
HEALTH STATUS, HEALTH INEQUALITIES IN INTERNATIONAL COMPARISON

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1. The importance of health inequalities

Health status can be viewed as a complex ‘outcome indicator’ of a country’s socio-economic and political processes (Sen, 1995) because a long and healthy life is in itself a valued outcome for individuals. It is also one of the key components of well-being at both the societal and the individual level that are fundamentally influenced by government policies. Furthermore, the right to health is one of the fundamental dimensions of human dignity, human rights and the fulfilment of democratic norms. Currently, the growth in health inequalities poses a serious threat to the economic performance and long-term social progress of Hungary. Alleviation of these inequalities is of fundamental importance to Hungarian society (Orosz and Kollányi, 2014).

Health inequalities have received increasing attention in the international arena since the early 2000s, following a long period of ‘being forgotten’ (Marmot and Wilkinson, 2000). The greater attention to health inequalities is part of a broader paradigm shift. Research – as well as increasing social and political tension – has highlighted the fact that social polarization, disintegration and the upsurge in political extremism represent threats not only to individual well-being, security and life satisfaction, but also to long-term economic development (OECD, 2011). Demographic change – and the declining share of the active population – has drawn attention to the human factors of economic growth. This has brought about a new approach in the European Commission’s health policy: governments have been encouraged to consider good health and health care as a key factor contributing to a quantitative and qualitative improvement in labour supply, as well as to long-term economic growth (European Commission, 2007). However, the economic crisis that broke in 2008 did have a number of negative effects on health and health care: on the one hand, it aggravated the social risks associated with health inequalities; on the other, it further reduced the availability of resources to tackle those inequalities (WHO, 2013). Public spending on health fell in real terms

in a number of countries – including Hungary – in the early 2010s (Quaglio et al., 2013).

Different aspects of the inequalities in health and health care have been addressed by social research in Hungary since the early 1980s, and thus a substantial body of knowledge has accumulated over recent decades (see, for example, Habcsek, 2007; Józán 1994; Kovács 2007; 2012; Kopp and Szedmák, 1998; Losonczy, 1989; Orosz, 1990). Nevertheless, considering their importance, health inequalities have thus far received limited attention among the political elite and the public.

1.1 Conceptual framework and main questions

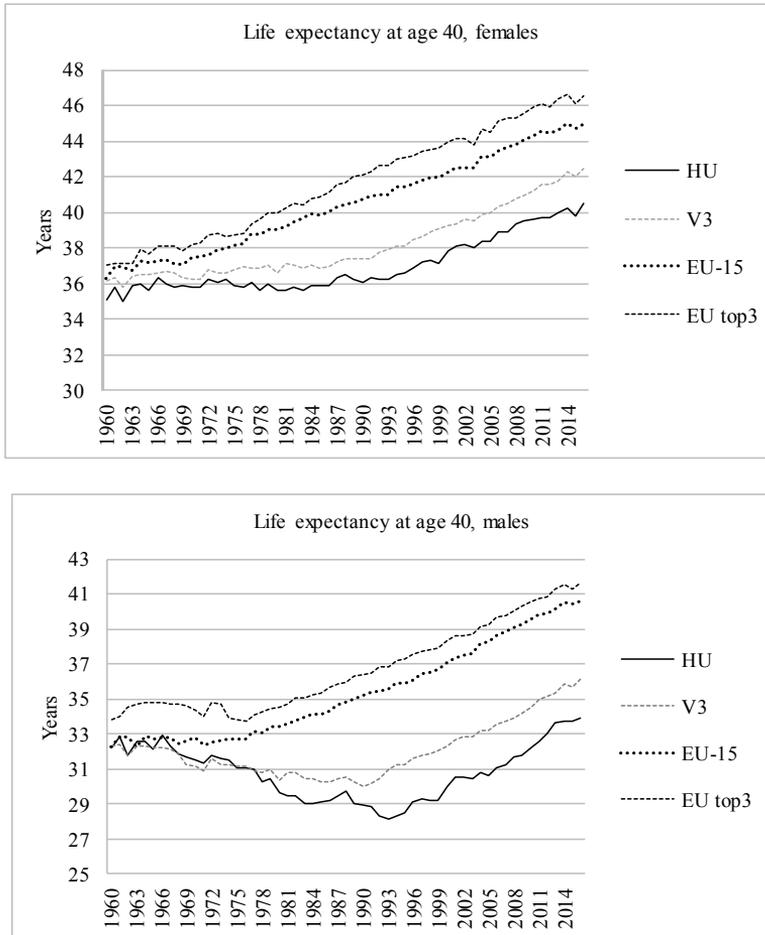
This study, first of all, assesses the position of Hungary in terms of health status and health inequalities in the European arena; and secondly, it examines inequalities between different social groups within the country. The analysis addresses the following main questions: what is the situation in Hungary in terms of health status and health inequalities in international comparison? Has the gap between Hungary and the leading countries narrowed in the decades since the political transition of 1989–90? Is general health in Hungary better or worse than might be expected on the basis of the country's level of economic development? How have inequalities changed within the country? The final part of the study will also address some of the causes of health inequalities. The analysis is based primarily on various Eurostat and OECD datasets.

