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**Opportunism of Public Policies as an  
Underlying Determinant of Health  
Inequalities in Hungary**

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# Opportunism of Public Policies as an Underlying Determinant of Health Inequalities in Hungary

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## Abstract

A steep health gradient is a key characteristic of the Hungarian population's health status. The "health gap" between Hungary and the EU15 countries is greater now in several key indicators than at the end of the 1980's. By now, social inequalities, including health inequalities, have become a major obstacle to economic development, social progress and political stability. This paper intends to highlight how the opportunism of public policies has contributed to increasing health inequalities on the one hand, and to the ignorance of the problem on the other.

**Keywords:** Opportunism of public policy, health inequalities

## Introduction<sup>1</sup>

The first part of the paper presents the "health gap" between Hungary and the EU15 countries and the growing health inequalities within Hungary, as well as the underlying inequalities in socio-economic status of the population. The second part of the paper focuses on the opportunistic features of public policies most relevant from the perspective of health-inequalities: economic, labour market, tax and welfare, education and health policies.

Health inequalities are the results of a series of interconnected causes. Social, economic and political macro-structures and processes shape the socioeconomic position of individuals (i.e. the layers of society based on income, education, employment, etc.). In turn, individuals' social status

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<sup>1</sup>The paper is partly based on the authors' contribution to the project on „*Health inequalities and social determinants of health in Hungary*” commissioned by the WHO Regional Office for Europe, but goes beyond that in several respects.

real question is whether Hungarian public policy-making will be keeping its current characteristics, and hence aggravating health inequalities, or will be gradually shifting towards the desirable direction. This challenge can also be seen from a wider international perspective. In the developed world, encouraging economic growth, or rather, sustainable economic development, while also reducing income inequalities seem to be today's primary challenge. The OECD stresses that "*rising income inequality creates economic, social and political challenges. [...] Inequality of opportunity will inevitably impact economic performance as a whole [...] Inequality [...] generates political instability. It can also fuel populist, protectionist and anti-globalisation sentiments. [...] People will no longer support open trade and free markets if they feel that they are losing out while a small group of winners is getting richer and richer.*" (OECD, 2011.p. 40.)

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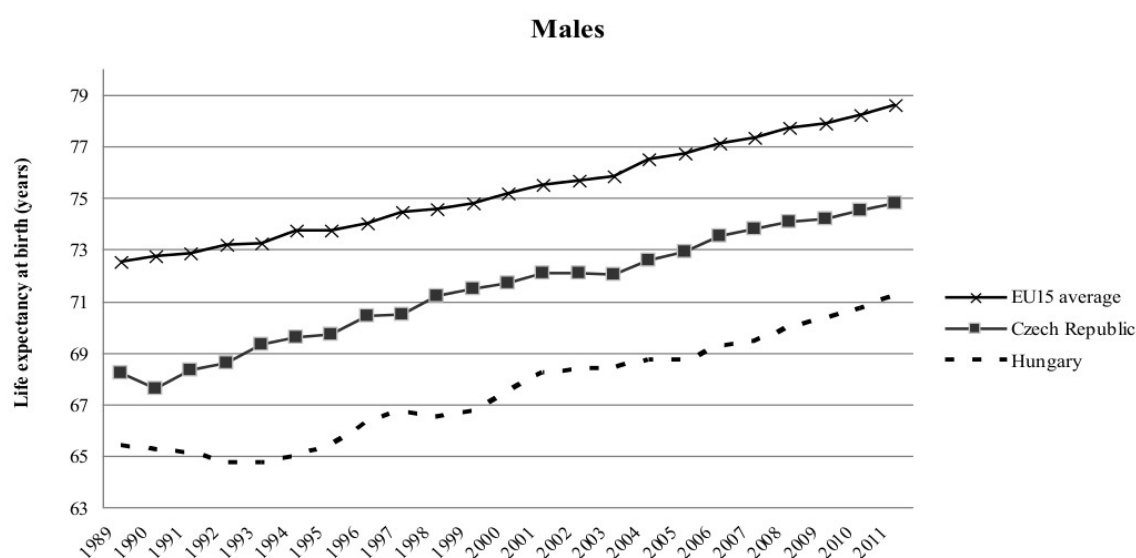
fundamentally influences their material circumstances, psycho-social condition and health behaviour, that is, the risk factors directly influencing an individual's health status and ability to cope with risk factors (WHO, 2008; Solar, 2010). Public policies can influence all these social determinants. In this article, the term of opportunism of public policies is used in a wider sense: it means that a government's decisions are made with little regard for the long-term social progress of the country, including the improvement of its health status. Instead, decisions are guided often by self-interested motives such as holding on to power, selfish and personal financial advantage, etc. Other guiding factors include the imperatives of short-term constraints (stemming partly from opportunistic policy-making in the past); ignorance, and the inadequacy of public administration in tackling severe social problems.

## Health Inequalities in Hungary

### *Inequalities between Hungary and the EU15 Countries*

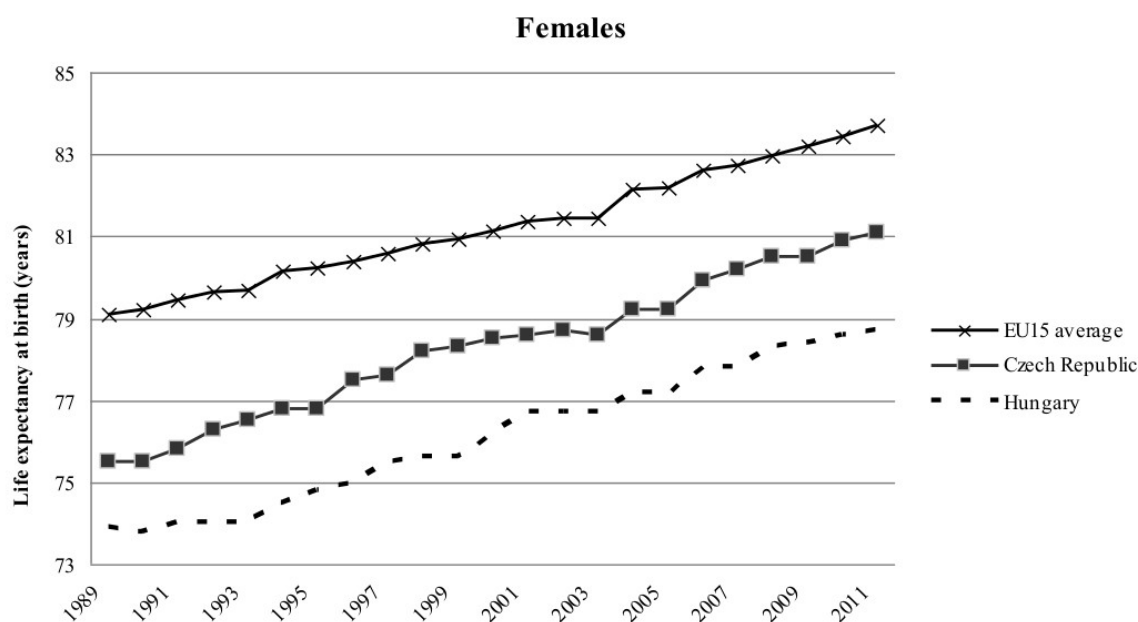
There are persistent and profound health inequalities both between Hungary and the most developed European countries, and within Hungary. The health status of the Hungarian population is one of the worst among the EU countries. Despite the improvement in life expectancy at birth in the 2000's, Hungary is lagging behind more than in the late 1980's not only compared to the EU15 average, but also compared to the Czech Republic (Figure 1). In 2011, Hungarian men had 7.4 years less while women 5 years less to live than the EU15 average<sup>1</sup>.

