



ESPN Thematic Report on Inequalities in access to healthcare

Hungary

2018

Fruzsina Albert
June 2018



EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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European Social Policy Network (ESPN)

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Summary/Highlights

Hungary has a social insurance-based compulsory healthcare scheme with practically universal coverage. Gainfully employed and assimilated persons are insured and coverage is extended to defined non-contributing groups as well. Around 5% of the population are not insured, mainly for not paying their health insurance contributions, but even they cannot be denied necessary care. The Hungarian healthcare system is a benefits-in-kind system and some co-payments are also charged (e.g. on pharmaceuticals). The healthcare expenditure per capita was €1,371 in 2015 at purchasing power parity, which was 7.1% of GDP.

Although availability of healthcare in both the public and private sectors can be considered satisfactory, the concentration of infrastructure and capacities generates geographical inequalities in access to care, those living in disadvantaged regions and smaller settlements having worst access. There are substantial regional differences in the availability and participation rate of screenings, and in waiting lists. The shortage of health professionals continues to restrict access to care, particularly in the public healthcare sector and in rural areas, and this problem continues to worsen. Private outpatient capacity exceeds that in the public sector and is concentrated in the most developed and affluent regions, as well as in specific fields (e.g. physiotherapy, dentistry, optometry, plastic surgery) – including alternative medicine, in which publicly financed services are not available at all. In addition, around one third of diagnostic services are provided by privately financed providers, especially concentrated on ultra-sound diagnostics. Private services are most often used to shorten waiting times for diagnostics or specialist services or access better-quality ones.

The share of out-of-pocket payments (OOPs) is very high, double the EU average: these include direct payments, cost-sharing for services outside the benefit package, and informal payments – accounting for almost 29% of all health spending in Hungary. Informal payments have long played an important role in healthcare delivery in Hungary and are estimated to make up at least 2.1% of total health expenditure – a much higher share than in most EU countries – and are often used to get quicker access and better-quality care. The share of medicines in total OOPs has been quite high, suggesting challenges in terms of both the accessibility and affordability of pharmaceuticals. The low level of public expenditure, when coupled with the high level of OOPs by households, raises serious concerns on equity and access in itself, since it makes access to care more and more dependent on ability to pay. Some studies indicate that inequalities in access have increased over recent years. Those with a low educational level have worse health status at the population level; this is connected to lifestyle and health behaviours, but also worse access to health services.

In 2014 catastrophic medical expenditure (defined as household OOP spending exceeding 40% of total household spending net of subsistence needs) affected 21.6% of households, and in particular those in the lowest income quintiles. Between 2011 and 2014 the share of OOPs and the number of those affected by catastrophic medical expenditure both increased – over a period when state support for the cost of prescription medicines decreased. Unmet need for medical care affects only a small fraction of society but indicates significant differences based on socio-economic status, and it is especially high among the unemployed and the Roma population.

There is a danger that access to healthcare will increasingly depend on the ability to pay rather than the health needs of patients, and that under-the-table payments will become a more common feature of the system. The magnitude of avoidable mortality indicates a vast potential for improving the performance of the healthcare system: however, the lack of a sufficiently complex approach, insufficient emphasis on preventive health measures, persistent underfunding and structural problems all inhibit this.

