténeti Tanulmányok V.* Budapest, 1983, Tankönyvkiadó. 305-319., illetve az 1886-os rendezéshez STIPTA, ISTVÁN: Parlamenti viták a területi önkormányzatról (1870-1886). In: *Hatalommegosztás és jogállamiság.* (szerk. Mezey Barna) Budapest, 1998, Osiris Könyvkiadó. 77-94.

[17] VÖRÖS, KÁROLY, 1956, KMETY, KÁROLY: *A magyar közigazgatási jog kézikönyve*. Budapest, 1900, Politzer Zsigmond könyvkereskedő kiadása. KMETY KÁROLY: *A magyar pénzügyi jog kézikönyve*. Budapest, 1902, Politzer.

have any considerable assets which could give them a certain financial playground, there remained only the very limited possibility of the supplement-taxation as a plausible aid with which they could count.

The cities on the contrary had – in comparison to the municipalities – reserved all their financial liberties. The cities normally had much more property than the municipalities did, and they had flexible opportunities to levy their own taxes which they could do with their own staff. In accordance with laws of 1870s' the cities could impose taxation on the indirect state taxes, and could introduce customs and duties as well.[18] After all, these kinds of incomes didn't appear in the outlays concerning the public health of the cities, it remained rather the use of the different duties such as the duty on the use of canalization, the duty on the meat-inspection, etc. [19] So the communities could have used the system of the so called supplement-taxes, which was attached to the normal taxes of the state. This form of taxation, which aimed to finance the different expenses of the communities, in principle didn't have a ceiling, so it was the financial possibilities of the contributors of the city which could have formed a bar to the levy. During this period the communities expressed their opinion against the ruling system of the supplement-taxes which - in its argumentation – surcharged the whole system of taxation of the communities while the communities accomplished a state task maintaining an expensive public health institution. Therefore the cities claimed that the state ceded to them a part of the state taxes admitting that the cities' costs concerning the public health form a part of the central budget.[20] Whatsoever the supplement taxation of the cities continuously augmented and the difference between the levels of taxation became more and more considerable, which caused an unjust and unequal situation.

Tasks of public health in the communities

To make it precise the possibilities of the presence of the medical staff on the local level, it is to detail that there were two types of doctors in sense of the public administration. Firstly there was the so called doctor of the district and the municipality who worked in fact in the system of the administration of the municipality, with the most important task of controlling the public health institution and its situation, and secondly there was the so called doctor of the community/village/medical circle, who had the primary task of the medical attendance and curing the local patients. The system adjusted in 1876 with the public health act created a slightly confused situation because the purview of the two positions in certain cases

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[18] FABÓ, BEÁTA: *A budapesti vámvonalrendszer változása a XIX-XX. században.* Tanulmányok Budapest Múltjából (a továbbiakban TBM) XXV. (1996) 61-84.

[19] MÁRFFY, EDE: *A városi adók és illetékek*. Budapest, 1908, Szfőv. Háziny. 33.

[20] MÁRFFY, EDE: *A magyar városok háztartásának joga*. Bp, 1914, Szerzői kiadás.

overlapped, and in many occasions it was the doctor of the district who replaced the vacant doctor of the community/village/medical circle. Firstly it is worth to examining the situation of the community doctor because that should have been the key-position in the functioning of the public health system.

The base was given in the act of communities (1871), in the decree concerning the poor people (1872) and in the act of public health (1876). In accordance with these laws the community had to accomplish multiple obligations towards the poor people and had to maintain a more or less functioning public health system.

The act of public health (1876) determined precisely the position of the community in the system of public administration concerning public health: in this point of view the community formed the very last chain-link in the public administration, and enumerated the tasks as well: so from the tasks concerning the poor inhabitants came the obligation of medical attention of the poor and unrecoverably insane people, the blind, the deaf and dumb people, the foundlings and the foster-children. The vaccination and the social-hygiene were a community-obligation, as the maintenance of the cemetery and mortuary. Within this circle the community had to effect the food-[21], and water control, and assure the cleanness of the streets. All these tasks were to accomplish by the local police which was in this period - except in Budapest - a community institution, so its costs burdened the local budget.