2. Long-term trends in health

From the mid-1980s, a number of authors highlighted the worsening of the health status (mortality) of the Hungarian population, which has resulted in a widening gap compared to the developed countries. This decline is comparable only to that seen in other socialist countries after the second half of the 1960s (Józán, 1994; Orosz, 1990). In 1960, there were no differences in the average life expectancy of men in Hungary and in (what would become) the EU-15 countries or the three other Visegrád countries (Czech Republic, Poland and Slovakia – here, the V3) (Figure 1). Life expectancy – life expectancy at age 40, in particular – started to fall in the mid-1960s, and this trend accelerated in the early 1990s, up to 1993.

Things changed in 1994, and life expectancy has since been increasing, primarily thanks to a fall in cardiovascular mortality (HCSO, 2015; Bálint and Kovács, 2015). However, the extent of the improvement has not been sufficient to raise Hungary's relative position in international comparison (*Figure 1*).

Figure 1 *Life expectancy at age 40 in Hungary in European comparison, 1960–2016 (years)*



Note: EU top 3: the average of the three best-performing EU Member States.

Source: Life expectancy – World Bank Life expectancy at birth, total (years) (code: SP.DYN.LE00.IN), Eurostat [demo_mlexpec], stats.oecd.org: Health status – Life expectancy; Population – Eurostat [demo_pjan] (downloaded September 2018).

The health of the Hungarian population remains among the worst in the EU. The severity of the situation is highlighted by the fact that since the end of the 1980s, the gap between Hungary and not only the EU-15 but also the V3 countries has widened on a number of key health indicators – in the case of men,

both life expectancy at birth and at age 40. In 2016, male life expectancy at age 40 was 6.7 years lower in Hungary than in the EU-15 and 2.2 years lower than in the V3 (in 1989, the gap was 6 years and 1 year, respectively).

The gap has also increased for women since the late 1980s: in 2016, the difference in life expectancy at age 40 between Hungary and the EU-15 was 4.5 years, compared to 3.9 years in 1988. In fact, the gap that had opened up for women by 1993 has stayed essentially the same ever since. It is also clear that in the late 1980s and early 1990s, the gap between the V3 countries and the EU-15 was narrower than that between Hungary and the EU-15.¹

The fact that the life expectancy of Hungarian men at 40 was only 1.7 years more in 2016 than in 1960 can also be interpreted as suggesting that the socio-economic developments of the past 50 years or more have had a very limited impact on the overall life prospects of Hungarian men.²

One of the key determinants of health is the economic development of a country – measured here (for want of a better indicator) as GDP per capita.

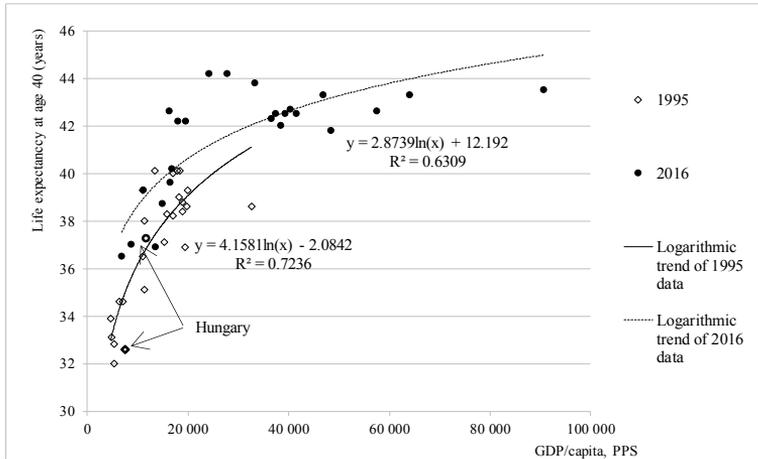
The regression curves of *Figure 2* show – in a slightly simplified form – the health status (life expectancy at 40) that could be ‘anticipated’ at certain levels of economic development. In countries where life expectancy is below the curve, health in general is worse than the level of economic development of those countries would predict, due to factors other than per capita GDP (e.g. economic efficiency, social indicators, health system, etc.). In countries that are above the curve, the situation is the opposite.

During the period under consideration, life expectancy in the Hungarian population at age 40 increased by 4.7 years, which in itself can be regarded as a positive outcome and places Hungary in this respect in the top third of the countries examined. However, in both years (1995 and 2016) the health status of the population (life expectancy at 40) was considerably worse in Hungary than might have been expected on the basis of the country’s level of economic development. Although life expectancy has increased in recent years, that increase has been more modest than in the other post-socialist countries, and our position relative to our economic development has not improved.

¹ In the dramatic deterioration in the early 1990s, the trends felt in the previous state socialist period combined with the shocks of the regime change (e.g. job losses). There is no scientific analysis available to show the size of the impact for the two factors.

² Life expectancy at 40 is a more appropriate indicator in this context, because life expectancy at birth is heavily influenced by infant mortality.

Figure 2 Relationship between life expectancy at age 40 and GDP in EU Member States in 1995 and 2016 (logarithmic regression)



Source: Eurostat online database, [demo_mlexpec] and [nama_gdp_c] datasets (down-loaded September 2018).