1 Description of the functioning of the country's healthcare system for access

The healthcare system in Hungary is social insurance-based; participation in the statutory scheme is compulsory for all citizens living in Hungary, and opting out is not allowed. Gainfully employed and assimilated persons are insured – including employees (including in the public sector); the self-employed (including members of co-operatives); several assimilated groups; and recipients of income subsidy, job-seeker benefit and job-seeker assistance paid prior to retirement. Various groups of those not gainfully employed are also entitled to healthcare benefits: minors permanently resident in Hungary; those who have reached the minimum retirement age and whose monthly income does not exceed 30% of the minimum wage; homeless people; full-time students; pensioners; recipients of various benefits, allowances, or income supports; those in residential institutions receiving personal care; those in prison; those with a need recognised by the district office (including unemployed people receiving income support); those receiving social support; and those whose ability to work is reduced by at least 50%. For asylum-seekers, based on the 301/2007 government decree, healthcare provision is limited. For refugees and beneficiaries of subsidiary protection (BOSPs) healthcare is provided for six months after recognition. Otherwise, it is provided as for other Hungarian citizens. Other third-country nationals should have health insurance, and without this they cannot reside in Hungary. For undocumented migrants, care is provided only in an emergency situation. The law regulates what care is included (52/2006.regulation XII.28.). An emergency is a change in the state of health that without immediate medical treatment would result in a danger to life or serious or irreversible harm to health.

The self-employed, sole entrepreneurs and owners of small companies, and those not insured mandatorily need to pay healthcare contributions (of 7,320 HUF, or €23, per month in 2018), if they have been continuously resident in Hungary for at least a year. Their spouses and dependent close family members also need to pay healthcare contributions unless they are exempt from doing so for social reasons, which must be agreed by the local authority.

There is no required qualification period. There are no specific limits to the duration of benefits. Although **coverage** should be universal, the insurance status of about 5% of the population was unclear in 2015,¹ mainly because of unpaid insurance contributions. Still, necessary care (see in detail above) cannot be denied to patients who have not paid their contributions.

The Ministry of Human Capacities is responsible for the health insurance system. Healthcare services can be received from authorised healthcare providers, including private providers contracted by the National Institute of Health Insurance Fund Management (NEAK, short for *Nemzeti Egészségbiztosítási Alapkezelő*). The doctors are either employed by state-run health institutions or are private doctors contracted by the NEAK. Employed doctors are salaried, while contracted doctors receive a per capita fee-for-service, which is paid by the NEAK on a contractual basis, and a lump sum provided by public authorities. Hospitals are also contracted and financed by the NEAK: patients have to register with one general practitioner (GP), but they have a free choice of (employed or contracted) GP without geographical restraints. Patients are allowed to change their doctor once a year – more than once a year only for a good reason. Except in cases of emergency, access to specialists in general happens upon referral by the GP. Direct access is provided to dermatology, gynaecology, laryngology, ambulatory surgery and accident/emergency surgery, ophthalmology, oncology, urology, and psychiatry. The referral is addressed to the type of specialty and to a service provider who is obliged to offer care within a geographical area. Patients enjoy a free choice of specialist. Provision

¹ This is the number of people wanting to access healthcare and who have a social security number (TAJ), but who have not (according to the system) paid their health insurance contributions.

of care can only be refused if it would endanger the care of those patients who are living in that geographical area which the specialist is bound to.

The Hungarian healthcare system is a **benefits-in-kind** system, and **co-payments** are charged for the following: pharmaceuticals (the major part of co-payments); medical aids; extra services; extra meals and accommodation for inpatient and sanatorium treatment; inpatient chronic care; non-emergency specialist services obtained without a referral; visiting a provider other than the one to whom the patient is referred; services going beyond those prescribed by the physician; using sanitary provisions; certain dental prostheses; orthodontic braces provided for persons under the age of 18; and a change of external sex organs, except in cases of developmental abnormality.² The amount of the co-payment for the above services is fixed by the service provider and there are no exemptions or reductions.

Hospitalisation generally happens upon referral by a GP, except in cases of emergency and for some specialties. The referral is addressed to the type of specialty and to a service provider who is obliged to offer care within a geographical area. In the case of dental care, co-payments are made towards the costs of certain materials and treatments. Dental care is free of charge for patients under 18 years of age, those studying at secondary school or training school, pregnant patients (from the date of recognition of pregnancy until 90 days after the birth) but this does not include technical costs, e.g. dental prosthesis. For patients above 18 years emergency treatment dental surgery plaque removal and treatment of gum deformity are free of charge. For patients above 62 years emergency treatment, dental surgery, plaque removal and treatment of gum deformity plus a full scale of basic and specialised treatment are financed, except for their technical costs. Dental and dental surgical treatment relating to a basic medical problem and search for the origin of dental infection is financed without an age-limit, but referral is required, together with dental protection (according to a special regulation). Co-payments are charged for an orthodontic brace (under age 18) and dental prosthesis (needed to restore the patient's ability to chew). The amounts are fixed by service providers and the rest is directly paid by the health insurance system.

