



State of Health in the EU

Hungary

Country Health Profile 2023

The Country Health Profile Series

The *State of Health in the EU's Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the *Country Health Profiles* are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys

and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Hungary, 2022

Demographic factors	Hungary	EU
Population size	9 689 010	446 735 291
Share of population over age 65 (%)	20.5	21.1
Fertility rate ¹ (2021)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP ²)	27 259	35 219
Relative poverty rate ³ (%)	12.1	16.5
Unemployment rate (%)	3.6	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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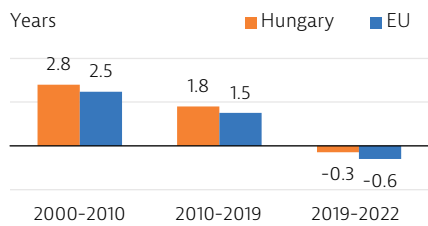
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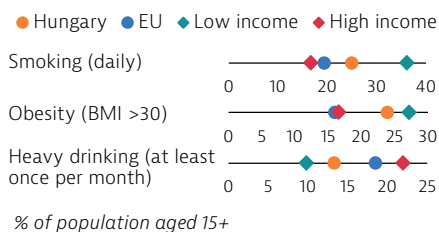
1 Highlights



Changes in life expectancy at birth

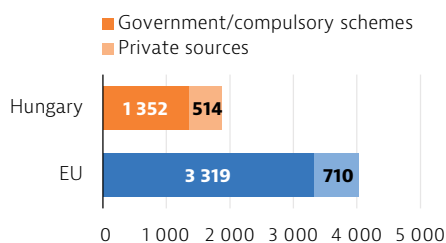
Health Status

After outpacing the EU average in gains in life expectancy at birth for nearly two decades from 2000, Hungary experienced an overall drop in life expectancy of 0.3 years between 2019 and 2022. This is half the average reduction across the EU during the COVID-19 pandemic. In 2022, life expectancy at birth was 76.2 years, which is the fifth lowest level in the EU.



Risk Factors

Hungarians smoke more and have higher levels of obesity than their EU counterparts. In contrast, the population engages in less heavy drinking than the EU average. People in the lowest income quintile are much more likely to smoke and be obese. Conversely, Hungarians in the highest income quintile are twice as likely to report heavy drinking as those in the lowest quintile.



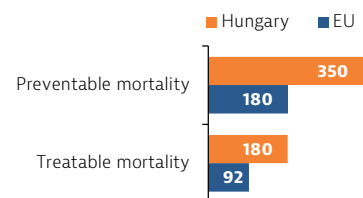
EUR PPP per capita, 2021

Health System

Although total health spending has been increasing steadily, at EUR 1 866 per capita in 2021, Hungary spent less than half the average health expenditure across the EU. The share of public funding on health in Hungary (72.5 % of current health expenditure) is also well below the EU average (81.1 %.)

Effectiveness

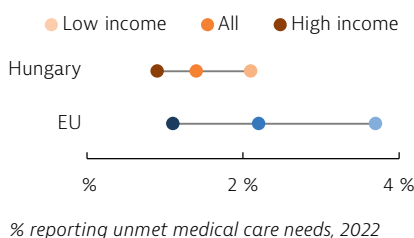
Avoidable mortality rates are much higher in Hungary than across the EU: both preventable and treatable mortality rates per 100 000 population are nearly double EU averages. After declining steadily for several years, preventable mortality spiked in 2020, as deaths attributed to COVID-19 are classified as preventable in mortality statistics.



Age-standardised mortality rate per 100 000 population, 2020

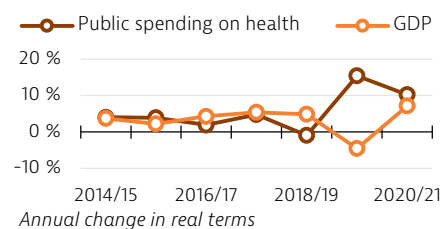
Accessibility

According to EU-SILC data, the share of Hungarians reporting unmet needs for medical examinations was below the EU average in 2022. In addition, the difference in self-reported unmet health needs between high-income and low-income groups in Hungary was much smaller than the EU average.



Resilience

Growth in public spending on health in Hungary stayed below GDP growth rates from 2016/17 to the beginning of the COVID-19 pandemic. Large spending increases to aid the health system during the public health emergency mean that the public spending growth rates in 2020 and 2021 far outstripped those in previous years.



Mental Health

An estimated 14 % Hungarians had a mental health condition in 2019, compared to 17 % across the EU. The shares of Hungarians with mental health conditions are largely similar to EU averages, with slightly fewer anxiety and depression diagnoses in Hungary. Despite a considerable decline since 2020, Hungary has one of the highest suicide rates among men per 100 000 population in the EU. Around 15 % of unmet healthcare needs reported by Hungarians during the COVID-19 pandemic were related to mental healthcare.

