

People and their Values in the Society

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Health Inequalities in Hungary – Challenges for Health Care System

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Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. The issue of health inequalities has been in the consciousnesses of policy makers. In Hungary marked differences can be experienced in population health socially as well as spatially.

The paper focuses on the main challenges and facilities of the Hungarian health system regarding health inequalities. Results and facts are based on literature review, content-analysis and expert interviews to discover the role of access to health care in existing health inequalities. The scope of this examination is to interpret the most important determinative factors and relevant reasons of the Hungarian health deterioration with the special focus on the functioning problems and anomalies of the health care system.

Actually, the primary challenge of the Hungarian health care system is that functionally, structurally and financially cannot reduce health inequalities, the overall policy response to the issue remains slow.

Introduction

There are marked health inequalities in Hungary which can be experienced among different social groups as well as different regions of the country. Although there have been substantial increases in life expectancy in the last 20 years, many health outcomes remain poor, placing Hungary among the countries with worse health status and one of the highest rates of premature death in the European Union. The main causes of death are based on diseases of circulatory system, neoplasms,

diseases of digestive and pulmonary system, and external causes (including suicide) – with mortality from each of these causes being higher than the Central European average, and among the highest rates in EU28.

A variety of health care reforms have been implemented after the economic and political transition of 1989 with varying success in Hungary to reduce health inequalities. The most important aims of these reforms were to reshape the financial mechanisms and organization of the health care system in several ways, such as by strengthening the integrated forms of health care, and introducing new ways of regulating the capacities of health care providers (Gaál et al., 2011). A key problem is that the Hungarian health policy faces many challenges regarding health inequalities.

The paper is focusing especially on the main features of the Hungarian health care system to describe its relevant challenges and facilities which are accumulated after 1989. The study consists of three major structural parts. The introduction part provides a very short insight to the definition of so called 'Central European health paradox'. The second part contains an interpretation of the determinant factors and the most important reasons of the Hungarian health deterioration with the special focus on the functioning problems and anomalies of the health care system. Lastly, at the end of the paper will some words and thoughts about facilities and future tasks of the Hungarian health policy.

Methodologically, all results and experiences of this paper is based on literature review, content-analysis and expert interviews (n=21), which were prepared in a three years course research project (<https://egeszsegugyihozzaferhetoseg.wordpress.com/>, 2016-2019). The aim of this research is to analyse regional differences of the Hungarian health inequalities through the role of access to health care. The primary outcomes of this project are suitable to make some proposals for evidence-based decision-making.

Definition of 'Central and Eastern European health paradox'

So called 'Central and Eastern European health paradox' is a typical situation in the European post-socialist countries as well as in Hungary. The general state of health of the population is worse than justified by the level of economic development. The social effects of the transformation such as the acute problems of unemployment and poverty among low-income population groups have had gone together with 'health recession' and it has resulted a decreasing tendency in life expectancy after 1989.

On the other hand, there is a marked differentiation between the general health status of the population between Western and Eastern Europe. This is the main reason that the specific phenomenon of 'health paradox' is a typical public health situation in Central and Eastern Europe (Cornia-Paniccia, 2000; Kopp et al., 2007). In this part of Europe the rate of premature death is higher, the average life expectancy at birth is lower, the main health indicators are worse than in the Western part of Europe (Egri-Tánczos, 2015). The mortality crisis mostly affected middle aged men, and this is one of the worst among all countries of the world. The main determinative factors of epidemiological crisis are based on high rate of cardiovascular disease, malignant neoplasms, diseases of digestive and pulmonary system. The non-communicable diseases such as heart attack, stroke, cancer, chronic pulmonary illnesses or diabetes etc. are the leading cause of mortality (Józan-Prokhorskas, 1997).

The typical 'health paradox' situation in Central and Eastern Europe is associated with the following factors (WHO, 2013):

- Traditionally, unhealthy lifestyle (e.g. unhealthy nutrition, no physical activity, stress etc.) and its consequences (e.g. high blood pressure, diabetes etc.) play a very important role in the marked deterioration of health status.
- Originally, health inequalities regarding socio-economic inequalities are based on barriers in accessibility and availability (Levesque et al., 2013).