Pharmaceuticals are subsidised by the NEAK: pharmaceuticals provided during inpatient care are free of charge; those provided during outpatient care are subsidised at different rates varying from 25% to 90% depending on the pharmaceutical. In the case of certain chronic or serious diseases, the subsidy is 100%. Elderly or disabled persons on a low income receive a special card providing entitlement to free medicine and free medical aids. There is 100% coverage for all victims of accidents at work and occupational diseases.

Other free-of-charge benefits include prophylactic medical examinations, transportation and costs of travel, medical rehabilitation, obstetrical measures and ambulance transport.

Apart from those detailed above, cost-sharing is also required when patients fail to follow specific healthcare pathways and seek specialist care without a referral from a family doctor. People seeking care from providers outside the social health insurance system or for services outside of the defined limits of the benefit package must cover all costs out of their own pocket. Additionally, informal payments to physicians are a common practice to get quicker and better-quality care (see also later in section 2).

In Hungary, **healthcare expenditure** per capita was €1,371 in 2015 at purchasing power parity, placing it in the lower third of EU member states (the EU-28 average was €2,781). Health expenditure as a share of GDP was 7.1%, compared with the EU-28 average of 9.9% (KSH 2017). Two thirds of total health expenditure (67%) is public expenditure funded primarily through compulsory, non-risk-related contributions made

² Regarding mental care, the main problems are limited capacity and underfinancing. The availability of publicly financed psychotherapy is very limited. See in more detail: http://www.mptpszichiatra.hu/upload/pszichiatra/document/Vezetoi_osszefoglalo_WHO2014_20150831.pdf?web_id and https://index.hu/tudomany/2017/10/28/pszichoterapia_hozzaferes_allami_egeszsegugy/.

by eligible individuals or by the government (from the state budget), and one third is paid by private households (WHO, 2017). The share of OOPs within healthcare costs was the second highest (after Greece) in the EU (Orosz and Kollányi 2016:349-350, OECD 2017b:93). Between 2010 and 2015 households' health expenditure increased from 561 billion HUF (€1,809 million) to 714 billion HUF (€2,303 million), around half of it (48-50%) being spent on pharmaceutical products (KSH 2017). Hungary has reduced spending on preventive health measures by nearly half since 2005, allocating only 2.6% of overall spending to it (OECD 2017b: 10). A substantial share of private spending on health can be attributed to **informal 'under-the-table' payments**, a deeply rooted characteristic of the health system, and estimated to make up at least 2.1% of total health expenditure – much higher share than in most EU countries (OECD 2017). In 2014 Hungarians paid 8.3 billion HUF (€26.7 million) in the form of such payments, which was a 18% real value increase compared with 1998, but constituted a similar share of total household income (0.08%), indicating that habits have not changed much over the years. Half of the payments are made to hospital doctors, one third to GPs and specialists, 14% to dentists and 6% to nurses (Statisztikai Tükör 2015).

As indicated above, the share of OOPs in health spending in Hungary is high. This may indicate a preference for services/treatments in the private sector, or a lack of (readily) available care in the public sector. Cost-sharing through voluntary health insurance schemes is not included by Hungary in its OOP estimates, although it is among the countries that acknowledge the case for doing so (EC 2017a:12).