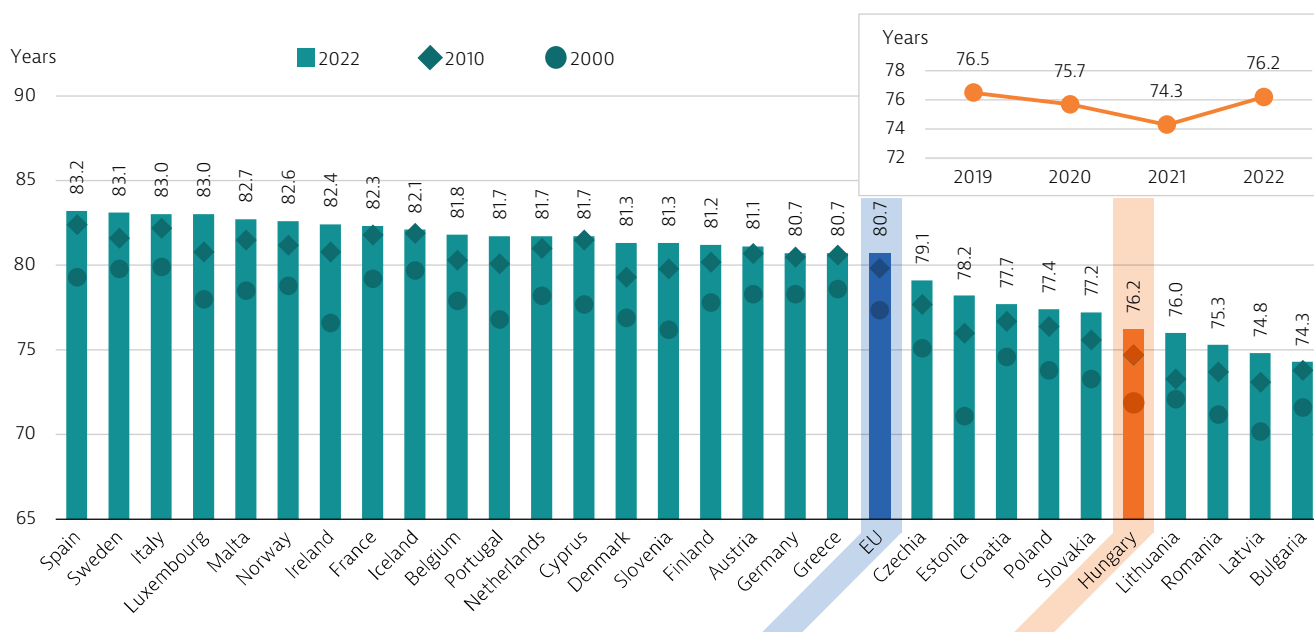
2 Health in Hungary

Life expectancy at birth in Hungary is 4.5 years lower than the EU average

In 2022, life expectancy at birth in Hungary was 76.2 years – the fifth lowest in the EU and below the other Visegrád countries (Czechia, Poland and Slovakia). Preceding the COVID-19 pandemic, it had been gradually converging with the EU average for nearly two decades, and by 2019, life expectancy at birth was 76.5 years – less than five years below the EU average. However, after the outbreak of the COVID-19 pandemic, life expectancy at birth in Hungary reduced by more

than two years between 2019 and 2021 (Figure 1), the largest observed decrease in two decades. It rebounded to sit at four and a half years below the EU average in 2022. As in other EU countries, men in Hungary tend to have shorter lifespans. In 2022, Hungarian men were expected to die, on average, 6.8 years earlier than women. This gender gap in life expectancy (nearly 1.5 years above the EU average) is largely due to greater exposure to risk factors – particularly smoking and excessive alcohol consumption (see Section 3).

Figure 1. Life expectancy fell by more than two years after the beginning of the COVID-19 pandemic

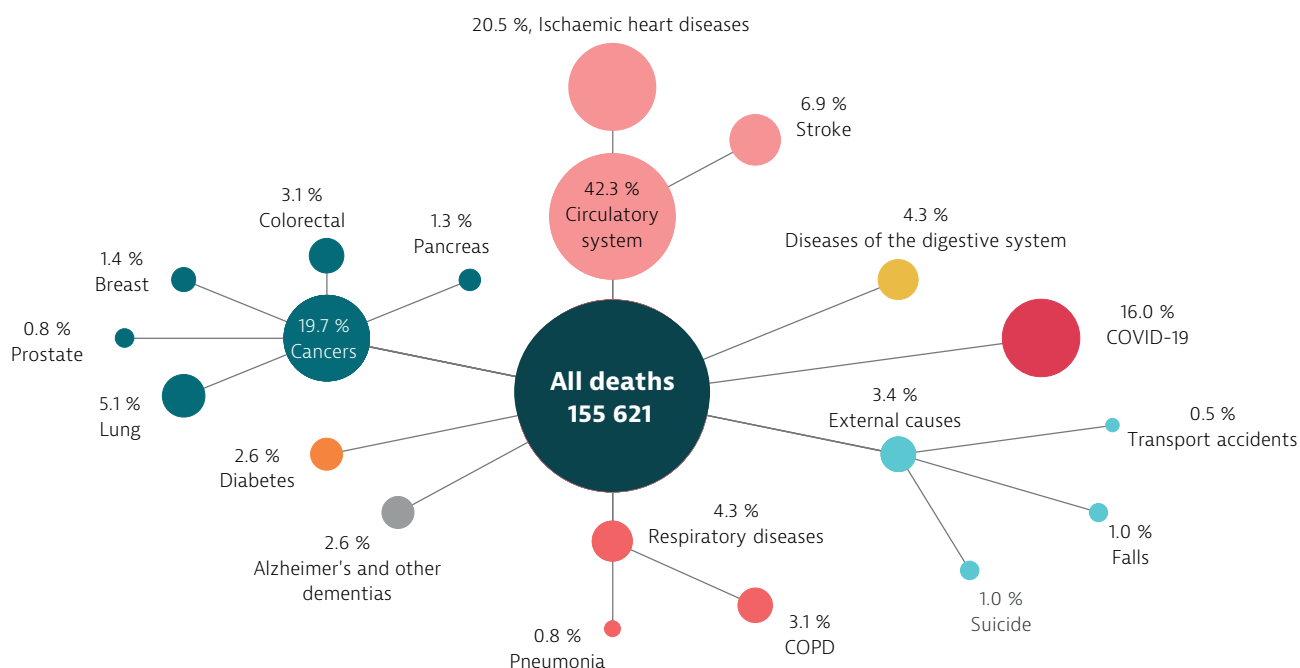


A large portion of all deaths in Hungary are caused by ischaemic heart disease and stroke

Circulatory diseases, such as ischaemic heart disease and stroke, are the leading cause of death, accounting for just over 40 % of all registered deaths in Hungary in 2021. Hungary's gains in life expectancy in the years prior to the COVID-19 pandemic were primarily driven by reductions in mortality from circulatory diseases and, to a lesser degree, cancer. Lung cancer remains the most common cancer death, followed by colorectal and breast cancer (Figure 2). In the second year of the pandemic, Hungary reported nearly 25 000 confirmed deaths due to COVID-19, amounting to 16 % of all deaths in 2021: 75 % of these occurred in people aged 65 and over.

The broader indicator of excess mortality, defined as deaths that occurred (regardless of their cause) above a five-year baseline derived from pre-pandemic levels (2015-19), provides a more comprehensive account of the pandemic's impact. Between 2020 and 2022, the approximately 43 350 excess deaths that occurred in Hungary accounted for 11.1 % of deaths above the historic baseline, just below the 12.6 % average change in excess mortality across the EU. Like other Visegrád countries, Hungary experienced the largest increase in excess mortality during 2021 (19 %). This large increase in excess deaths can be largely explained by the occurrence of two major COVID-19 waves within a single year, during the spring and then the winter.