In 2016, only Lithuania was in a worse position: with a somewhat higher level of economic development, life expectancy at 40 was even lower than in Hungary. All the other post-socialist countries either – in the worst cases – achieved comparable health status at a substantially lower level of economic development (e.g. Romania and Bulgaria) or else they attained considerably higher life expectancy at a similar level of economic development (e.g. Poland).

In Hungary, the gap between actual and ‘anticipated’ life expectancy at age 40 was estimated to be 1.8 years in 2016 and 2.4 years in 1995. Some of the many explanatory factors for this shortfall are the catastrophic levels of health inequality between social groups and other social inequalities that exacerbate these.

It is worth highlighting the fact that ‘anticipated’ life expectancy (on the whole) was higher for any given level of economic development in 2016 than in 1995; thus, a specific level of economic development predicted higher life expectancy at the end of the period. Of the many potential reasons for this, the development of health technology should be underlined. Various studies have pointed out the significant contribution of health technology development to the improvement in life expectancy in recent decades, in particular progress in the prevention and treatment of cardiovascular disease (e.g. drug treatments

for high blood pressure) (Nolte et al., 2012). However, it is also clear that the curve did not simply ‘shift upwards’, but rather the gap widened between life prospects at lower and higher levels of economic development.

3. Premature and avoidable mortality

The premature (early) mortality of the Hungarian population declined substantially between 2001 and 2015 – by 25.7 per cent calculated as the death rate per 100,000 population below the age of 65³ and by 19 per cent calculated as the mortality rate for four major non-communicable diseases (NCDs) between the ages of 30 and 70.⁴ However, our relative position is still worse in this respect than in terms of total mortality (*Table 1*).

Table 1 *Relative position of Hungary among the Visegrád countries with regard to premature and avoidable mortality, and public spending on health, 2015*

	Hungary	Czech Republic	Poland	Slovakia
	(EU-14* average = 1)			
Total mortality	1.57	1.34	1.33	1.45
Premature mortality***	2.09	1.32	1.79	1.76
Preventable mortality	2.21	1.51	1.46	1.91
Amenable mortality	2.66	1.78	1.67	2.48
Per capita public expenditure on health**	0.38	0.6	0.37	0.52

Note: *EU-15, without Luxembourg.

Source: Eurostat, basic data for calculations: age-standardized mortality rates per 100,000 population. ** OECD Health Data 2015, *** Here: based on the Eurostat data-base, deaths occurring before the age of 65.

The difference between premature and avoidable mortality is that the former includes all causes of death, whereas the latter considers only ‘preventable’ and ‘amenable’ causes, where death before a specific age can be avoided with optimal-quality treatment and effective prevention. The concept of avoidable mortality emerged in the international literature in the 1990s (Mackenbach et al., 1990) – one of the approaches that seek to develop a measurement method

³ Source of data: <https://ec.europa.eu/eurostat/web/health/causes-death/data/database>

⁴ This is a key indicator of the WHO. The four major non-communicable diseases are: cardiovascular disease, cancer, diabetes and chronic respiratory disease. Source of data: https://gateway.euro.who.int/en/indicators/h2020_1-premature-mortality/

to provide a general indicator of the performance of healthcare systems. According to Eurostat, ‘While the amenable mortality indicator is not meant to be a definite or unique measurement of the quality of health care in the Member States, it provides some indication of the quality and performance of healthcare policies in a country’ (Eurostat, 2016: 1).⁵

The relative position of Hungary is particularly unfavourable for both preventable and amenable mortality: whereas in 2016 the total (standardized) mortality rate was 1.6 times higher in Hungary than in the EU-14,⁶ for amenable mortality the figure was 2.7 times and for preventable mortality – 2.2 times higher (*Table 1*). Thus, mortality is markedly higher for causes that are heavily influenced by the performance of the healthcare system. Compared to the Czech Republic and Poland, our relative position is much worse in terms of avoidable mortality than in terms of total mortality.

The performance of the health system is heavily influenced by the level of healthcare expenditure, especially public spending. With regard to per capita public expenditure – that is, an indicator of the volume (quantity and quality) of health services used by the population – the gap between Hungary and the EU-15 has widened since the political transition of 1989–90; and the same is true even of the gap between Hungary and some of the V3 countries. In 1992, per capita public expenditure on health in Hungary was 47 per cent of the EU-15 average (and slightly higher than the figure in the Czech Republic); in 2016, it was only 38 per cent of the EU-15 average (and a mere 63 per cent of the level of per capita spending in the Czech Republic). The extent of the ‘withdrawal of funds’ from health can, without fear of exaggeration, be described as dramatic. This is further illustrated by the fact that in 2016 public spending on health in Hungary amounted to only 4.9 per cent of GDP, compared to 6 per cent in 1992. The decline in health expenditure as a percentage of GDP is almost unique in the EU: public spending on health as a percentage of GDP was higher in every other country (except Latvia) in the early 2010s than in the early 1990s. The withdrawal of funds from health care had an impact on a number of areas, especially access to and quality of health care, resulting in slower improvement in amenable mortality than, for example, in the Czech Republic and Poland. Therefore, our disadvantageous relative position

⁵ Obviously, it is not realistic to assume that a situation can be achieved where no deaths occur due to these reasons before a specific age; however, the comparison of amenable mortality across time or geographical units is a good indicator of the performance of healthcare systems and their effect on health status.