**Figure 1.** *Changes in Life Expectancy at Birth between 1989 and 2011*



Source of data: OECD Stat

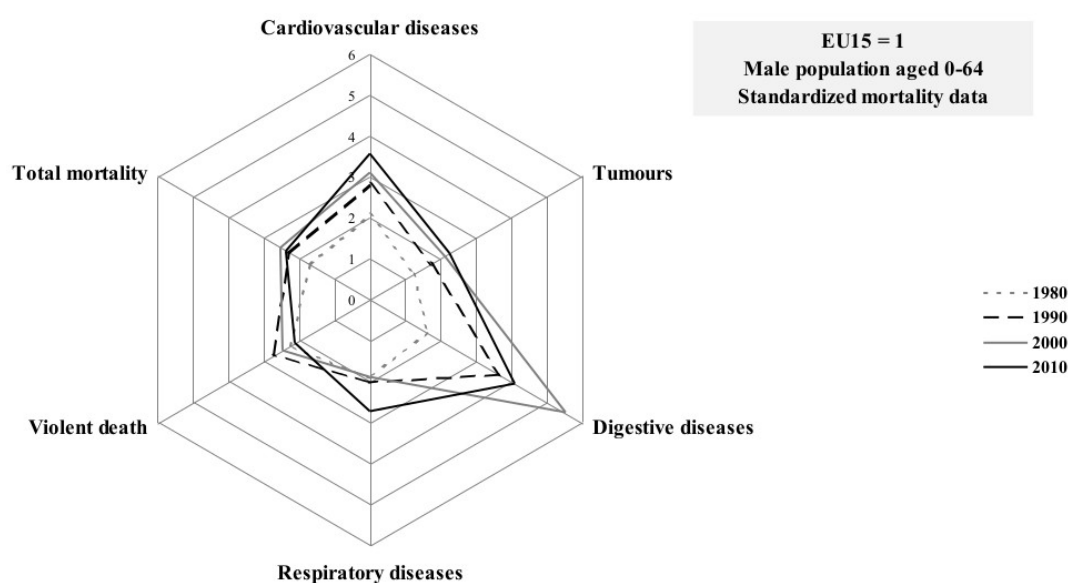
<sup>1</sup> In 2011, life expectancy at birth for Hungarian men was 71.2 and for women 78.7 years. The difference in life expectancy between the Czech and the Hungarian males was 2.8 years in 1989 and 3.6 years in 2011; in the case of females 1.6 and 2.4 years, respectively.



Source of data: OECD Stat

For the two leading causes of death (cardiovascular disease and cancer), the gap between premature mortality in Hungary and the corresponding EU15 average became ever wider over the last three decades (Figure 2). The mortality excess in Hungary reached 354 percent for cardiovascular diseases in 2010 among men, and 334 percent for women. In the case of cancers it equalled 224 percent and 168 percent, respectively (Sándor, 2013).