Figure 2. Diseases of the circulatory system accounted for the largest share of deaths in 2021



Note: COPD refers to chronic obstructive pulmonary disease.

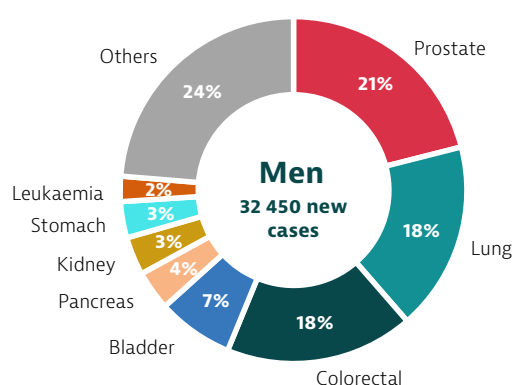
Source: Eurostat Database (data refer to 2021).

Lung and colorectal cancers are major cancer sites in Hungary

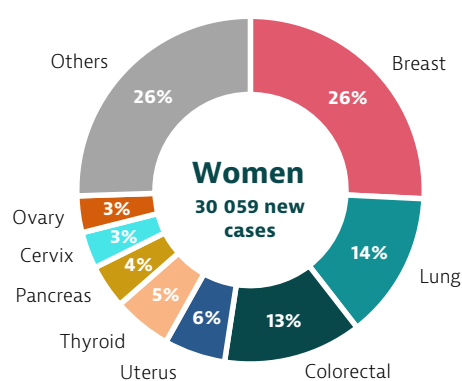
According to estimates from the Joint Research Centre based on incidence trends from previous years, Hungary was expected to record over 62 000 new cases of cancer in 2022. This translates into an estimated 786 cancer cases per 100 000 people among men and 528 per 100 000 among women – both above respective EU averages. Relatively

high estimates of incidence from cancer may in part reflect risky health behaviours among the population, such as smoking and alcohol consumption (see Section 3). In Hungary, the leading cancer diagnosis is breast cancer for women and prostate cancer for men, followed by lung and colorectal cancer for both men and women (Figure 3).

Figure 3. More than 62 000 new cancer cases in Hungary were expected to be diagnosed in 2022



Age-standardised rate (all cancer): 786 per 100 000 population
EU average: 684 per 100 000 population



Age-standardised rate (all cancer): 528 per 100 000 population
EU average: 488 per 100 000 population

Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.

Source: ECIS – European Cancer Information System.

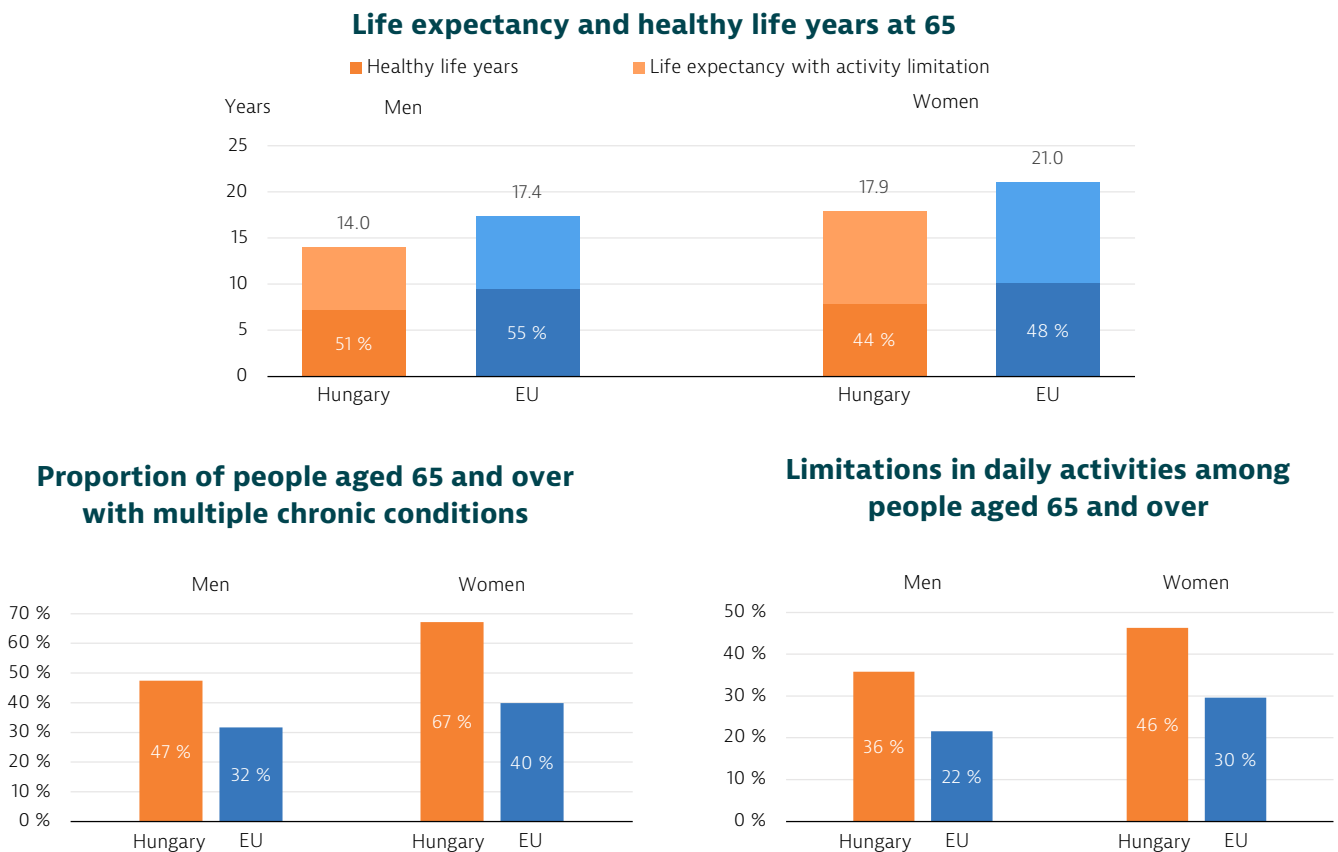
Many Hungarians above the age of 65 live with chronic conditions and disabilities

In the last decade, Hungary has experienced a demographic shift towards an older population. The proportion of people aged 65 and over in Hungary rose from one sixth of its total population in 2012 to over one fifth in 2020. This share is projected to increase to more than one in four by 2050, which is slightly under the projected EU average.