In this respect the so called Central and Eastern European health paradox, that is the morbidity and mortality crisis can be experienced in these transforming societies. This health paradox can result significant health inequalities within and between European countries, and increasing these inequalities will remain a challenge for the European Union in the future (Forster et al., 2018). For example, a review of health inequalities for the WHO European region found that life expectancy differs significantly across the region (WHO, 2013).

Determinative components of health inequalities in Hungary

Average life expectancy at birth in Hungary was 75.9 years in 2018, up from 71.9 years in 2000 (Data source: www.ksh.hu). Large gaps exist in life expectancy between men and women, with men living on average nearly seven years less than women. Life expectancy of the Hungarian men was 72.6 years in 2018, while women's was 79.2 years. The gap in life expectancy by socio-economic status is even larger: Hungarian men with the lowest level of education live on average about nine years less than men with the highest level of education (<http://www.health-inequalities.eu/about-hi/at-national-level/hungary/>). The spatial gap is well-marked between the Eastern and Western part of the country which can result Western-Eastern division of the Hungarian health inequalities (Uzzoli, 2017).

After the transition in 1989 a deep deterioration in mortality in Hungary has resulted increasing health inequalities. But the marked deterioration in the state of health of the Hungarian population has been going on since the middle of the 1960s. As the consequence of this process Hungary is lagging behind the countries with more developed health culture. Hungary's life expectancy at birth is 5 years below than OECD average and is one of the lowest among all EU countries (Uzzoli, 2016a, 2016b). This relatively low life expectancy is linked mainly to the fact that it has the highest mortality rate from malignant neoplasm in Europe.

The most important reasons of the Hungarian health deterioration are coming from three different but interrelated health issues:

- the first is epidemiological crisis,
- the second is demographic crisis,
- the third is structural and financial dysfunction of the Hungarian health care system.

The Hungarian epidemiological crisis was influenced by mortality trends from the end of the 1980s. The unfavourable mortality trends were particularly acute in all post-communist countries in Eastern Europe (Meslé, 2004). The main features of these unfavourable mortality trends were the following: continuous and significantly increasing mortality rate, internationally high rate of premature death, large differences in mortality rate by sex and age, decreasing life expectancy. The deepest period of the Hungarian epidemiological crisis reached its bottom at the beginning of the 1990s, which was the result of the decades-long worsening of health indicators, and the social consequences of the transformation processes (Józán, 1996). *'The mortality situation in Hungary, which had been worsening for decades, developed into an epidemiological crisis by the early 1990s, and it presently hits the whole adult population'* (Józán, 1994a, 1994b). Life expectancy declined in each age group, especially in the case of middle-aged males. This could result internationally disadvantaged health position in the world. It is worth mentioning that average life expectancy at birth is increasing continuously from 1996 so health transition is an actual and recent process in Hungary. The Hungarian epidemiological crisis is now over and it has turned into a new epidemiological stage from the second half of the 1990s. Despite of this relatively advantaged health process health inequalities remain well-marked in Hungary (Uzzoli, 2016b).

Unfavourable demographic processes in Hungary are contributing to the disadvantaged health situation. Continuous natural decreasing can be experienced from 1981, which was caused by a decline in the birth rate and high mortality rate. From that time in each year the mortality rate is higher than birth rate. That is, the natural population growth in Hungary fell below zero in 1981, much earlier than in any other Central and

Eastern European countries. On the other hand, birth rate is internationally very low, because Hungary's fertility rate is below EU average. Like many countries in the European Union, Hungary is facing a demographic crisis with a population that is slowly contracting (Szabo-Borsanyi, 2006). Hungary has the second-worst negative growth among EU countries. While the gradual ageing will be affected the distribution of age structure in the future. The ageing index has been increasing constantly since 1990 and is not expected to change in the coming decades (Hablicsek, 2004). Hungarian society is rapidly aging, which expects the rate of the population over age 65 to minors under 18 to reach 1.66 to 1 by 2030 (Data source: www.ksh.hu).

According to the worse morbidity and mortality situation of Hungary, some problems and challenges as well as facilities related to the Hungarian health care system will be discussed in the next chapter.