**Figure 2.** *Relative Mortality Due to Leading Causes of Death in Hungary compared to the EU15 Average*



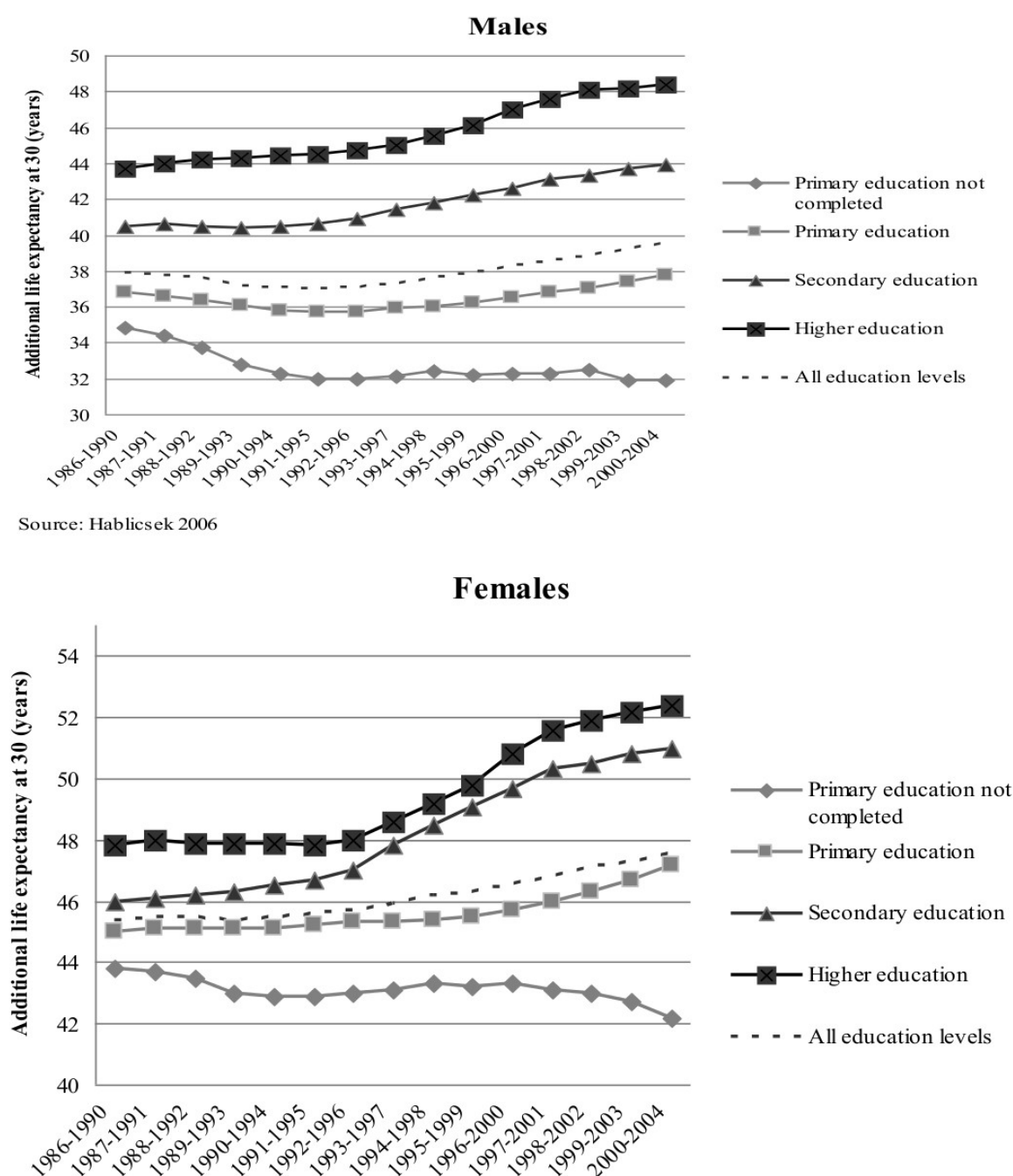
Data source: WHO HFA

### *Inequalities within Hungary*

The social and regional inequalities in health status are alarming, and have grown significantly since the political changeover in 1989-90. Less qualified

social groups are the worst affected: overall, their health declined (according to several key indicators) in the past decades. As estimated by Hablicsek (2006), in the mid-2000's men with less than 8 grades of primary education at the age of 30 could reckon with 16.5 years less to live than men who had an academic degree (Figure 3). The difference between the two social groups was far smaller (9 years) at the end of 1980s. Life expectancy of women with less than 8 grades of primary education at the age of 30 was 10.2 years lower than that of women having an academic degree in the mid-2000's. The difference between the two social groups was only 4 years at the end of 1980s.

**Figure 3.** *Additional Life Expectancy of Males and Females at the Age of 30 by Educational Attainment*



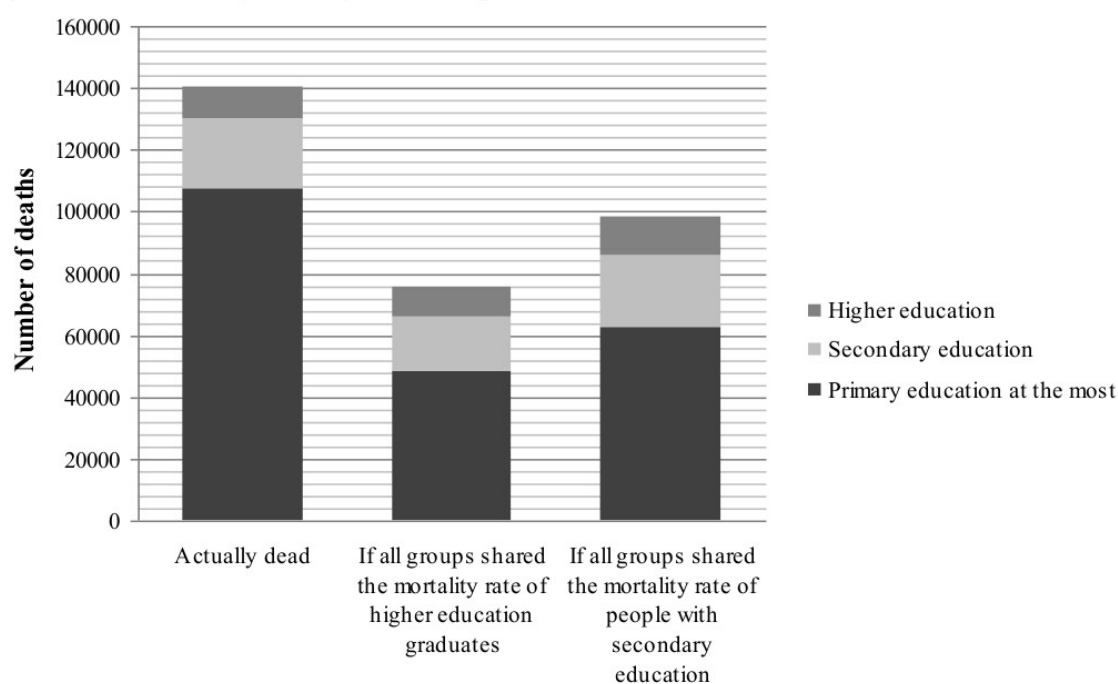
Source: Hablicsek 2006

Source: Hablicsek 2006

As can be seen in Figure 3, the slight growth in the total population's life expectancy actually hides a steepening gradient of the 'social ladder' of life expectancy. The almost stagnating average value consists of a significant increase in the life prospects of the highly qualified and a minimal improvement for those with primary education only, as well as a *decrease* in the life expectancy of the unqualified. Unfortunately, there are no similar data available for more recent years. However, a continuation of these trends in health status can be expected due to increasing social inequalities in the past decade. Education is closely connected to other facets of social status (employment, income), lifestyles, physical circumstances and social relationships, behaviours. Therefore, it should be emphasised that health inequalities according to educational attainment not only reflect the effect of education, but also the disadvantaged social status of the lowly qualified determined by many factors.