In 2020, 65-year-old women in Hungary could expect to live a further 18 years, while men could expect to live a further 14 years; figures which are each more than three years below their respective EU averages. Hungarian men and women aged 65

also live a lower share of their remaining years of life free from health problems and disabilities than the EU average, and there are regional differences within Hungary, with those in urban areas (particularly Budapest) experiencing more healthy senior years than those in rural areas. Nearly half of Hungarian men and over two thirds of women aged 65 years and above report having multiple chronic conditions, which are among the highest shares across EU countries. Similarly, Hungary has the highest share of men (36 %) and women (46 %) aged 65 years and older reporting limitations in basic activities of daily living (such as dressing and showering) in the EU (Figure 4).

Figure 4. Rates of multimorbidity and limitations in activities of daily living in Hungarians aged over 65 are among the highest in the EU



Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for chronic conditions and limitations in daily activities). Data refer to 2020.

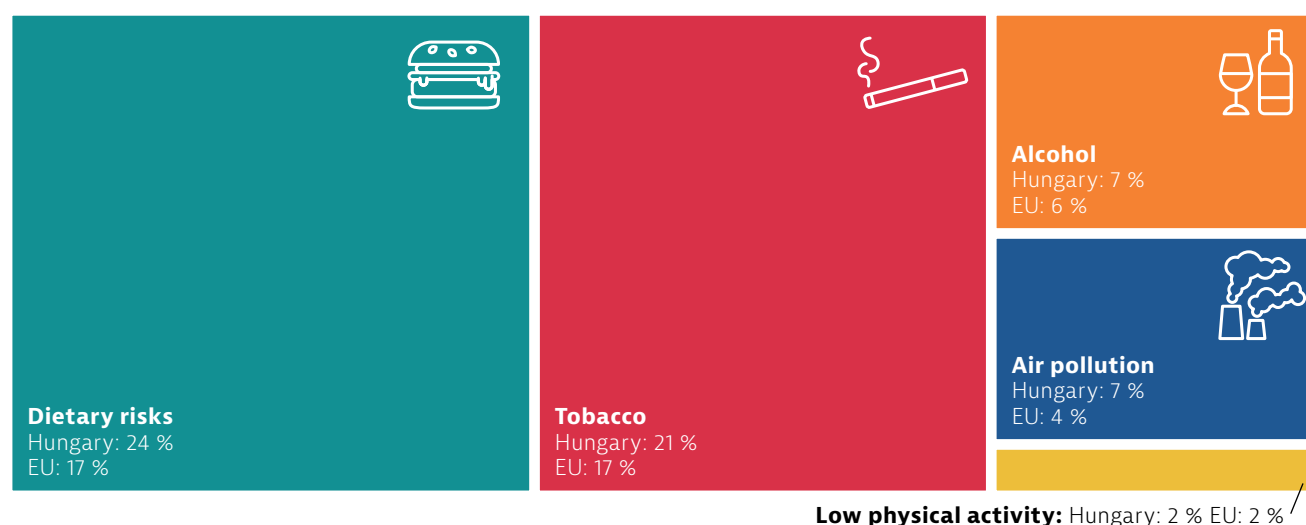
3 Risk factors

Behavioural and environmental risk factors account for more than half of all deaths

Approximately half of all deaths in Hungary were attributable to behavioural risk factors in 2019 (Figure 5). Nearly one quarter (24 %) of all deaths in 2019 could be attributed to unhealthy diet, which is above the EU average (17 %). Tobacco consumption, including direct and second-hand smoking, caused a further 21 % of all deaths, and around 7 % were

attributable to alcohol consumption and 2 % to low physical activity. Air pollution, in the form of fine particulate matter (PM_{2.5}) and ozone exposure alone, accounted for an estimated 7 % of all deaths, a proportion markedly higher than the EU average (4 %). Deaths from air pollution are mostly related to circulatory diseases, respiratory diseases and certain cancers.

Figure 5. Poor diet and tobacco smoking drive mortality rates in Hungary



Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components, such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to fine particulate matter (PM_{2.5}) and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Despite reductions in smoking rates in the past decade, Hungarians are among the heaviest smokers in the EU

One in four Hungarian adults reported smoking daily in 2019. Together with Greece, the smoking rate for Hungary was the second highest in the EU after Bulgaria.¹ Tobacco consumption has declined at a slower rate in Hungary than in many EU countries over the last two decades. While concerted measures put in place between 2010 and 2014 resulted in noticeable declines, the trend has since reversed, with heated tobacco products rapidly gaining ground (Joó et al., forthcoming). Smoking rates in Hungary show a large gender gap: almost one in three Hungarian men reported that they smoked daily in 2019, compared to approximately one in five women. Among adolescents, rates are also high: 29 % of

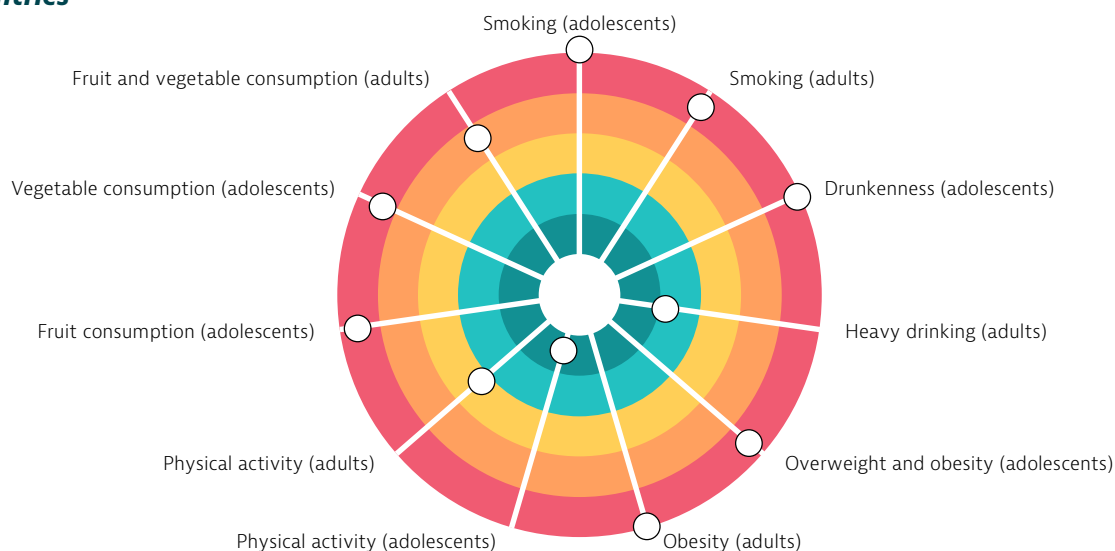
15-year-olds reported having smoked tobacco in the past month in 2022, which is above the EU average of 17 %. Following a ruling by the Court of Justice of the European Union, in 2021 Hungary significantly increased excise taxes on most tobacco products to meet the minimum required on manufactured tobacco set by EU Regulations, as previous rates in Hungary were lower on tobacco and other nicotine products (European Union, 2021).