The **voluntary health insurance** (VHI) share of private spending on health in 2017 was 2% (WHO, 2017). However, these data should be interpreted with caution, because national health accounts data for Hungary do not clearly distinguish between VHI (*üzleti betegségbiztosítás* – commercial health insurance) and voluntary medical savings accounts (VMSAs) (*önkéntes egészségpénztár*) managed by voluntary mutual health funds. VHI was introduced in 1993: initially the larger part of VHI premiums went to individual accounts and could be used by the account holder; only a smaller portion of the premium was a real health insurance premium, paid into a common fund or risk pool. Consequently, VHI was mainly a VMSA scheme. The risk-pooling element of the system was abolished in 2003 and since then the VHI system has worked as a pure VMSA, with no risk-sharing element. The stated aim of this change was to encourage people's own responsibility for financing their healthcare. The contribution is either paid by the users or as a fringe benefit by their employers. The main motivation for joining the mutual funds (VMSAs) is to benefit from tax advantages – 20% of user charges up to the maximum amount of 150,000 HUF (€488) per year can be reclaimed from personal income tax. (Where the employer provides it as a fringe benefit, the tax rate for the employee is 40.71%, slightly less than the cost as wages). The services covered by voluntary mutual insurance funds range from home care to medicines, medical aids and recreational activities. These are either not in the package of care under compulsory health insurance (e.g. special treatments) or subject to co-payments (primarily the costs of medication). In 2013, 79% of mutual funds' expenditure on services went on reimbursing the costs of medicines and medical aids, and 18% on services that were supplementary to those covered by the statutory health insurance system. Commercial VHI is very limited and mainly provides cash benefits in the case of sickness. These policies are offered by commercial insurers. People buy supplementary VHI to have access to better amenities and faster access to care. No public information is available on the socioeconomic characteristics of those who purchase VHI or whether VHI take-up is more common for individuals or groups. Only a few employers use the tax exemption (available since 2012) to purchase VHI for their employees (Szigeti et al. 2016). In 2017, the government modified the relevant regulations and increased the taxation of fringe benefits (from 43.66% in 2017 to 40.71% in 2018); as a result employer contributions to VHI and self-help funds for their employees decreased from 30.55 billion HUF in 2016 to 17.7 billion HUF in 2017. In the meantime, probably due to the 20% tax refund on contributions, individual payments significantly increased from 19.2 billion HUF in 2016 to 25.2 billion HUF in 2017, though the overall balance is still negative. The number of

members of VHI schemes is quite high, at nearly 1.4 million people: but as many as a half do not actually pay their membership fee.³

The **availability of healthcare** in Hungary can be considered generally satisfactory. The number of physicians is similar to the EU average (3.3 practising doctors per 1,000 population, OECD 2016). Healthcare provision, both private and public, is concentrated in the more densely populated areas. This generates geographical inequities in access to care. Fortunately, GPs⁴ are highly accessible and available: but the increasing number of vacant positions for GPs, as well as for district nurses and dentists, is an important issue. In June 2016 the number of permanently vacant GP districts was 258, 2.5 times more than in 2001, mainly in disadvantaged regions of the country (Orosz and Kollányi 2016:350). In the same year, 6% of all GP districts were maintained by substitutes (KSH 2017).⁵ The shortage of health professionals continues to restrict access to care, particularly in the public healthcare sector and in rural areas. Conversely, the authorised capacity of private service providers exceeds that of public providers, which further increases inequalities of access.

There are **waiting lists** in the case of specialised inpatient and outpatient surgical procedures, e.g. hip and knee replacement as well as cataract surgery. The average waiting times were 146, 266 and 88 days respectively in 2015 (ÁEEK 2016:492). In 2015, 5 billion HUF (€16.1 million) was spent on reducing waiting lists: the number of patients on waiting lists decreased from 70,000 in 2012 to 35,000 in 2015. The current length of a waiting list can be checked online.⁶ The government has accepted new legislation which makes it compulsory for publicly financed CT and MRI diagnostic service providers to provide a diagnosis within 14 days for patients with a potentially malignant tumour: the number of available CT and MRI machines in Hungary is among the lowest for OECD countries (OECD 2017b:170). Unfortunately, despite early CT or MRI results, it usually takes months for patients to receive the necessary life-saving treatments, as they have to wait a long time for the complementary tests necessary for a final diagnosis.⁷