Challenges and outcomes in the Hungarian health care system

The socio-economic and political regime change also generated conflicting effects in the functioning and financing of health care system and was accompanied by intense social conflicts. The effective treatment and the development of medical technology launched favourable processes in medication. However the heritage of state socialist system, the weak role of preventive approach in the primary health care, and the conflicts of health insurance system are the causes of serious dysfunctions nowadays. The Hungarian health care system in the 21st century essentially combines the anomalies of the socialist system with the distortions of market mechanisms. [Note: the following short and straightforward analysis is only focusing some significant health care issues regarding health inequalities, and it is not aimed to give comprehensive review about all problems and challenges of the Hungarian health care system.]

Actually the most determinative challenge of the Hungarian health care system is that functionally, structurally and financially cannot reduce health inequalities which exist in the

country. Summarizing the primary results of literature review and the experiences of the prepared expert interviews the following key problems can result dysfunctions and anomalies in the Hungarian health care system (e.g. OECD, 2017; Makara, 2015; Vinkovits, 2012; Gaál et al., 2011; Land, 2006; WHO Regional Office for Europe, 2000).

Prevention and health promotion are underfunded, their organization underdeveloped and intersectoral activities are poorly coordinated and growing inequities are not addressed properly. According to the new Hungarian law on primary health care (2015), especially preventive issues are emphasized in policy recommendations for general practitioners.

Health care reforms have also been unable to address increasing problems related to allocative efficiency. To achieve a more efficient and more equitable service delivery system is to reorganize existing capacities based on health needs assessment. It would require more evidence-based, performance-monitoring and transparent policy-making at the health policy level.

There is a human resource/health workforce crisis emerging due to the aging of health care professionals (mainly among general practitioners), staff shortages, lower income and increasing migration, especially among physicians.

The basic level the primary health care is not able to supply efficiently its gatekeeper function, which can result that many patients are supplied at higher level in the health care system than their health status needs that (weak progressivity in the health care hierarchy).

It is also worth mentioning some outcomes and facilities which can be realized after the economic and political transformation in the Hungarian health care system from the beginning of the 1990s (e.g. OECD, 2017; Makara, 2015; Vinkovits, 2012; Gaál et al., 2011; Land, 2006; WHO Regional Office for Europe, 2000):

Hungary has achieved a successful transition from an overly centralized, integrated health care system to a purchaser-provider split model with output-based payment methods. Since 1995, legislation has defined the minimum requirements in terms of equipment and personnel institutions need to get a licence. There is prior to that the legal protection of non-

smokers had been in effect since 1999 to protect all persons from exposure to tobacco smoke and to regulate the consumption of tobacco products. Health insurance covers all costs related to health check-ups, all level of health care, deliveries, emergency medicine and blood transfusions. Pharmaceuticals, medical aids, dental care and rehabilitation are also included in the insurance scheme, but out-of-pocket payments are always required. Hungary is a target country in cross-border health care, mainly for dental care, but there are excellent facilities for rehabilitative services, such as medical spa treatment. The health industry is seen by the government as a potential strategic area for economic development and growth for the future.

Conclusions

Hungary has achieved a successful transition from an overly centralized health care system of the communist era to a purchaser-provider split model with output-based payment methods after the transformation in 1989. The balance between existing capacities and the health care needs of the population remains less than ideal, but improvements have been made over the past more than 25 years. The central government has almost exclusive power to formulate strategic direction and to issue and enforce regulations regarding health care in Hungary (Gaál et al., 2011).

It is clear that significant challenges are existing in Hungary in the need to reduce health inequalities and to increase the accessibility of health care services. The most urgent task for policy making is to make more specific interventions for quality-development oriented financing and for improving the management of care for non communicable diseases. The need for comprehensive health care reform will become apparent in the near future to solve all problems and challenges of the Hungarian health care system. Research on the relationship between health inequalities and access to health care must be strengthened in the future, including some focus on the difficult questions of effectiveness and efficiency as well as social justice which often result inequity in health and health care. Better understanding of the drivers of health inequalities as well as

influencing factors of accessibility can help to support evidence-based policy making.

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