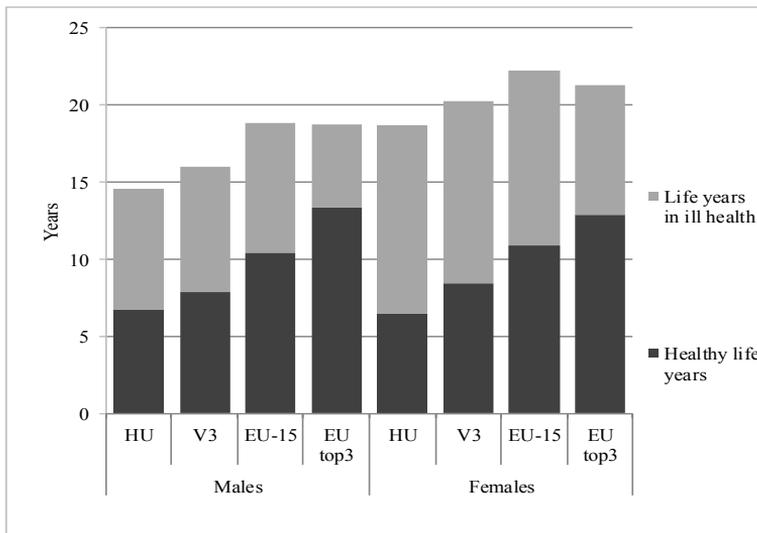
⁶ EU-14: EU-15 Member States without Luxembourg.

in amenable mortality can be interpreted as the price paid for the increasing gap in financing, measured in deaths that could have been avoided.⁷

4. Life expectancy and healthy life years at age 65

One of the key demographic and social challenges is the health status and quality of life of the elderly. From an economic and social perspective, the health status attainable in older age is important for a number of reasons. On the one hand, better general health is likely to increase the labour supply of older workers – even beyond pension age. On the other hand, care needs associated with poor health might divert working-age family members away from the labour market to look after elderly relatives. Recognition of this challenge has led to the adoption of healthy ageing policies in the EU and a number of Member States. One way of describing the general situation is by comparing life expectancy and healthy life years at age 65 (*Figure 3*).

Figure 3 *Life expectancy and healthy life years at age 65, 2016*



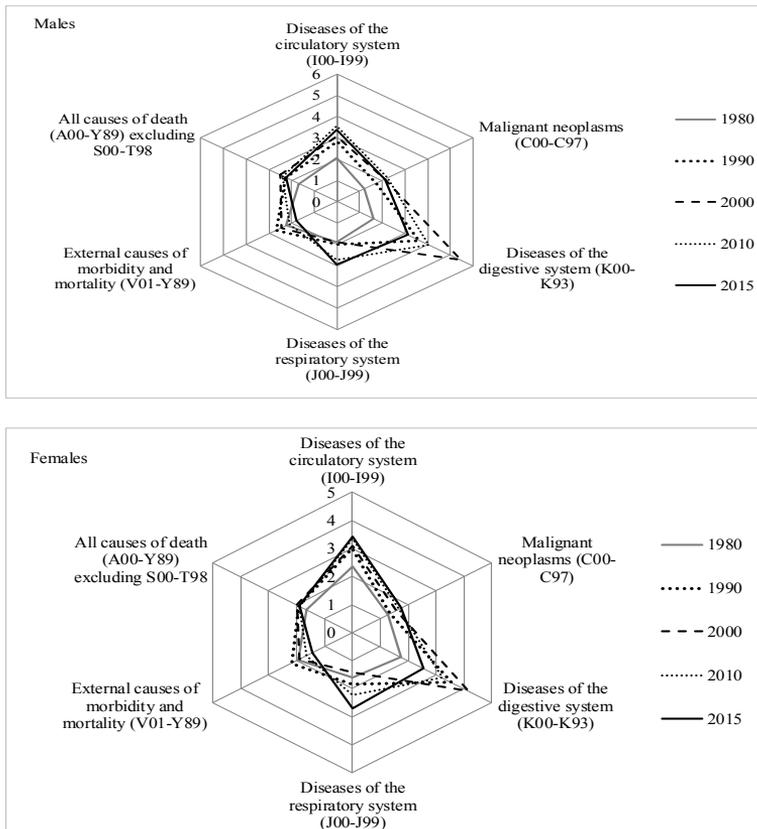
Note: population-weighted averages; EU top3: average of three best-performing EU Member States in terms of healthy life expectancy.

Source: Eurostat [hlth_hlye] and [demo_pjan].

⁷ Obviously this is not just about the scale of expenditure, but also about how efficiently the health system uses the resources available.

The differences between the two types of life expectancy can be substantial – not just when we compare Hungary and the EU-15, but also when we look at the different developed countries. In the three best-performing EU Member States, men can expect to live an additional 18.7 years after the age of 65, with 71 per cent of this (13.4 years) in good health; in the EU-15 generally, average life expectancy at the age of 65 is similar (18.8 years), but only 55 per cent of this (10.4 years) will be spent in good health.