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Life expectancy in Hungary is among the lowest in the EU for both the female and male populations, with very significant inequalities based on place of residence and educational level. A man with primary education has 12 years less life expectancy than one with tertiary education – this difference is 5.6 among Hungarian women. These figures are among the worst of the EU countries. There is a threefold difference in **infant mortality rates** in the case of mothers with primary versus tertiary education, and it also highly correlates with settlement structure. The proportion of those considering their **health status** to be good or very good among those with maximum primary education is half of that for those with higher education (ÁEEK 2016:53). People living in the most disadvantaged small regions die 13.5 years earlier on average than those living in the most advantaged ones (Orosz and Kollányi 2016). In economically more developed regions avoidable mortality is lower than in underdeveloped regions (in central Hungary it is 15.3 per 10,000, whereas in northern Hungary it is 20.4 per 10,000), and it is twice as frequent among men than women (ÁEEK 2016:54). In 2014 14% of total mortality

³ <http://www.azepenzenem.hu/cikkek/itt-vannak-a-hivatalos-adatok-a-nyugdijpenzrol-es-az-egeszsegrol/4737/>.

⁴ There are GPs only in the public system.

⁵ There has been a number of governmental measures over recent years designed to tackle this problem: e.g. the government recently provided significant additional funding for a programme to subsidise GPs and dentists to purchase a practice or fill a vacant position (the sum depending on the length of the vacancy), on condition that they provide services there for at least 6 years. See: <http://www.kormany.hu/hu/emberi-eroforrasok-miniszteriuma/egeszsegugyert-felelos-allamtitkarsag/hirek/egymilliard-forinttal-noveltek-a-haziorvosi-praxisvasarlas-es-letelepedesi-tamogatas-osszeget>.

⁶ https://jogviszony.neak.gov.hu/varolista_pub/.

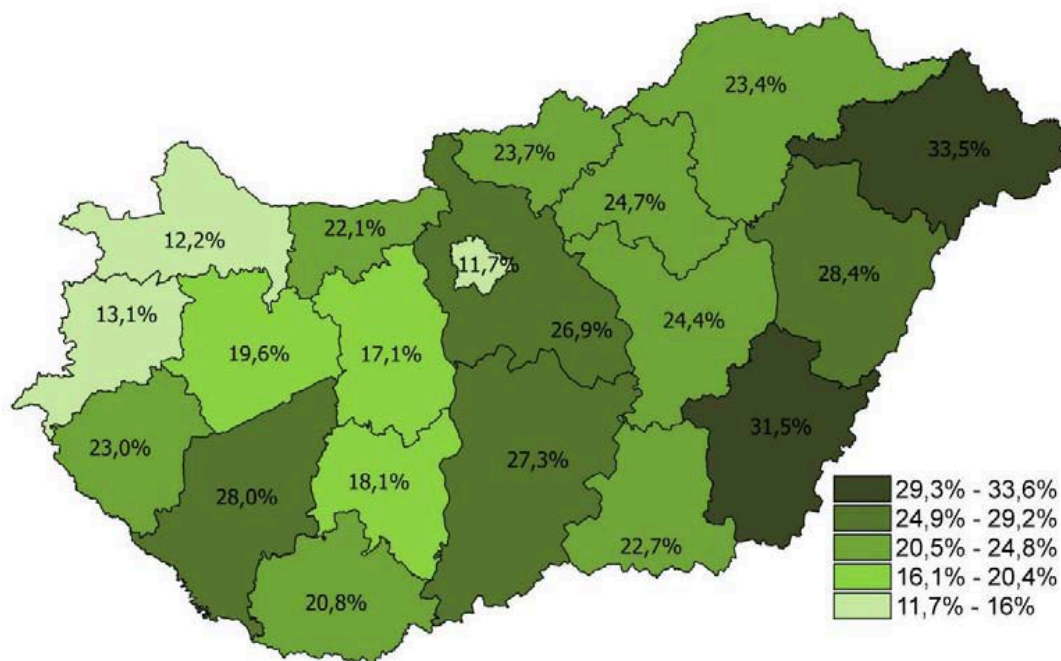
⁷ <http://mno.hu/tarsadalom/tobb-penz-kevesebb-orvos-1321889>.