Other health indicators show a similarly alarming picture in the late 2000s. According to the 2009 European Health Interview Survey (EHIS 2009) those with a very low income (based on data concerning self-assessed financial status), had a 6 times higher chance of poor/very poor health, 7 times higher likelihood of disability, and 3 times higher probability of chronic illness than those with a very high income (Vokó, 2011). An analysis comparing a 2001 survey and the aforementioned 2009 EHIS seems to confirm the decline in health in absolute terms (Kovács, 2012). Kovács (2012) analysed self-reported health status in two different age groups (25-54 and 55-74) in relation to education and income. In both social dimensions and both age categories it is only young higher education graduates whose health has not deteriorated between 2001 and 2009 (i.e. the ratio of those reporting bad health has not increased). Apart from them, the proportion of those who thought their health was bad grew in all categories. For people between 25 and 54 years of age, the difference between people with the lowest and the highest qualification concerning the proportion of those deeming their health bad grew from a little more than twice as much to three times as much.

Consequences of inequalities can be measured in "excess loss" of human lives for society by comparing the actual data to a hypothetical situation without inequalities in mortality. The results are shown by Figure 4. According to our estimates, if all members of society had the same mortality rate as higher education graduates, in 2005, for example, more than 65,000 fewer people would have died in Hungary. This is equal to 46 percent of total number of deaths. Obviously, it would be unrealistic to assume that inequalities can be totally eliminated; nevertheless, their current magnitude could be reduced.

**Figure 4. Mortality Loss from Inequalities**

Own calculations based on data source: Hablicsek, 2007; data covering 2005.

### Social Structure as a Key Structural Determinant of Health Inequalities

The main factors *directly* jeopardising health are, on the one hand, unhealthy living and work conditions, poor diet, health-damaging habits, and psycho-social factors (stress, lack of prospects, hopelessness, etc.) on the other. The individuals' exposure to and the capacity to cope with these risk factors is fundamentally influenced by their socio-economic position. For this reason, it is essential to understand the drastic changes that have taken place in the structure of Hungarian society in the past twenty five years.

The socio-economic processes taking place since the political changeover in 1989-90 led to the emergence of drastic social inequalities, polarization and geographic segregation of society. A small group of the population accumulated extreme wealth connected to the rapid privatization in the economy at the beginning of the 1990s. A relatively restricted stratum of society, representing around two million people (around fifth of the Hungarian population), felt the changes that were probably expected from the political changeover by everyone: improvement in material circumstances and growing opportunities (Ferge, 2006). The political changeover, however, was synonymous with the end of financial security for a great part of society. A sharp decline in the employment rate, long-term unemployment, and an increasing reliance on the shadow economy followed. Families affected by unemployment and with declining means have been increasingly marginalized. Child poverty has also alarmingly increased and the process of passing deprivation on to next generations has aggravated. People living in deep poverty are unwanted by the labour market, go without any notion of a constructive survival strategy, disdained and judged by the (non-poor)

majority, and increasingly, by public administration. For their children, without fundamental changes in public policies, there remains no route other than the one taken by their parents (Ladányi, 2012). The prospects of the Roma minority are gloomy and progressively deteriorating. While Roma employment was relatively high during the communist era for a range of reasons, this minority group was the biggest loser of the political changeover. Their lack of education and qualification, the resulting extreme poverty characterised by severe and complex disadvantages, and at least of equal significance, the growing prejudice and discriminative tendencies against them held across the whole of society have obstructed all channels of social ascension for them (Ladányi, 2012).

In 2013, 14.3% of the entire Hungarian population (around 1.4 million people) and 23.2% of children (about 400,000 children) lived in income poverty. 42.2 percent of the total population was materially deprived and 26.8 percent severely deprived, according to the definitions used by Eurostat (Eurostat, 2014). In 2012, 76% of the Roma population lived in income poverty (Gábos et.al., 2013). Poverty is also segregated in terms of territory, whether in regional, local or community-level terms. Therefore, poverty has come to represent not only a social but also a geographic divide, with its own institutions, schools, doctor's offices, shops, pubs and even entire settlements for the poor and the rich. This contributes to the phenomenon that the wealthier portion of the country is practically "blind" to the poorer side.

Since the onset of the economic crises, income poverty (at-risk-of poverty) and severe deprivation<sup>1</sup> further increased, in particular among children and adults with low educational levels (Table 1). In Hungary, the proportion of those living in severe deprivation is at least 3 times, and in many cases 4 or 5 times higher than the average of the EU28, in the case of every social group examined.

**Table 1.** *At-risk-of-poverty and Severe Deprivation in Different Groups of Hungarian Society in 2008 and in 2013*

	At-risk-of-poverty rate (%)		Severe deprivation index (%)		
	2008	2013	2008	2013	2011, EU28
<b>Total population</b>	12.4	14.3	17.9	26.8	8.9
<b>By activity status (among people aged 18 or more)</b>					
Employed	5.8	6.6	12.8	20.2	5.7
Unemployed	49.2	50.8	42.7	59.1	25.1
Other inactive (not retired)	23.3	21.9	21	33.4	12.2

<sup>1</sup>At-risk-of-poverty rate used by Eurostat shows the proportion of those in a certain social group that live on less than the 60% of the median equivalent household income in Hungary. Deprivation rate and severe deprivation rate is also based on the Eurostat methodology of measuring material deprivation (Eurostat, 2014).



<b>By age group</b>					
0 – 17	19.7	23.2	21.5	35	10.1
18 – 64	12	14.3	17.6	27	9
64 –	4.3	4.4	14.4	16.7	7.3
<b>By educational level (among people aged 18 or more)</b>					
Pre-primary, primary and lower secondary education	25.7	37.4	28.4	42.7	13.3
Upper secondary education	10.2	11.2	15	23	8
First and second state of tertiary education	2.5	2.7	5.7	9.3	2.7

Source of Data: Eurostat

Individuals with poor education and unattractive labour market positions (unemployed, inactive, or performing inferior work), and those with low income are far more likely to be living under poor physical and social circumstances, to partake in health-damaging habits, to have poorer knowledge of health and finding their way in the health care system, etc. The spiral launched by accumulated social disadvantages can lead to other social disadvantages through the deterioration of health status, such as further unemployment, inactivity, poverty, poor performance at school, premature dropping out of school, etc. Furthermore, the social processes described are connected to psycho-social phenomena, such as faith, control, fear, trust, respect, etc. The features of “day-to-day culture” in Hungary today with the most impact on health inequalities, some of them with roots in the state-socialist past, are the crises of values. These include individualisation, weakening solidarity (the weakness of social capital and local society) and prejudice against the poorest and the Roma; the crisis of confidence in the political institutions and the economic and political elite; as well as the lack of sense of individual responsibility in wide groups of society (Muraközy, 2012; Tóth, 2010). By now, the impact of psycho-social milieu has come to a point where it represents a severe threat to the health status of the most vulnerable social groups through a range of mechanisms (e.g. stress, lack of prospects, marginalisation, lack of solidarity, prejudice, etc.) (Kopp – Skrabski 2009).