Figure 4 *Relative mortality by leading causes of death in the population aged 0–64 in Hungary, compared to EU-15 averages, 1980, 1990, 2000, 2010, 2015 (EU-15 average=1, standardized mortality data)*



Source of data: <https://ec.europa.eu/eurostat/web/health/causes-death/data/database>. [hlth_cd_asdr2] and [hlth_cd_hist] (downloaded September 2018).

At age 65, Hungarian men can expect to have 3.7 fewer healthy life years than the EU-15 average, while the number of years lived with limitations in activities of daily living is only 0.6 years shorter.

5. Trends in cause-specific mortality

The short life expectancy is due to substantially higher mortality in certain age groups in Hungary than in other countries in our comparison. *Figure 4* depicts trends in cause-specific mortality relative to EU-15 countries.

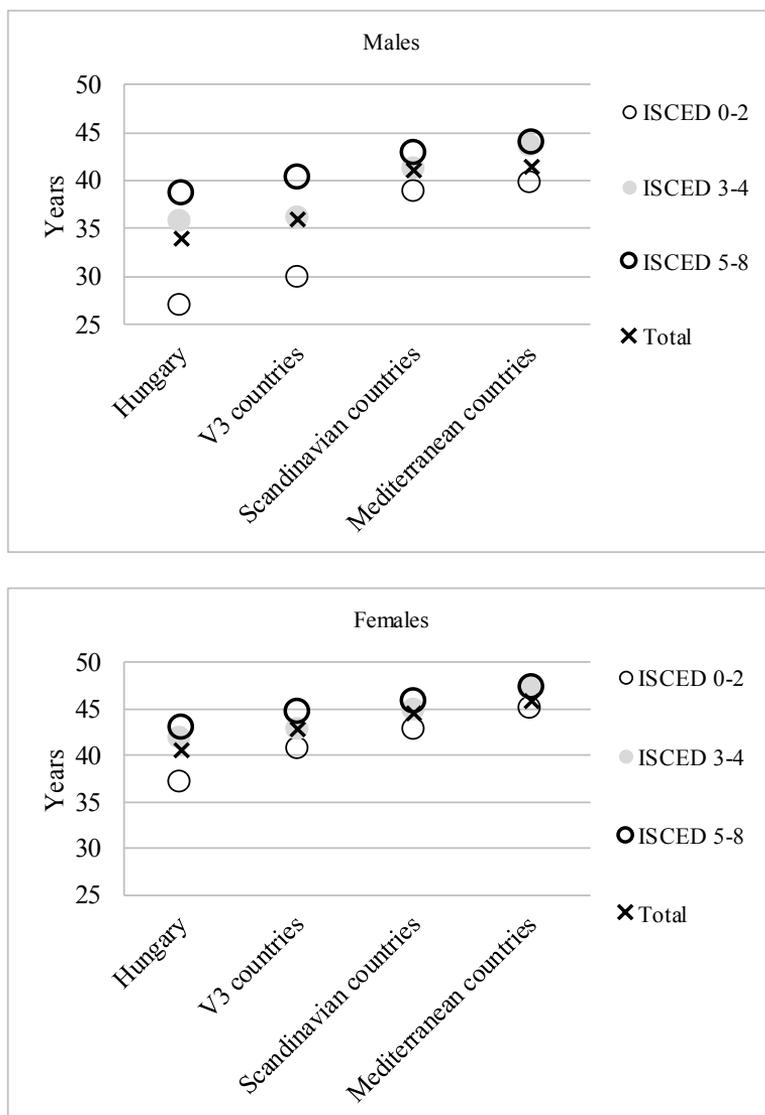
In 2015, among both men and women there were 3.4 times more deaths from cardiovascular (circulatory) disease – the most common cause of death – than the EU-15 average. Mortality from cancer (malignant neoplasms) was just over double the EU-15 rate for men and 1.8 times higher for women. The mortality gap for both men and women was wider in 2015 than in both 1980 and 1990. This is strongly associated with problems accessing health services and in the quality of those health services, as highlighted previously.

6. Inequalities by educational attainment

Health status is associated with all the various components of social stratification – both via their complex relationship with each other and directly, ‘in their own right’. Thus, health inequalities associated with educational attainment reflect not merely the impact of schooling, but also the combined impact of disparities in income, employment and material conditions, which are all related to education as well (Kovács and Bálint, 2014).

Regarding the levels of disparity in life expectancy by education observed in Hungary and the V3 countries, it is notable that low-educated men have far worse health status than their counterparts in Mediterranean and Scandinavian countries (*Figure 5*).

Figure 5 Life expectancy at age 40 by education level in different groups of EU countries, 2016 (year)



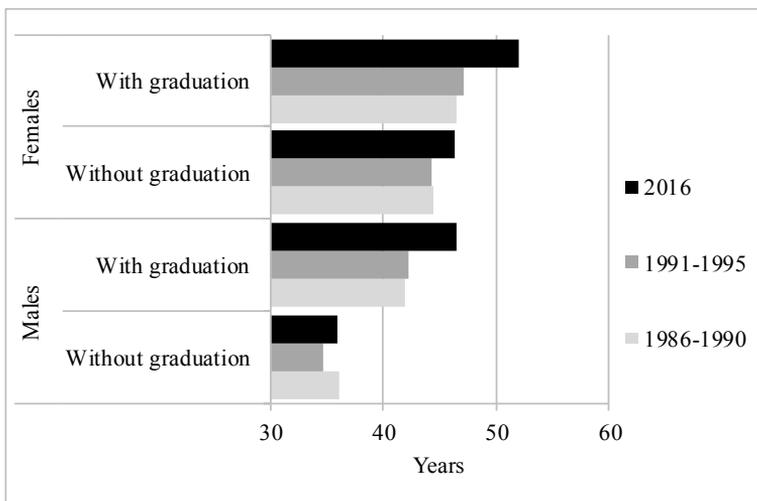
Note: population-weighted averages. ISCED 0–2: lower-secondary education at most (without graduation); ISCED 3–4: upper-secondary education (with graduation); ISCED 5–8: tertiary education.