could have been avoided by optimal medical interventions, which is approximately the proportion of mortality for which the healthcare system is responsible (**amenable mortality**). In the case of the population younger than 65 years, 57% of the 17,905 deaths in 2016 could have been avoided in this way (ÁEEK 2016:56). A further 12% could have been avoided by more efficient public health measures (**preventable mortality**) (ÁEEK 2016:24).

As mentioned in the previous section, in Hungary the rate of OOPs is quite high, at 28.3% of all health-related costs. In 2014 5.51% of household expenditure was made up of health-related OOPs: it was highest in Central Transdanubia, at 5.9%, and lowest in the North Plane, at 5%. Most of these OOPs are legal, in particular those for pharmaceutical expenses (ÁEEK 2016:781): however, the above figure also contains the estimated value of the widespread and illegal 'under-the-table payments', which distort in many ways the functioning of the system. There is a danger that access to healthcare will increasingly depend on the ability to pay rather than the health needs of patients, and with under-the-table payments becoming a more common feature of the system (Gilly 2018). Poor households spent a smaller proportion of their income (4.3%) on OOPs than households above the poverty line (5.3%) (ÁEEK 2016:803), despite the fact that they have a higher risk of bad health – i.e. those people who can least afford to pay for access to adequate (timely and good-quality) care are precisely those in the largest need of it. A recent study showed that, on average, the availability of care has been improved in general, but at the same time inequalities in access have increased (Orosz and Kollányi 2016). In a publicly funded public service, such inequities are also simultaneously inefficiencies, since those people who are in the largest need systematically receive less adequate treatment – the mortality figures well reflect that. In Hungary people's level of satisfaction with health services is below the European average, but with an improving trend (5.7 on a satisfaction scale from 1 to 10 in 2016 - Eurofound 2017:51, 57).

As poor people are generally in a worse health condition than the rest of the population, their medical expenses tend to be higher in relation to their income (Gaál et al. 2012). In 2014, **catastrophic medical expenditure** affected 21.6% of all households. Catastrophic expenditure is defined as household OOP spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities). The figure is highest in the disadvantaged North Plane region (28.9%), and lowest in Western Transdanubia (16.9%). County-level data show an even greater range, from a high of 33.53% in Szabolcs-Szatmár-Bereg county to a low of 11.74% in Budapest (see map). This index, comparing the household expenditure levels with the national poverty line (60% of the median of the equivalent consumption costs), differentiates between households which (1) having paid direct health-related costs, did not get under the poverty line, (2) those who got under the poverty line after paying such costs and (3) those who were already below the poverty line when these costs incurred. The proportion of households with **catastrophic medical expenditure** was 92.13% in the lowest, 18.97% in the second lowest, 8.82% in the middle, 3.5% in the 4th and 1.72% in the top income quintile (for further details on these indicators see ÁEEK 2016: 676-689). The European Quality of Life Survey data also indicate that only 32% of Hungarians in the lowest income quintile considered that they could cover primary care costs (Eurofound, 2017:56).

Map 1: The proportion of households suffering catastrophic medical expenditure in 2014, by county



Source: ÁÉEK 2016: 674.

Between 2011 and 2014 both the proportion of OOPs and the number of those affected by catastrophic medical expenditure increased. It should be noted that, over the same period, state support for the costs of prescription medicine decreased – in 2015 it was 87% of the amount in 2011 (ÁÉEK 2016:657).