## Public Policies Influencing Health Inequalities

As already discussed, public policies are key determinants of health inequalities: they exert their effects through influencing the structural and psycho-social characteristics of society, the individuals’ socio-economic position, as well as the risk factors directly affecting the individuals’ health status. The remainder part of the paper first highlights the general features of



Hungarian policy-making then it discusses the main components of public policies in more detail from the perspective of health inequalities.

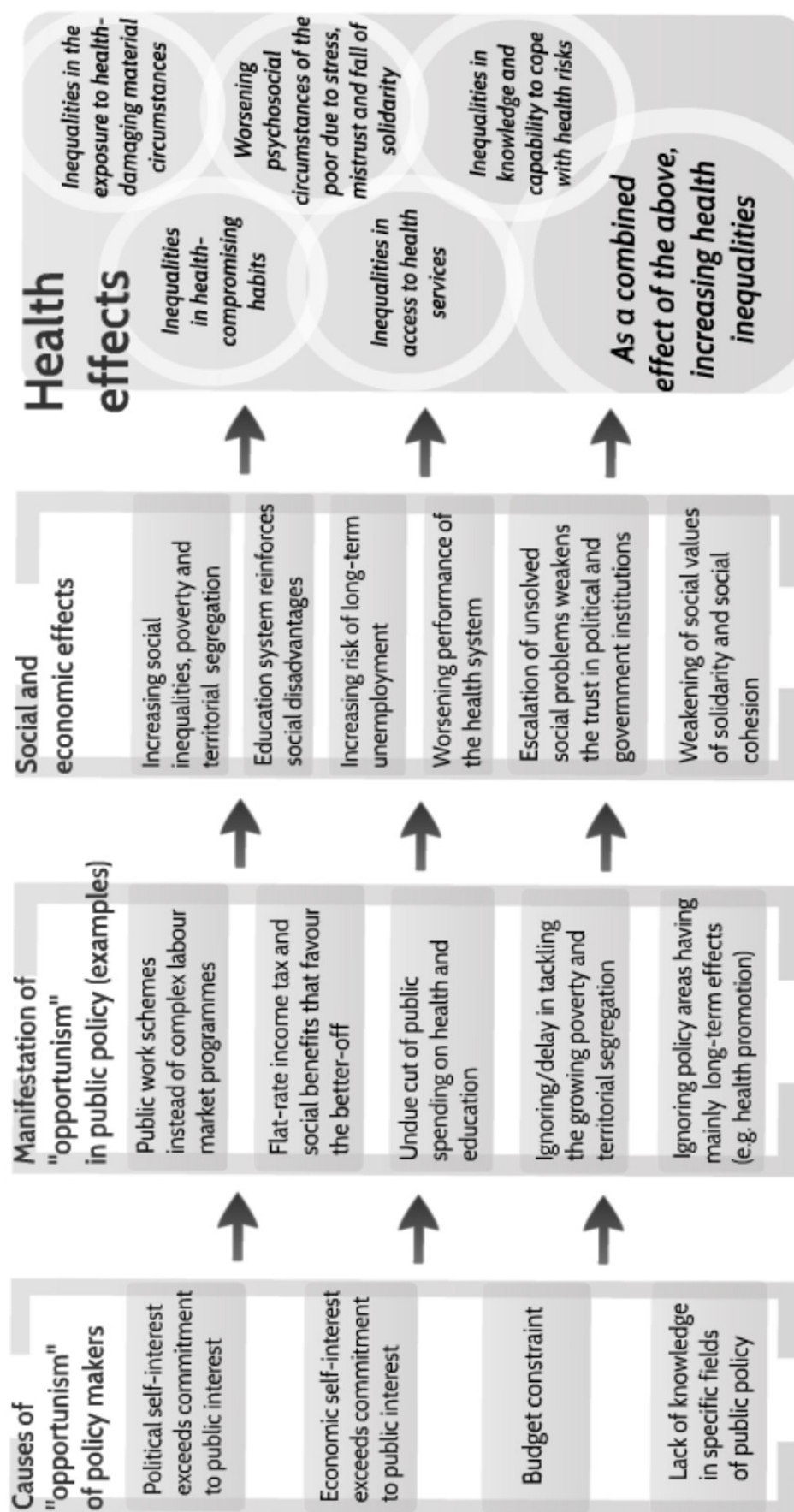
During most of the past 25 years government decisions were characteristically shaped by budgetary constraints and short-term motives, but decisions necessitated by lacking resources were also made alongside the minimisation of political costs (Scharle, 2012). The actions rewarded by votes were characteristically steps geared towards directly improving the short-term material welfare and income of the “median voter”. Opportunistic political behaviour also included catering for corruption in the form of direct financial transactions or the enshrinement of lobby interests in legislation. Decision-makers have failed to develop strategies prioritising the long-term interest of the socio-economic development of the country, and tended to ignore problems not having strong political representation (e.g., child poverty). The source of opportunistic behaviour has been a varying combination of the fear of popularity loss by the governing parties, budget constraints, lack of awareness of the grave social problems or consequences, as well as lack of adequate knowledge and experience of the public administration to choose proper measures. It is important to note that budget constraints and low performance of public administration can be understood as partly a consequence of opportunism of policy-making in the preceding periods.

In Figure 5 we summarize the sources, key elements and consequences of the opportunistic features of Hungarian policy-making. The last column presents how all these processes influence health status and health inequalities. It should be emphasised that opportunism of public policies is not the only cause of the detrimental social and health processes listed in Figure 5. Public policies, however, can mitigate or aggravate the effects of economic, social and cultural factors in force.

### *Economic and Employment Policies*

The last two or three decades were characterised by the instability of stop-go economic policies: upswings saw excessive (if compared to economic growth) increase in the real income of the population, which “heated” the economy up through domestic consumption in an unsustainable manner and resulted in budgetary deficit. This was always followed by fiscal tightening which restored the balance, and the process then started over. The stop-go economic policy was connected to opportunism of public policy: the governments tended to overspend in election years attempting to “buy votes” (Brender – Drazen, 2004). This policy resulted in increasing indebtedness, which became unsustainable by the period directly preceding the economic recession in 2008. Therefore, the Hungarian government had to introduce budgetary adjustments in 2006 that exacerbated the effects of the severe external economic recession. The economic growth could not recover since then: the Hungarian GDP was still below the 2008 level by almost 3 percent in 2013.