Source: Eurostat [demo_mlexpededu] and [demo_pjan].

The disadvantage of low-educated men is much greater in the Visegrád countries than in the other two groups of countries; accordingly, at the age of 40 they can expect to live for 11–12 years less than their peers in Mediterranean or Scandinavian countries. Meanwhile, the gap is only 4–5 years among the highly educated. In other words, the fact that overall life expectancy is much lower in Hungary – and in the other Visegrád countries – than in Western Europe is largely due to massive disparities in health status by education level, and particularly the huge disadvantage of low-educated men compared to other groups in society.

Not only could low-educated men expect to have a shorter life, but their life expectancy also continued to decline in the first half of the 1990s – a trend that was quite different from that observed in developed countries, as highlighted earlier. Meanwhile, during the same period, life expectancy at age 30 increased substantially for those with higher levels of education (*Figure 6*).⁸

Figure 6 *Life expectancy at age 30 by sex and education, 1986–2016 (years)*



Note: Time series for different educational groups have been standardized using rough population distribution estimates by education based on census data.

Source: Hablicsek (2007: 19); Eurostat [demo_mlexpedu]; HCSO Population Census 2011, Education: http://www.ksh.hu/nepszamlalas/tablak_iskolazottsag

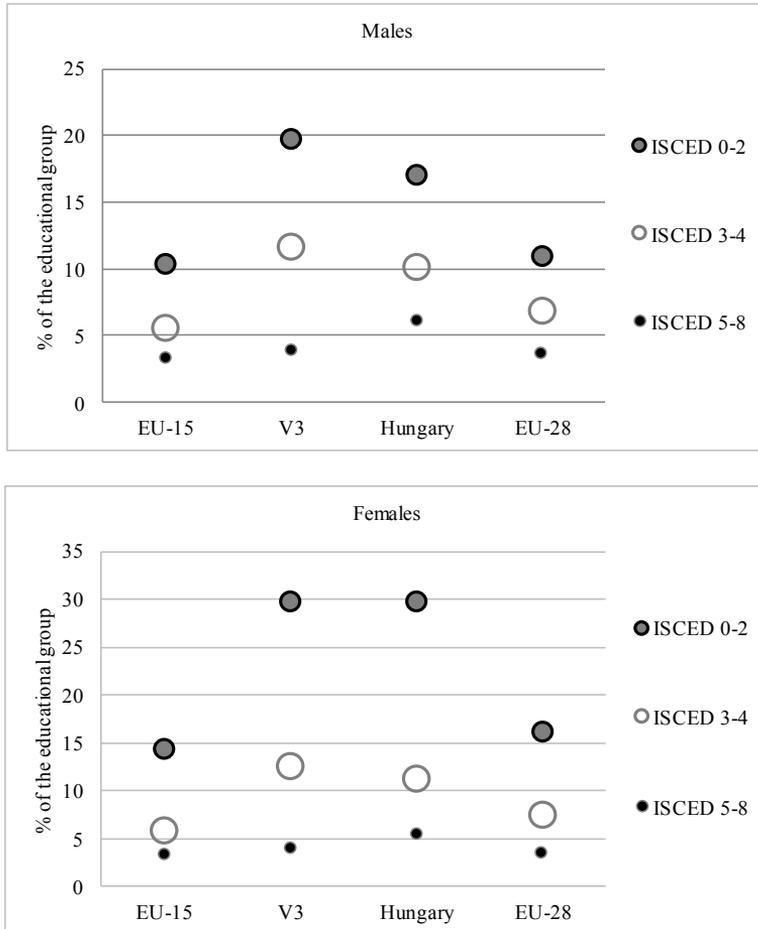
⁸ The availability of data explains why the indicator of life expectancy at age 30 is used here instead of life expectancy at age 40.

After a long period of stagnating (or even deteriorating) life expectancy (depicted in *Figure 1*), in the early 1990s life expectancy started to increase in all social groups, except for low-educated men. Their life prospects continued to deteriorate until 1995, and they only returned to their late-1980s level in the mid-2000s. The worst situation was observed among those with the lowest level of education, namely those who had not even completed primary school: according to available data, their life expectancy declined noticeably year on year until 2004, including a three-year drop between 1990 and 1995 (Hablicsek, 2007). Therefore, when the life expectancy of those in a better situation started to increase, the gap between the higher- and the lower-educated also started to widen. While life expectancy for men with secondary education (and with a leaving certificate) at age 30 was 5.7 years greater and for women 2.1 years greater than for those without secondary education in the late 1980s, by the mid-2000s this had increased to 8.7 years among men and 5.6 years among women. For men, the gap between those who had not completed primary education and those with tertiary education increased from 8.9 to 16.5 years; and for women it widened from 4.0 to 10.2 years (Hablicsek, 2007). By the middle of the 2010s, inequalities were deeper than in either the mid-1990s or the mid-2000s: men with secondary education at age 30 could expect to live 10.7 years longer than those without secondary education; and women could anticipate an additional 5.6 years.