Self-reported unmet need on average is quite low in Hungary: in 2016, it was 0.9% on the grounds of medical care being too expensive,⁸ 0.2% because it was too far to travel and 0.2% because of waiting lists. Unmet need for medical care affects only a small fraction of society but it exhibits significant differences based on socio-economic status and other variables. Unmet medical need (for any of the three reasons above) was 1.3% in 2016 in Hungary overall, but it was 1.6% among women and 1.1% among men. Older people (65+) were more likely to be affected (2.5%), as well as unemployed (3.7%) and non-employed (2.1%) people. There was a more than threefold variation by educational level: among those with no more than lower-secondary level education, unmet need was 2.4%, while among those with tertiary education it was 0.7%. The most significant difference was by income level: in the lowest quintile unmet need was 2.7%, while in the top quintile it decreased to 0.1% (EU SILC 2016 data downloaded on 13th April 2018). There is more detailed analysis available for 2015: in the case of the Roma population, unmet medical need was 2.2 times more prevalent than among the non-Roma population (ÁÉEK 2016:64). In 2015 the distance from providers was the most important reason for not receiving care in case of the elderly. Young people (16-24 years) had the lowest level of unmet medical need, while those aged 45-54 had the highest. In the case of the unemployed, the excessive cost of care was the most important problem (ÁÉEK 2016:528-536).

⁸ The figure for 2015 was significantly higher, at 2.2%. This significant change was unprecedented in previous years and there seems to be no good explanation for it, beyond the fact that income levels and poverty figures did improve.

There are significant inequalities in the **geographical distribution of services**, especially in specialist care. The publicly financed outpatient capacity per 10,000 inhabitants was 307.7 hours in 2015 nationally, while it was 224.7 in Western Transdanubia and 416.1 in Central Hungary. Privately funded outpatient capacity was 342.8 hours nationally, but only 124.1 hours in the very disadvantaged Northern Hungary compared with 597.8 hours in Central Hungary. Private outpatient capacity exceeds that in the public sector and is concentrated in the most developed and affluent regions of Central Hungary and Western Transdanubia; it is also highly concentrated in specific fields (physiotherapy, dentistry, optometry, plastic surgery) – among them alternative medicine, for which publicly financed services are not available at all. In addition, around one third of diagnostic services are provided by privately financed providers, especially concentrated on ultra-sound diagnostics (ÁEEK 2016: 354). So those who can afford to do so often use these private services to shorten their waiting times for diagnostics or specialist services and/or access better-quality ones.

There are substantial regional differences in screenings and **waiting lists**. In the case of the latter there is a more than threefold difference between Central Hungary and Southern Transdanubia (31 days versus 110 days). Regarding breast cancer screening for women aged 45-65, participation rates varied in 2016 between regions from 34.2% to 58.6% (ÁEEK 2016: 84). Similar regional inequalities in access are also reflected in the average time an ambulance takes to arrive, or the time needed to access emergency care. Southern Transdanubia is in the worst situation regarding these as well, which is mainly attributable to the distribution of settlements. Regarding unfilled **vacancies for medical personnel**, the situation is especially grave in disadvantaged micro-regions, which means that even in the short run a drastic shortage in general practice and dental care can be expected. Data show sharp differences: in Nógrád county 23.7% of district nurse positions are vacant. In **disadvantaged** districts the magnitude of shortages is double that of non-disadvantaged ones, and the trend between 2013 and 2015 was for a further widening of the gap (ÁEEK 2016: 84). In disadvantaged settlements there are significantly more tuberculosis patients, and the risk of not having good-quality drinking water is 1.5 times higher than in non-disadvantaged ones and housing quality indicators are also significantly worse.

In the framework of monitoring the health care system in Hungary, a special indicator has been created to monitor the access of **homeless** people to healthcare, a serious limitation of which is, however, that it can only take into account the fraction of the homeless population who are registered as homeless with the health insurance system. Over the three-year period of analysis of this monitoring, 10% of these people died, on average at the age of 55 in the case of men and 54 in the case of women. They used emergency care services three times more than the average population (every third versus every tenth person); and they were admitted to hospital as emergency inpatients even more frequently (on a yearly basis every eighth person versus one in a hundred) (ÁEEK 2016:520).