The budget of the communities was charged with the costs of the doctor's salary, which was a common obligation of the communities over 6000 inhabitants. The smaller villages could accomplish this obligation in the so called "public health circle" in which they could form groups and hire the medical personnel together. The forming of these circles caused serious tension between the participants, added to which, that sometimes the municipality intended to expand the obligations of the medical personnel, to assure the functioning of the public health in the villages as well.[22]

As in accordance with the law the doctor had ordinary salary from the community but the level of the salary wasn't defined, - it was always defined by the municipalities (in accordance with the proposal of the community) - there were unimaginable differences between the incomes of the doctors of the communities. As in general the salary of the medical personnel depended on the financial situation of the community, and it was clear to the experts that the situation in which practically large districts remained without medical presence, could have changed only with a radical

[21] BM 1876/31.026

[22] MOL K150-748-1879-IV-1-48400

reform of the salary-system, which could have affected the political interests of the municipalities and communities as well.[23]

The program of the nationalization of the public health system

By the end of the 19th century it became clear that the whole system was set to reform. The following questions remained to be clarified: how deep should the public health be restructured, where are the limits of the possibilities of the politics of the government, and how efficiently could the municipality defend its interest, because beyond the real quotidian problems of the financing of the public health system. In a wider point of view the great question was the re-definition of the role of the municipalities and communities in the structure of the public administration, and the marking of the new limits of its autonomy. As this point seemed to be a great, crucial point, a long debate could be observed which contained as much a political, as a professional argumentation. So by the examination of the events it is worth to considering the complexity of the problem.

The restructuring of the financing of the hospitals

In the former system it was the municipality which took place at the end of the queue of the participants obliged to pay for the poor patients. This solution created an obvious chaotic plight in which serious differences emerged between the levels of deficits of the municipalities. As the rules of the law of 1875 which gave a solution concerning medical treatment fees were deeply modified by the law of the mutual-aid society and the law which arranged the relation in this term between the farm-servant and the boss, it was high time to create a new law in which all the rules and modifications of this domain would be placed.

The real importance of the law of 1898 was given by the new institution of the so called ‘national fund of medical-treatment’ which aimed to counterbalance the immense differences between the poor and rich regions of the country. The cover of the costs of the new institution was created by the supplement taxes added to the direct taxes such as the direct state tax (taxation of property), the income tax and the company-tax. From this new resource the costs of treatment of the poor patients (in case of lacking relatives, mutual-aid societies etc.), the costs of the defense against the contagious diseases (except the cholera and the pest, because the costs of these diseases were to pay from the budget directly), the costs of the foundlings till age the of 7, and finally the costs of the accouchement in hospitals were paid.

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[23] *A magyarországi községi- és körorvosok országos értekezletéből felterjesztett kérvény a nm. belügyminiszter urhoz.* in: Közegészségügyi Kalauz, 1879/21 (nov. 1.), 1-2.

The restructuring of the situation of the village doctors

In the forming of the public health system diverse associations of doctors participated which worked out drafts for the reform of institutions in the early 1870s', and naturally the association of the so-called district or circle doctors was founded as well. These forms of the profession could make pressure on the Home Office and deliver information during the process of planning of the reforms.

The fact that the location of the doctors wasn't balanced and the cities abounded with medical praxis was well known by the government. The internal migration of the medical personnel was a widespread phenomenon, and it became so intensive that it already imperiled the basic functioning of the system. In the poor regions it was to observe that the circles were too big, the consultation fees were too low and there wasn't any opportunity to create a private praxis for the doctors of the villages from which they could have had a supplementary income counterbalancing the absolutely low salary. That was the main reason of the internal migration which was strengthened by the erratic payment of the villages, which means that the doctors usually received their salary late, and they had to claim for their salary repeatedly which was a humiliating practice to them. Although the Home Office prescribed in some decrees that the salaries of the doctors should be payed on time, the roots of the problems didn't change, because the financial conditions of the villages didn't improve.[24] As the doctors claimed about the bad conditions again in 1881, the ministry decided to link the payment to the number of the inhabitants of the villages and to assure the payment on time, allowed the introduction of a supplement taxation, with which the costs of the medical personnel were incorporated in the official budget. With these measures the problem of the payment was resolved in many circles, but in certain strongly rural parts of the country it was possible to pay just once a year: at the harvest, when the country-folk sold the crop. In these parts of the country the doctors had to be satisfied with the part-payment and the payment in kind.[25]

The situation in the countryside became more and more serious, added to which that the municipalities found a tricky solution to the problem: as the villages announced the vacancies with such a low salary that no application were received, therefore it became the district doctor – who was paid in practice by the state - who had to fulfill the task of the vacant doctor of the circle. So the doctor of the district, who was originally staff of the administration, with tasks of the public administration, became a certain supplement-doctor in case of the circle-doctor's absence.