**Figure 5.** *Opportunism of Public Policies as a Determinant of Health Inequalities*



Employment, the primary and optimal source for making a living, is fundamental in terms of health inequalities. Being employed also affects health status in many other ways: a sense of purpose and value, being able to provide for oneself and one's family, the workplace community and the structuring of time imposed by work all play important roles in the impact of work on health status. Employment fell dramatically, by nearly one-third, following the political changeover in 1989. Only slightly more than half of active age individuals remained employed. This low level has persisted, and the structure of the labour market has barely changed over the past twenty years. In 2011, only 62.7 percent of the population between 15 and 64 was active in economic terms, that is, employed or seeking a job on the labour market. This was the third lowest rate in the EU. In the second quarter of 2013 in the same age group the employment rate was 58.3 percent, the fourth lowest in the EU<sup>1</sup>. The employment rate among poorly qualified individuals is nearly 20 percent lower in Hungary than the EU27 average, and nearly 16 percent lower within the 15-24 age bracket and 12 percent lower within the 55-64 age bracket (Hárs, 2013).

These problems stem mainly from the following interrelated causes: a distorted economic structure, the poor competitiveness of many areas of the economy, the widespread shadow economy and the high taxes and social contributions in the formal economy; as well as the effects of economic crisis and the decreasing confidence of foreign investors in the Hungarian economy due to unpredictable economic policy in the past few years. Opportunism of public policy is reflected in that governments failed to address the structural causes of unemployment and to develop appropriate reintegration programmes for the unemployed (Scharle et al 2011). Instead, governments tended to apply short-term measures. In 2010 income tax was reduced and made flat-rate, by which the government wanted to boost economic growth and employment, but failed to do so. The institutional system of the labour market has been ineffective in getting people back to work, recently with an excessive focus on public works projects.

### *Tax and Social Welfare Policies*

Tax and social welfare policies have a great effect on redistribution of income, and also play a role in fostering, or conversely, detracting from entrepreneurship and work. Hungarian social policy, despite mitigating inequalities in market-based income, was unable to prevent the emergence of extreme poverty. Due to changes in the past few years, the tax and social welfare system implements "inverse redistribution" in several respects: higher-income groups gain from the flat-rate income tax introduced in 2010 and, as a whole, also receive a higher social benefit (per capita), compared to the poor (Krémér, 2012). Under the pressure of economic crises, policy-makers tended to cut public spending on unemployment, disability benefits and social assistance, instead of touching on the middle-class "voters' pocket" (e.g., tax

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<sup>1</sup>A slight increase in total employment in 2012-13 came from the considerable growth in public work; however, employment in the private sector in Hungary decreased by around 120 000 people between 2008 and 2013 (MNB 2013)

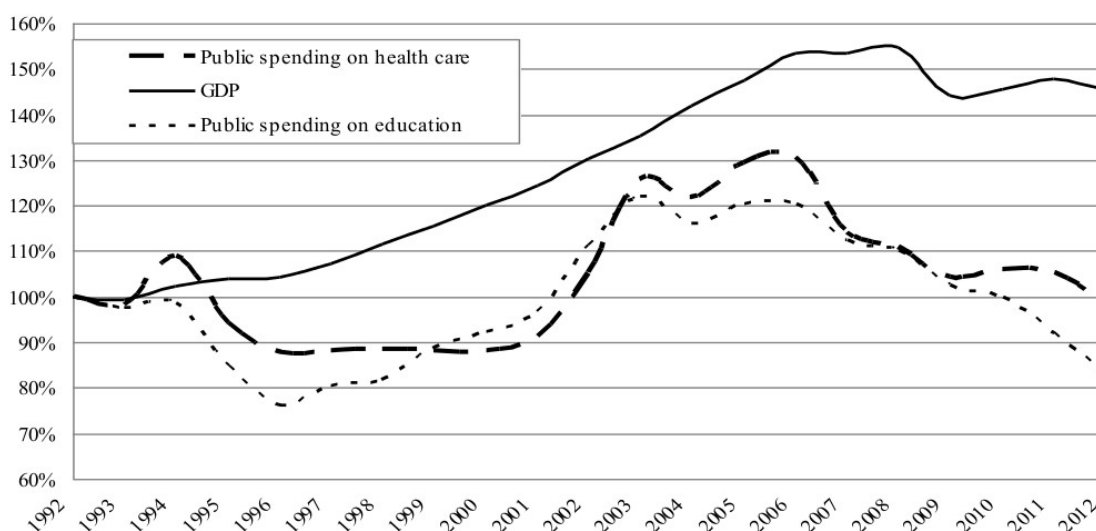
allowances). Policy-makers seem to overlook that the stability and future development of society are jeopardised by the previously inconceivable rise in poverty and the growing hostility towards the Roma and the poor (Ferge, 2012).

### *Education Policy*

The quality of education is a determining factor of health inequalities through early childhood development, employment opportunities, knowledge of health and lifestyle, and better communication skills that allow easier navigation within the health care system. The Hungarian school system exacerbates inequalities that are derived from the social and economic background of families instead of mitigating them. According to the OECD PISA survey in 2009, the influence of family background on reading comprehension was the strongest in Hungary among OECD countries (Balázs et al., 2010).

The relative position of the health care and education sectors within the national economy, already disadvantageous under the communist regime, became even worse than it was at the political changeover (Figure 6). The insufficient level of investment in human capital is one, though not the only, reason of the fact that the state of human capital (i. e. overall health status, health inequalities, inequalities in the level of knowledge and skills) is worse than what could be expected according to the level of the country's economic development.

**Figure 6.** *Trend in GDP, Public Spending on Health Care and Education (1992=100; real values)*



1992 = 100. Real values.

Source of data: Hungarian Central Statistical Office; OECD Health Data; Statistical Yearbook of Education 2012/2013, Ministry of Human Resources, Budapest, 2013.