Excessive alcohol consumption remains an important public health concern

The average amount of pure alcohol consumed every year by Hungarians aged 15 years and above was 10.4 litres in 2021. This figure represents a decline from 2000, but was nevertheless 5 % higher than the average quantity consumed per capita across EU countries. On the other hand, heavy

¹ Based on another source – the Eurobarometer survey – the proportion of current smokers in Hungary was 28 % in 2020, which is also higher than the EU average (25 %), but the rate in several countries was higher than in Hungary.

Figure 6. Most lifestyle-related risk factors for health are more common in Hungary than in other EU countries



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.

Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

drinking² among adults is less prevalent than in the EU (Figure 6). Although the rates of heavy drinking among Hungarian adolescents have been declining since 2010, they still pose a significant concern. In 2022, 37 % of 15-year-olds in Hungary reported having been drunk more than once in their lifetime, compared to 18 % in the EU.

Obesity is a major public health concern in Hungary

According to self-reported data from 2019, more than one third of the Hungarian population were classified as overweight and 24 % were obese. The obesity rate was higher than the EU average of 16 %, and had increased from 21 % in 2014. Data on the prevalence of obesity in Hungary based on the actual measurement of people's body mass index indicate even higher rates: one third (33 %) of the population was obese in 2019, an increase from 29 % in 2009. This trend is especially worrying among men, as their prevalence of obesity rose from 26 % to 36 % between 2009 and 2019, while it remained fairly stable among women. The severity of overweight issues is similar among adolescents. According to survey data, 25 % of Hungarian 15-year-olds were overweight or obese in 2022 – the fourth highest rate in the EU.

The state of dietary habits partly explains the increasing prevalence of obesity in Hungary. In 2019, only 8 % of adults reported consuming five

portions of fruit and vegetables every day – lower than the share from 2014 (10 %) and lower than the EU average (12 %). In contrast, levels of physical activity are relatively higher for both adolescents and adults compared to their EU peers.

Socioeconomic conditions exacerbate behavioural risk factors

As with nearly all other EU countries, several behavioural risk factors tend to follow a socioeconomic gradient in Hungary. In 2019, 36 % of adults in the lowest income quintile reported smoking daily compared to 17 % of those in the highest quintile. This income gap in smoking rates is the largest in the EU. There is also a large income gap in obesity among adults, with those in the lowest income quintile being nearly twice as likely to be obese as those in the highest quintile.

² Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.

4 The health system

Hungary operates a social health insurance system with a single health insurance fund

The Hungarian health system is highly centralised. The National Institute of Health Insurance Fund Management (NEAK) administers the single health insurance fund in the Hungarian health system. The fund provides almost universal coverage, although insurance status is unclear for around 5 % of the population, namely citizens working abroad and people without a permanent address. Health system governance was recently (in 2022) shifted from the Ministry of Human Capacities to the Ministry of the Interior.

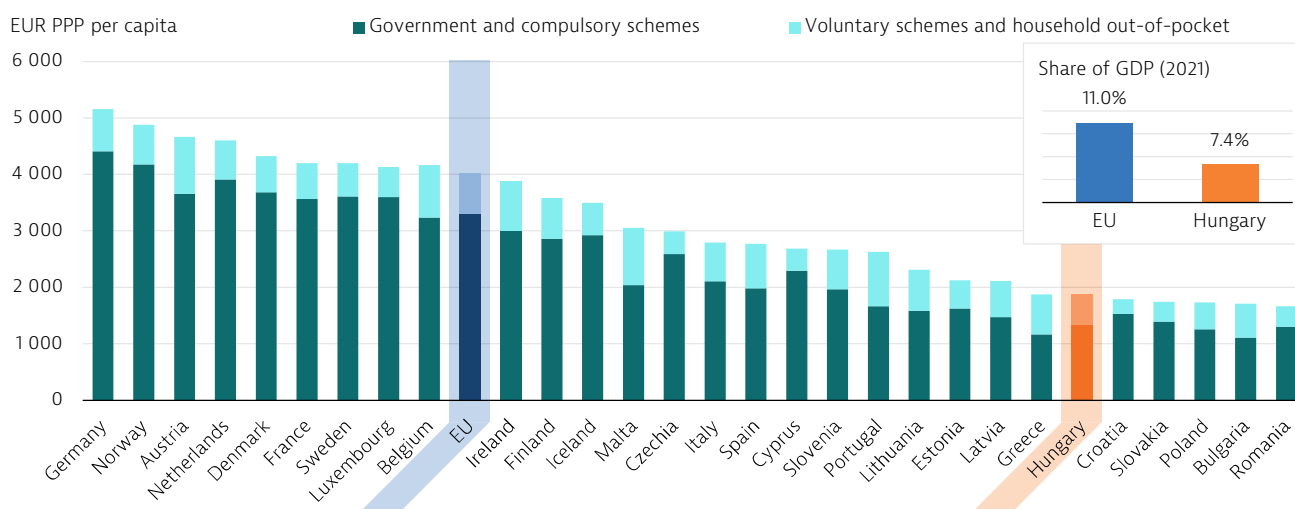
The provision of secondary and tertiary care is mostly public and shared among municipalities and the central government with a small role for private providers. Municipalities and local governments are responsible for organising primary care, where general practitioner (GP) services are predominantly provided by individual, private practices. However, with a new reform adopted in December 2022, the government aims to centralise responsibilities for defining the boundaries for primary care practices from local governments to the National Directorate-General for Hospitals and has provided financial incentives to GPs to encourage the establishment of group practices (see Section 5.3). A few municipalities

also own outpatient specialist facilities, called polyclinics, where secondary ambulatory care is provided for the local population in various medical specialties. Discussions are underway for management of polyclinics to be centralised but the decision lies with local authorities as to whether to transfer these to the central government.