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[24] BM 1881/56.284/80

[25] MOL K150-1641-1888-IV-6-12031

As the government couldn't find a solution to the above mentioned problems, and the professionals insisted on creation of a new law, the government – taking into consideration the proposals of the medical associations – prepared a new law which had a double target. After a long preparation-period the new regulation came into effect in 1908.

The first point of view of its creation was the better definition of the purview of the doctor of the community/circle, so the doctor, who was originally in charge of the tasks of the medical treatment of the inhabitants of the community, and secondly had to accomplish some obligations concerning the administration of the public health system of its.

It remained the doctors' tasks to do the administrative work, so in accordance with the new law it was the doctor of the community/village/circle who had to accomplish the vaccination, the food-control, etc., to give information about the general trends of public health in his domain, and to participate in the work of the health commission of the community/village/circle.

The most important changes concerned the financial position of the doctors and the relation between the medical staff and the community/village/circle though. The salary of the doctor was defined by the law and represented in fact a mixed system in which the poorness of the territory should have been compensated. The compound salary chart had four elements: 1) basic salary 2) age-allowance 3) local-allowance 4) personal-allowance. Added to this salary the doctor had an accommodation-allowance or a real flat, the costs of the transport (of the medical visits), the fee of the medical visits. The law made a system of paid holiday and a financial base for pension to those doctors. The paid holiday of the doctors didn't only aim the recreation of the doctors. By that time the retraining-courses for doctors, which were organized by the universities in the summer period had become widespread. To give them an opportunity to participate as well, the system of replacement was to be resolved to.

Concerning the pension-system, with this new law the government launched the elaboration of a pension-institute, in which the payment of the doctors was completed by the state.[26] The first budget in which the items of the pension of these doctors appeared was the budget of 1913.[27]

In the previous system it was the community in fact which defined the salary of the doctors, and it was clear enough that with a simple prescription even a new law couldn't change the reality, so that the communities/villages didn't have enough money to pay more to the doctors. Therefore it was the

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[26] *A nyugdíj*. Közegészségügy, 1913. szeptember 15.

[27] BM 1913/147.000

state which paid the points 1)-3) of the salary and it was only the 4) point of the payment which charged the budget of the community.

The points 1)-2) of the salary was to pay automatically, the local-allowance was to pay only in case of the poorness of the medical circle which formed a barrier to the creation of a private-praxis to the doctor. Theoretically it was the local-allowance which should have compensated for the immense differences between the levels of incomes of the doctors, so that should have been the financial device to assure the functioning of the public health in the poor territory of the country. The 4th point of the salary in the new system, so the personal-allowance was set to be the compensation in the domains in which the doctors had a higher salary level than in the new system they would have had.

The new law guaranteed the on time payment of the salary: the municipalities had to form a medical found in which the Home Office transferred the amount once a year while the communities/villages should have paid the sum of the personal-allowance, the accommodation-allowance and the travelling charges quaterly.

Conclusions

The process of the reform of the public health system was parallel with the general reform of the public administration system in Hungary. As at the time of the Ausgleich (1867) the Hungarian politician circles and the public opinion esteemed the relatively autonomic municipality as the gage of constitutionalism, the modern centralism wasn't realizable. Therefore the municipalities and communities became a branch of the public administration which effected the law and the decrees – in fact with subsidies from the state – with their own personnel. After 1875 the new policy of the government tried to reform this base, and launched a systematic codifications-work to press back the municipalities from the local public administration. As the direct step of the take-over under state-control of the entire public administration broke down in the 1890s', the government succeeded with a step-by-step policy, with which by the beginning of the 20th century the withstand-capacity of the municipal interest-groups was eliminated, and the local public administration came under direct financial control of the government.

Within the framework of the reform-process the government worked out the take-over of the majority of the public health system. With the categorization of the hospitals, with the creation of the national fund of medical treatment and with the assurance of the salary of the doctors in the countryside the government created a modern public health system with which it could defend the population against the most dangerous contagious diseases of the period and to provide a basic medical attendance.

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