Policy-makers failed to handle the dilemma between structural reforms and the requirement of increasing resources. One side of this dilemma is that any increase of resources in itself, not aligned with structural reforms, would

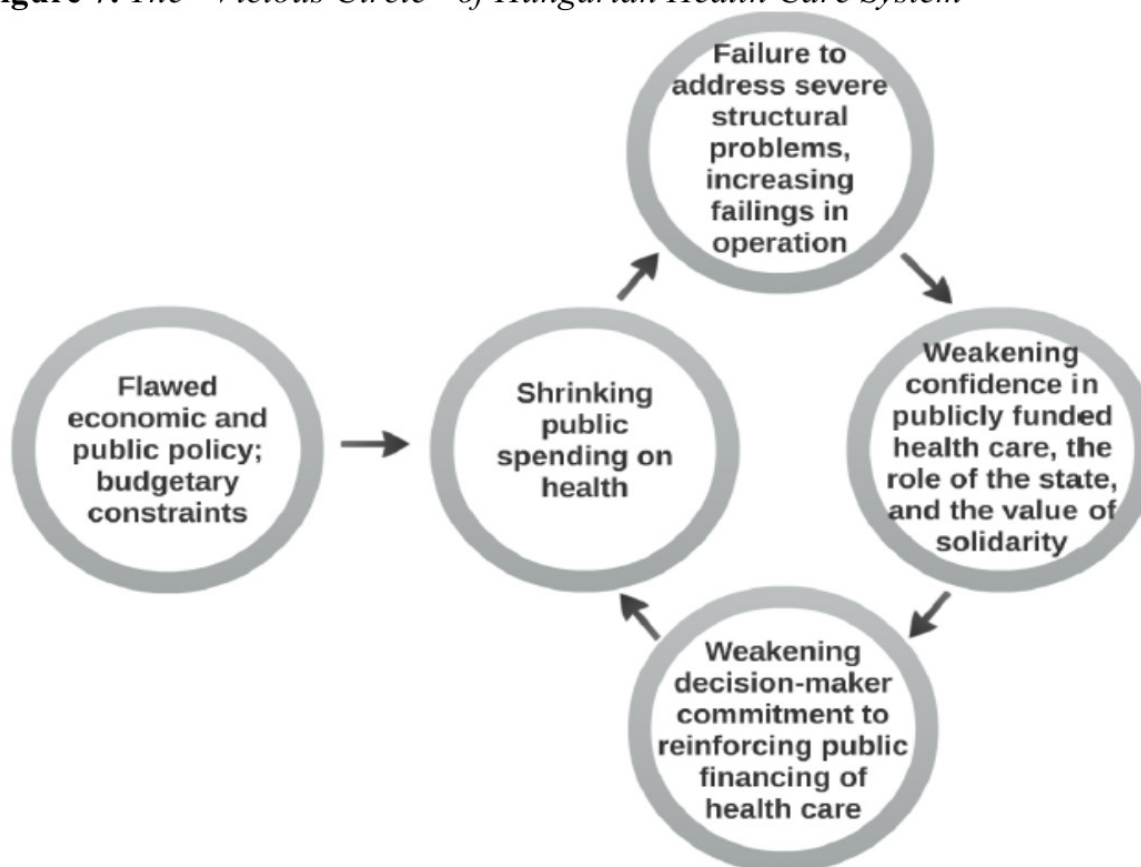


be insufficient in improving the performance of the health and education sectors. This has been an argument the political elite could always use to further constrain the resources devoted to these sectors. The other side of the dilemma is that without increasing financial resources it seems, however, impossible to implement adequate restructuring of capacities and create motivation to improve quality of services in these sectors.

### *Role of Health Policy*

Due to shifts in dominant views in the past decade, on the international scene health expenditure is now considered as “growth-friendly” (European Commission, 2013), and medical care is believed to play a significantly bigger role in influencing the population’s health than it did 40 or 50 years ago. (Figueras et al, 2008). In Hungary, however, the views of the economic and political elite got stuck in the misconception that health care is a ‘non-productive’ branch of the national economy, only a burden on the state budget. This has greatly contributed to that Hungarian health care system has been trapped in a “vicious circle” (Figure 7) since the mid-1990s (Orosz 2010).

**Figure 7.** *The “Vicious Circle” of Hungarian Health Care System*



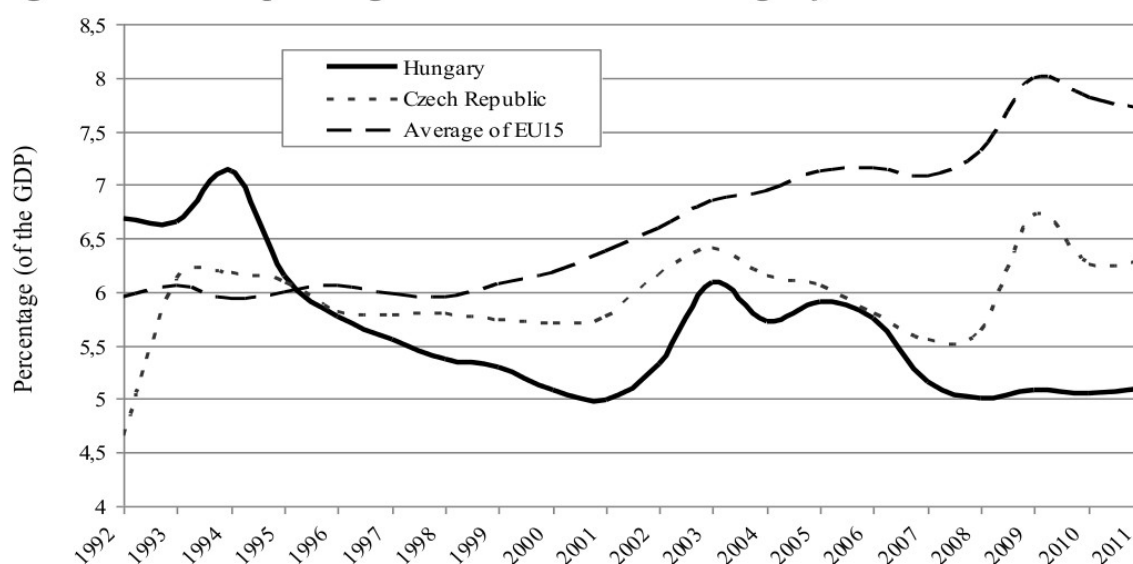
This “vicious circle” illustrated by Figure 7 has even exacerbated since the mid-2000s. Some symptoms of the crisis, such as the brain-drain among the medical profession, the insufficient number of students in nurse training, growing waiting lists, can be quantified. The other group of crisis symptoms cannot be quantified, but can nonetheless be perceived: changes in the doctor-patient relationship, increasing burnout among health professionals, corruption,

lack of confidence in every key aspect of the system, and last but not least, the lack of realistic and credible vision for the future of the health care system.