Aside from objective life expectancy, there are also differences in self-reported health across the different educational groups. In all countries, approximately 5 per cent of those with higher levels of education assessed their health as 'poor' or 'very poor', but among the low-educated population, self-rated health appears to be considerably worse in Hungary and the other Visegrád countries than in the EU-15 (*Figure 7*).

It must be noted that although self-rated health is a good indicator of health status, it is also heavily culture dependent; thus caution must be exercised in using it to compare countries.

Figure 7 Percentage of people self-reporting poor or very poor health, by level of education in Europe, 2016 (per cent)



Note: population-weighted averages. ISCED 0–2: lower-secondary education at most (without graduation); ISCED 3–4: upper-secondary education (graduation); ISCED 5–8: tertiary education.

Source: Eurostat [hlth_sile_02] and [demo_pjan].

7. Geographical inequalities

Health inequalities in Hungary are substantial not only along lines of social stratification, but also across different geographical areas; and these have also

increased considerably in a number of areas since the political transition of 1989–90 when set alongside the general improvement of health status in the 2000s (Hablicsek, 2007; Juhász et al., 2010). The territorial inequalities in health to a large extent reflect the social disparities of different regions. However, risk factors specific to particular regions – e.g. pollution, housing conditions, healthy drinking water, and poor access to health care – also play a role. In terms of male life expectancy at birth, the difference between the best and the worst microregion was nearly 13.5 years in 2014 (data supplied by the Hungarian Central Statistical Office).

8. Inequalities in access to health care

Two general aspects of access to health care are unmet need and inequalities in healthcare utilization. Information on the first aspect can be obtained from surveys that report the percentage of the population that cannot access certain services, even though they would like to. The other aspect indicates inequalities among those who manage to access particular services, in terms of the financial burden, waiting times and quality of care (in other words, whether they access adequate care for their condition). In this regard, the extent of out-of-pocket expenses associated with healthcare utilization is crucial.⁹

Among the European OECD countries, only Swiss and Greek households spend a higher share of their income on health care than Hungarians. In 2015, 4.4 per cent of the final consumption of Hungarian households was direct health expenditure, above the OECD average of 3.0 per cent.¹⁰ Furthermore, among EU Member States, one of the highest shares of out-of-pocket payments in total health expenditure was in Hungary – a total of 29.0 per cent in 2015; meanwhile the EU-28 average was 21.8 per cent and the average of the EU-15 countries was only 18.3 per cent (Eurostat, 2018).¹¹ Another important aspect of service utilization is its quality. For example, a general indicator of quality is the percentage of hospital admissions for chronic conditions where hospitalization is unnecessary if there is adequate quality primary care. In the

⁹ This does not include social insurance contributions or private insurance fees paid by households.

¹⁰ Data from the OECD database *Health expenditure and financing* (downloaded September 2018).

¹¹ Direct household expenditure is usually estimated on the basis of GDP calculations by national statistical offices and also takes account of spending in the shadow economy, including ‘under-the-table payments’.

case of asthma and COPD,¹² for instance, in 2015 of the OECD countries the rate of avoidable hospitalization (a good measure of the quality of primary and outpatient care) was highest in Hungary: around 3 times as many people (per 100,000 population aged over 15) were hospitalized in Hungary as in the best-performing European countries (OECD, 2017). Various factors can contribute to this: from lack of knowledge and/or incentives of doctors in primary care through to unequal access to health care. In November 2018, there were 331 permanently vacant general practices in Hungary (National Institute of Primary Care, 2016; 2018) – almost double the figure in 2001 (Lakatos and Tokaji, 2009) and 30 per cent higher than in 2016. Furthermore, the absolute and relative share of vacant practices was highest in the economically most deprived counties.

9. Social determinants of health inequalities

Health inequalities do not exclusively affect people with the lowest income and lowest education; rather, life expectancy gradually declines as one goes down the social ladder – this is what the literature terms the *health gradient* (Marmot and Wilkinson, 2000). According to the World Health Organization (WHO, 2008; Solar and Irwin, 2010), the determinants of health status and inequalities can be categorized into three main groups:

- structural factors (economic, social, socio-psychological, public policy, plus stratification of the population by income, education and economic sector);
- risk factors that directly affect health (environmental hazards, stress, diet, health-damaging behaviours, etc.); and
- the operation of the healthcare system (e.g. massive inequalities in access to and quality of services, etc.).

The development and the mixture of direct risk factors – smoking, alcohol consumption, diet, body weight, living conditions – are strongly associated with social status. In other words, lifestyle and the physical environment ‘transmit’ the effect of social status onto health. Moreover, psychosocial factors, especially perceived stress, can have a significant impact, too (Wilkinson and Pickett, 2009; Kopp and Szedmák, 1998). The extent of stress is strongly related to an individual’s social status, on the one hand, and to the

¹² Chronic obstructive pulmonary disease is a common condition that mainly affects smokers and is characterized by breathing problems. In serious cases, it can become life threatening or lead to death.

cultural characteristics of society (primarily the level of social cohesion), on the other.