Hungary is financially supported by the EU Structural Fund to improve the quality and accessibility of its public health screening system, to increase low screening rates and reduce substantial inequalities in access. The 2017-18 public health action plan of the national public health strategy tried to address these issues, for example by setting up mobile screening stations to visit mainly small underdeveloped territories (with some of them providing digital mammography screening on the spot and others offering health counselling and cervical screening). Colorectal cancer screening was also expanded to ensure the coverage of the target population of women and men aged 50-70. In September 2014, human papillomavirus vaccine (HPV) was introduced as a free, non-prescription vaccine, and about 75% of 7th-grade schoolgirls were vaccinated.

However, **official health policies** and reforms have rarely, and only inadequately, addressed the significant inequalities in the social determinants of health, as it would have needed an integrated, multi-sectoral approach involving different social policy areas (e.g. housing and education). Prevention activities should be enhanced. In addition to

that, increased funding and more equitable and accessible healthcare would be needed (Orosz and Kollányi 2016). The magnitude of avoidable mortality, among the highest in the EU, indicates a vast scope for improving the performance of the healthcare system (Gilly 2018). One can agree with a recent analysis that the Hungarian health system is chronically underfunded and that there is no justification for allowing this situation to continue so long as the health status of the population is among the worst in the EU (and the OECD). The annually recurring serious indebtedness of hospitals is an apparent warning of the malfunctioning and underfunding of the system (Gilly 2018).

Those with low educational level have worse health status at the population level, which is connected to lifestyle and health behaviours (obesity, lack of regular physical exercise, smoking, alcohol consumption); but, as the above data suggest, the access of this group to health services is also worse and can be considered problematic. The situation of the unemployed and the Roma population is especially worrying, and should be highlighted as a target of health policies.

As a recent analysis states, in Hungary healthcare availability has improved for the better-off 60% of the population, whereas for the rest – especially for the poorest fifth – it has deteriorated, so increasing inequalities. Bad health is caused by the high concentration of risk factors: Hungary has the third highest rate of smoking in the EU, the second highest rate of obesity, and the third highest rate of people living in low-quality housing. Those with low education are in a worse, often significantly worse, relative position in all these dimensions. In addition, in Hungary social exclusion affects a significant portion of society: Hungarian society is characterised by weak solidarity, low trust and high stress levels, which are especially detrimental to those in poverty (Orosz and Kollányi 2016:453). The high level of OOP spending contributes to a comparatively high share of households facing catastrophic health expenditure and definitely hampers equity in access to healthcare – it has the biggest effect on poor households, who are also the most likely to be affected by health risks.

3 Measurement of inequalities in access to healthcare in the country

Hungary started monitoring its health system performance in 2013 by collecting system-level information along 76 key indicators. 23 of them refer to structure and availability, such as 3 indicators on prevention, 12 on the availability of care, 4 on the length of time to access various types of care, and 4 on the human resources capacities of the healthcare system. The overall objective of this health system performance assessment is to enable Hungarian authorities to identify key priority areas for which improvement is needed in terms of access, responsiveness and quality of care. The first comprehensive report published covers the period between 2013 and 2015 and represents an important step in improving performance monitoring of the Hungarian health system (AEEK 2016). In addition to giving a snapshot of the current performance of the health system, it can be used as a valuable source of information for identifying key challenges in the future.

Although the volume of unmet need for medical care fell to quite a low level in Hungary in the last survey year, a more detailed analysis (looking at factors such as income, education, activity status, and ethnicity) reveals the dynamics of the most significant inequalities. A possible limitation of these data is that the SILC (Survey of Income and Living Conditions) sample is relatively small.

The index of catastrophic medical expenditure seems to be quite suitable as a way to measure affordability problems in Hungary.

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