Health expenditure in Hungary has slowly yet steadily increased over the last two decades

Hungary spent 7.4 % of its GDP on health in 2021 compared to the EU average of 11.0 %. After seeing a high annual growth rate of 11.9 % in current health expenditure between 2019 and 2020, the rate slowed to 7.7 % in 2020-21. At EUR 1 866 per capita (adjusted for differences in purchasing power), Hungary spends less than half the EU average on health per capita (Figure 7). The share of public financing for health has been growing incrementally over the last decade and was 72.5 % in 2021, compared to the EU average of 81.1 %. Consequently, out-of-pocket (OOP) payments by households were high, amounting to 25 % that same year compared to an average of 15 % across the EU (see Section 5.2). Outpatient medical care and pharmaceuticals, medical devices and dental care are the main drivers of OOP spending (see Section 5.2).

Figure 7. Spending on health in Hungary is among the lowest in the EU



Note: The EU average is weighted.

Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

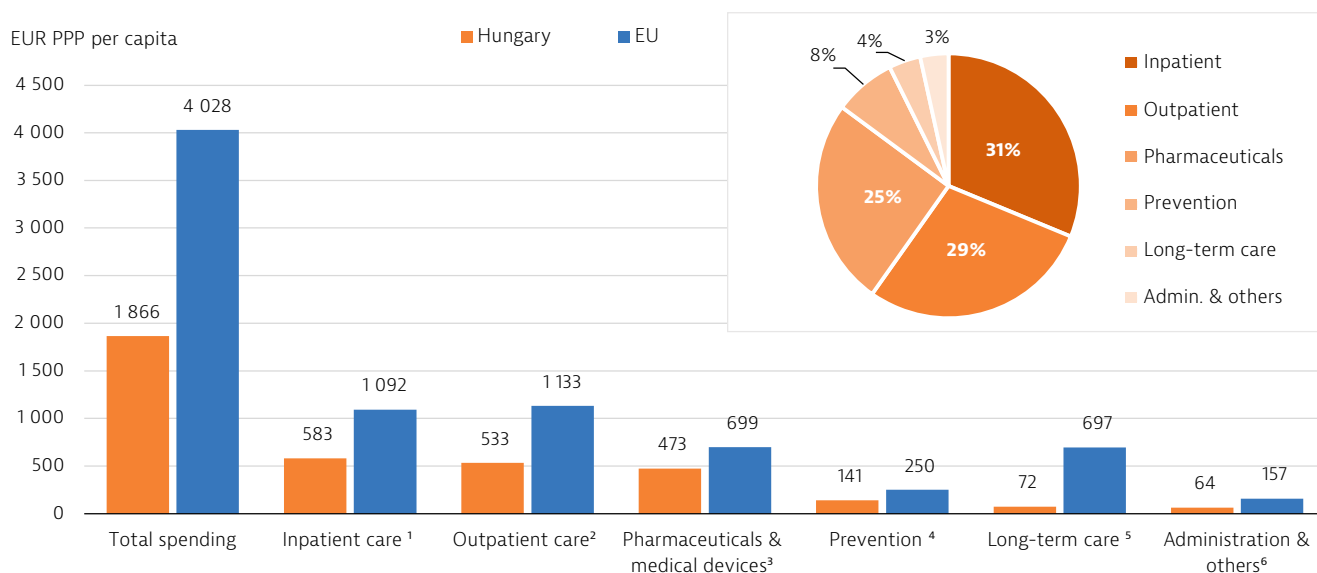
New measures aim to temper the use of informal payments

The elimination of informal payments has been debated for several years as they are seen as an obstacle to improving equity, financial protection, transparency and efficiency (Gaal et al., 2021). As part of a new employment status for health workers, the official salary of medical doctors was more than doubled by the government over a three-year period from 2021, and the giving and acceptance of informal payments was criminalised, with the exception of small value gifts (see below and Section 5.2). Nevertheless, Eurobarometer survey results from 2022 found that most Hungarians think giving gifts or doing favours are acceptable to receive public services (European Commission, 2022a).

Inpatient care makes up the largest share of health spending

In 2021, Hungary used approximately one third (31 %) of its healthcare spending on inpatient care, which is higher than the EU average (28 %). Hungary spends 29 % on outpatient care, which is equal to the EU average (Figure 8). Given that Hungary's total health expenditure is relatively low, outpatient pharmaceuticals and medical devices, whose prices tend to converge within the single market, absorbed 25 % of health spending, much higher than the EU average of 18 %. In contrast, Hungary allocated only 4 % of its spending on long-term care (LTC), much lower than the EU average of 16 %.³

Figure 8. Hungary spends less per capita in each category than the EU average



Notes: 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only spending for organised prevention programmes; 5. Includes only the health component; 6. Includes health system governance and administration and other spending. The EU average is weighted.

Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Due to the complex mix of public and private providers, doctors and nurses have multiple jobs within and across sectors

Like many other EU Member States, workforce shortages have been a problem in Hungary for many years. The number of doctors has more or less fluctuated around 3.0 per 1 000 population since 2000, reaching 3.3 per 1 000 in 2021, below the EU average of 4.1 per 1 000. In 2021 there were 5.3 nurses per 1 000 population, well below the EU average of 8.5 per 1 000 (Figure 9).