Hungary is ranked in the worst third of EU countries on all direct risk factors, with the exception of alcohol consumption¹³ and the consumption of vegetables and fruit (where the country ranks somewhere in the middle). In terms of both the proportion of smokers and the incidence of obesity, it is the third worst country in the EU, while the proportion of those living in poor-quality housing is also one of the highest.¹⁴ On a number of indicators, the relative position of Hungary is substantially worse for people with lower social status than for the total population.

Governance and public policies (economic, employment, social and health policies, etc.), and the cultural patterns, norms and values characteristic of a particular society make up one of the components of the structural determinants of health inequalities. The other – related – structural factor is the socio-economic status of individuals – namely the stratification of the population by income, education, economic sector, gender, etc. Then, one's position in the social hierarchy has a strong effect on one's material conditions (working and living conditions), psychosocial situation and health behaviours – that is, risk factors with a direct impact on health status. The health system can mitigate or exacerbate the effect of the other social determinants of health inequalities. Meanwhile, ill health can have an impact on an individual's social situation – for example, by reducing his/her labour market opportunities, and thus income.

The determinants of health inequalities are addressed in detail in other chapters in this volume, and therefore only a few key factors are highlighted here. The average level of education has increased steadily in Hungary since the regime change, which can certainly be regarded as a positive development from the perspective of general health status. However, the proportion of those who complete primary education, but do not subsequently graduate from school with a leaving certificate has remained unchanged (Eurostat);¹⁵ this is aggravated by the fact that the Hungarian education system is unable to equip these young people with the skills necessary for the current labour market (Hárs, 2012). The employment level in Hungary was among the lowest in the European Union until 2013 (Hungarian Central Bank, 2013; Eurostat¹⁶) – if

¹³ Measured as percentage of persons aged 15 and over who drink alcohol every day.

¹⁴ Eurostat (hlth_bmi), (hlth_cfv), (hlth_smok), (hlth_alk), (ilc_mdho01) datasets; accessed September 2018.

¹⁵ Eurostat online database [ilc_lvps04] (downloaded June 2016).

¹⁶ Eurostat online database [lfsi_act_a] (downloaded June 2016).

public workfare programmes that do not offer a real solution to long-term unemployment and international labour migration are not considered (Köllő and Scharle, 2011). The increase in income poverty and deprivation up until 2013 was a direct consequence of this. The proportion of people living in material deprivation increased by nearly 50 per cent in Hungary between 2008 and 2013, and the figure only started to decline in 2014. In the EU-28, only Bulgaria and – marginally – Romania had a higher proportion of people living in deprivation.

However, the impact of these material factors on health status is, to a large extent, determined by public policies and institutions, as well as by the subjective experience of poverty in a given society (Orosz and Kollányi, 2017). Hungary is characterized by weak solidarity, low levels of trust and high levels of stress among those at the ‘bottom’ of society (‘losers’), and this has the potential to turn the (‘hard’) structural and material factors into risk factors that are highly damaging to their health.

All the factors mentioned – including the low level of trust – are related to the fact that government decisions in the post-communist transition period were characterized by ‘public policy opportunism’.¹⁷ Public policies were motivated by budgetary constraints and short-term interests (Scharle, 2011): on the one hand, the radical reduction in public spending on education and health care as a proportion of GDP; and on the other, policies to boost the short-term material well-being and income of ‘median voters’ in the period running up to an election. Areas of policy that require long-term national strategies that span more than one parliamentary term – such as the environment, education or health care – became insignificant issues. Given that a sustainable improvement in health status and a reduction in the social disparities that lie behind health inequalities can only come about via coordinated and deliberate policies that are protected against the fluctuations of political cycles and that enjoy a high level of commitment from policy makers, public policy opportunism has had a particularly negative impact in this area.

10. Conclusion

Our study has presented an overview of the trends and determinants of the health status of the Hungarian population. Life expectancy was declining before the regime change, and continued to do so after it; however, life prospects

¹⁷ In this context, opportunism means that individual and lobby interests are placed above the public interest, and the country’s long-term interests are subordinated to short-term political considerations.

did start to pick up in the mid-1990s, although the trend continued to lag behind the EU-15 and the other Visegrád countries. Thus, in a number of areas our position relative to the EU-15 and the other Visegrád countries is less favourable than it was in the late 1980s. Despite some positive trends, health status is still worse in Hungary than might be expected on the basis of the country's economic development.

A modest overall increase in life expectancy has been accompanied by a dramatic increase in health inequalities. Inequalities between social groups and those living in different parts of the country run deep: for example, life expectancy at birth for men in the most deprived microregion is 13 years shorter than in the best-performing region.

Judged by both objective and subjective health status, health inequalities by level of education are substantially greater than the EU-15 average. Our relative position is especially unfavourable in terms of amenable mortality, which characterizes the performance of the health system. Behind all this lie the cumulative effects of the healthcare crisis and structural factors beyond the healthcare system.

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