State-of-the-art health promotion and prevention efforts aiming at the direct and broader causes of major health problems such as cardiovascular diseases or mental disorders would be essential for mitigating health inequalities. Since the political changeover, public health programmes adopted in Hungary have largely remained unimplemented (Gyebnár – Vokó 2011). Furthermore, these programmes have failed even to analyse the causes of health inequalities or to formulate an adequate strategy to tackle them.

A necessary precondition for reducing inequalities in access to health care is the availability of sufficient resources for the health system to provide the service-package of the compulsory health insurance at an adequate standard. This condition is not met in Hungary at present. The gap in public spending on health care services between Hungary and the EU15 has widened over the past two decades. In Hungary, the public spending on health as a percentage of GDP shrank between 1992 and 2013, from 6.6 percent of GDP to 5.1 percent (Figure 8). Furthermore, in 1992, public spending on health per capita in Hungary was 52 percent of the EU average and very close to the Czech Republic's figure. By 2011, it had fallen to only 38.5 percent of the EU15 average and 66 percent of the Czech Republic's figure. In addition, the share of public spending in total health expenditure is among the lowest in the EU: Hungarian public spending on health only amounted to 65 percent of the total health expenditure in 2011.

**Figure 8.** *Public Spending on Health as a Percentage of GDP*



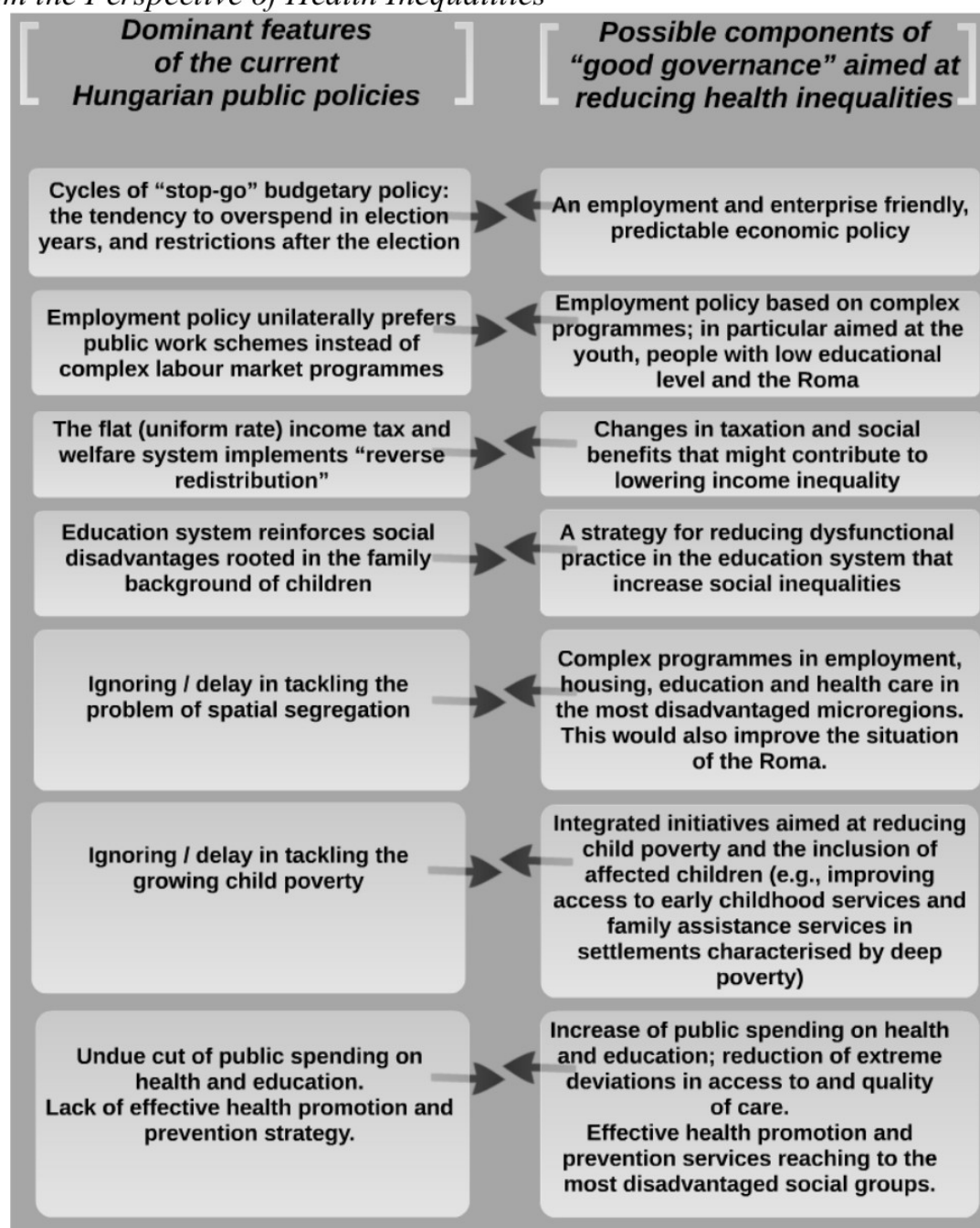
Source of data: OECD HealthData 2012

## Conclusions

As emphasised earlier, reducing inequalities, including health inequalities, is a fundamental interest of Hungarian society. Given that the improvement of

health status and the sustainable reduction of social and health inequalities can only be achieved through the orchestrated, elaborate and firmly committed effort of numerous sectors, spanning political cycles, the opportunism of public policies is particularly detrimental to these objectives. Tackling health inequalities would require a shift from the current opportunistic public policy towards “good governance” capable to develop an integrated, inter-sectoral and forward-looking public policy strategy. Figure 9 compares - from the perspective of health inequalities - the dominant features of the current public policies with key elements of a “good governance” strategy.

**Figure 9.** *Features of the Current Public Policies and a “Good Governance” from the Perspective of Health Inequalities*



Of course, we cannot expect the current public policy-making to be replaced overnight by a “good governance” strategy described in Table 2. The