Workforce shortages are tied to emigration to other European countries for higher pay and, to

an extent, to the private sector (Gaal et al., 2021). With the expansion of the private sector it is common for doctors and nurses to work multiple jobs within the public sector and across sectors. The new legislation on the employment status of health workers issued in 2020 was motivated by a number of factors, including: the growth of the private sector and its entanglement with the public system; health workers' dissatisfaction with their working conditions, and low pay; and the debate about informal payments. New regulations were introduced to separate the public and private sectors, though they have only been partially implemented. For example, while the original plan

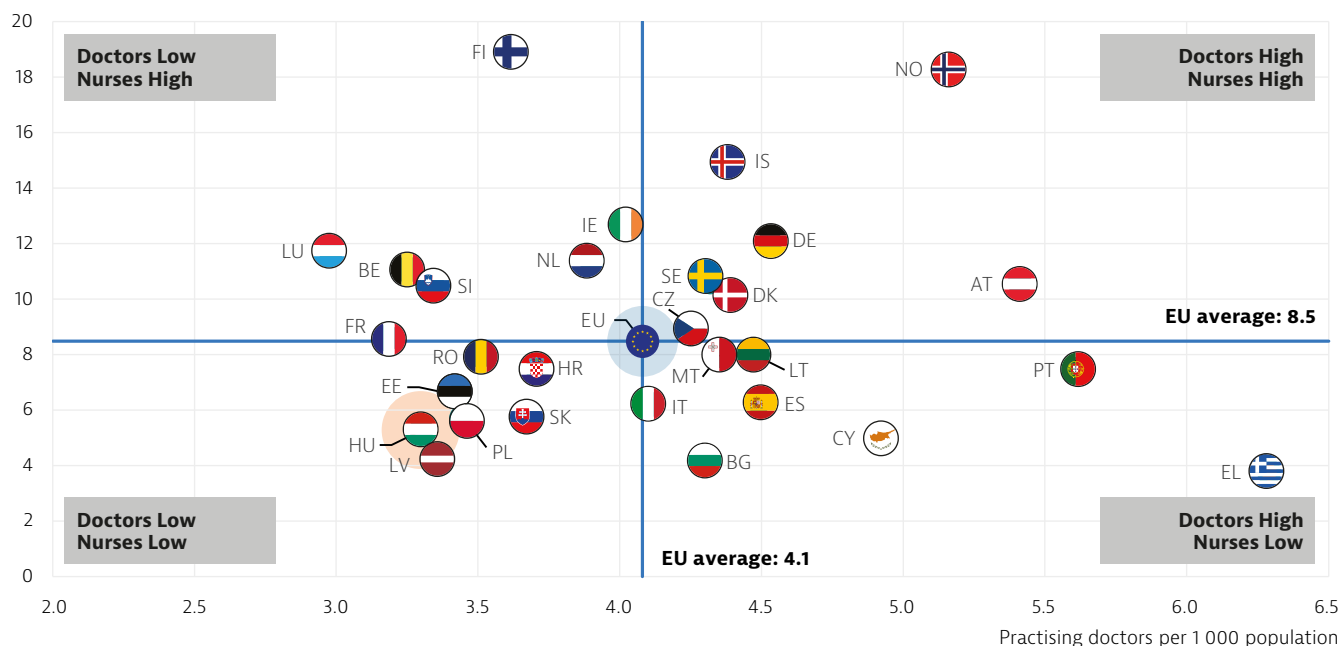
³ This is not only related to health services but reflects a broader tendency in administrative services.

was to force doctors to choose between public of private sector work, they have since only had to report part-time employment for approval by the

National Directorate General for Hospitals, and approvals were given to virtually everybody.

Figure 9. The numbers of doctors and nurses in Hungary are below EU averages

Practising nurses per 1 000 population



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Greece, the number of nurses is underestimated as it only includes those working in hospitals. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal).

Sources: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

Hungary has one of the highest rates of preventable mortality in the EU

The rate of preventable deaths in Hungary decreased in the last decade to 315 per 100 000 population in 2019, although it remained one of the highest in the EU over the same period. This spiked to 350 deaths per 100 000 population in 2020, which is partly explained by the fact that deaths attributed to COVID-19 have been classified as preventable in mortality statistics since 2020 (Figure 10). The three leading causes of preventable mortality in Hungary in 2020 were lung cancer (18 %), ischaemic heart disease (15 %) and alcohol-related diseases (11 %). Hungary has the largest prevalence of preventable deaths from lung cancer in the EU.

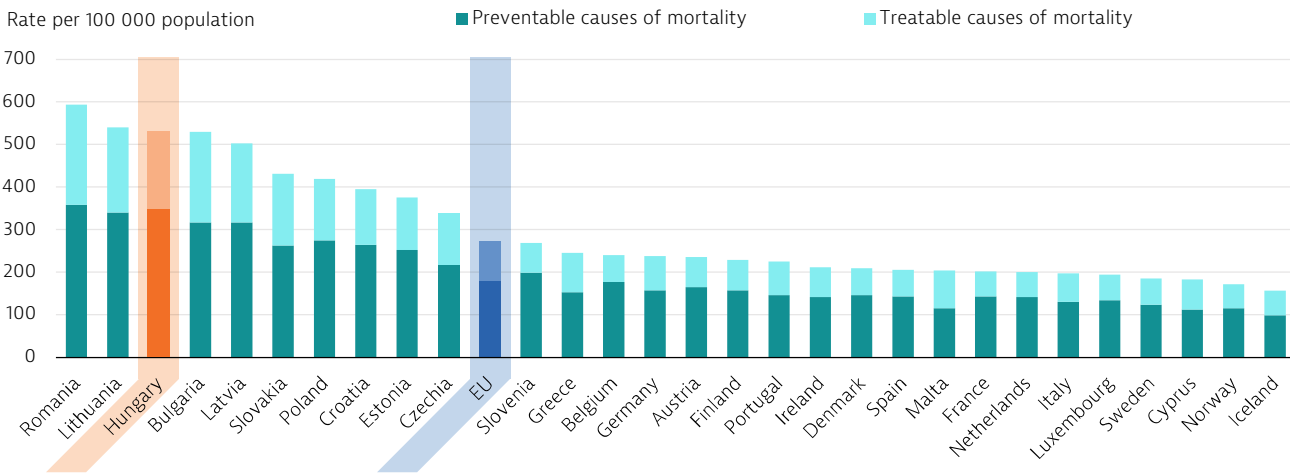
As with preventable mortality, deaths from treatable causes are also relatively high in Hungary. Though the rate declined in the last decade to

173 per 100 000 population in 2019, it rose to 180 per 100 000 in 2020. The three leading causes are ischaemic heart disease (29 %), which is one of the highest rates in the EU, colorectal cancer (16 %) and stroke (11 %).

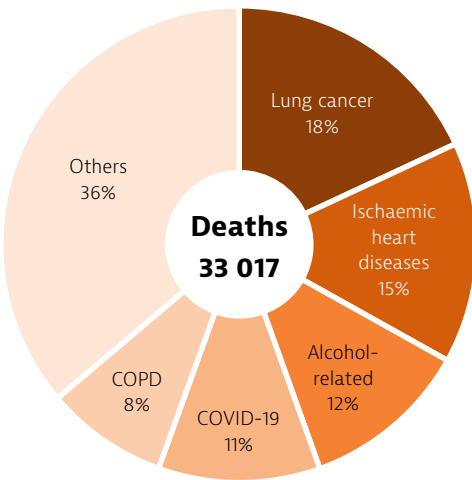
The previous five national health programmes to shift the health system towards preventive care are being updated

In 2019, to improve prevention in Hungary, the Minister of Human Capacities introduced five national health programmes for 2019-22 covering child health, circulatory diseases, mental health, musculoskeletal disorders and cancer. An initiative to develop a new national health programme was announced in 2023, but the new plans are still in their initial stages. Other prominent policies to improve public health and prevention include an expansion of the Public Health Product Tax to items such as alcopops and a planned investment of HUF 83.5 billion (EUR 229 million) for sports facilities.

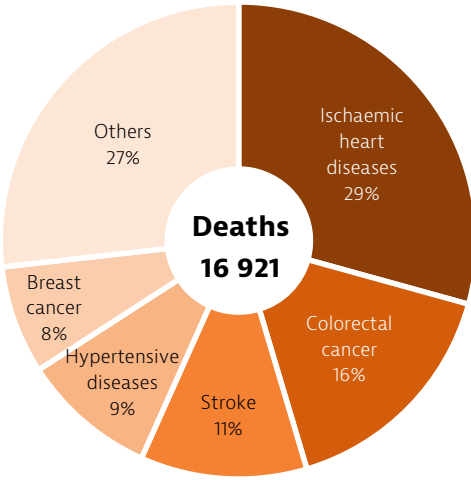
Figure 10. The avoidable mortality rate in Hungary is the third highest in the EU



Preventable causes of mortality



Treatable causes of mortality



Hungary

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2020).

The immunisation rate against influenza for the older population remains below the EU average

The influenza vaccination rate among older people (aged over 65 years) in Hungary has slowly declined since the early 2000s and remains below the EU average. It rose significantly during the first year of the COVID-19 pandemic, from 23.6 % in 2020 to 30.5 % in 2021. However, it declined again to 22.3 % in 2022, the lowest rate recorded in Hungary going back to 2003 and was the second lowest in the EU after Luxembourg.

The immunisation rate for human papillomavirus (HPV), on the other hand, is relatively high. In 2022, 80 % of 15-year-old girls received the recommended doses of the HPV vaccine. This is an increase from 74 % in 2017, and is well above the EU average of 63.4 % in 2022.

The COVID-19 pandemic exacerbated already declining breast and cervical cancer screening rates

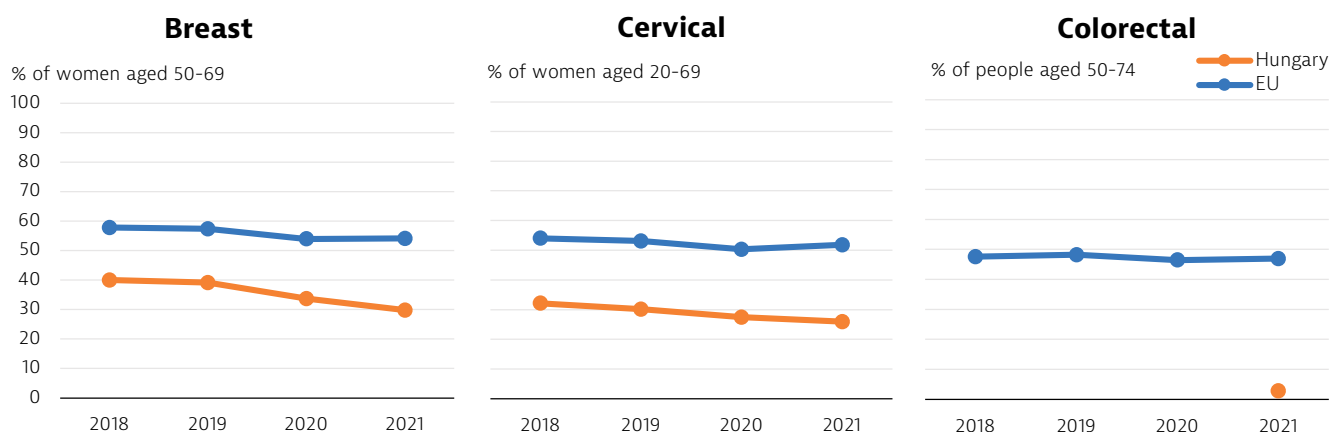
Cancer screening rates for breast and cervical cancer were declining in Hungary before the COVID-19 pandemic. They decreased further due to the implemented lockdown measures to contain the spread of the virus, such as the temporary suspension of all oncological screening activities in mid-March 2020 and again in April 2021. In 2019, 39.1 % of women aged 50-69 years were screened for breast cancer in the previous two years; this rate declined during the pandemic to 33.7 % in 2020 and further to 29.8 % in 2021 (Figure 11). The same trend of gradual decline between 2019 and 2021 emerges when looking at the screening rate for cervical cancer among women aged 20-69. In 2018, a screening programme was introduced for

colorectal cancer among those aged 50-70 years. In 2021, the participation rate in the screening programme was 2.8 %, the lowest among the 16 EU countries reporting data on colorectal cancer screenings.

There are notable differences in screening participation across educational and income levels. For example, 72.5 % of women aged 20-69 years

with a higher education reported having accessed cervical cancer screening at least once within the past two years. For women aged 20-69 years with a lower education, the self-reported rate was only 45.7 %. For income levels, the same picture emerges, as the difference among women with higher (75.1 %) and lower (50.8 %) incomes is also pronounced.

Figure 11. Breast and cervical cancer screening rates have fallen and are below the EU average



Note: Rates refer to the share of individuals within the target groups who have undergone screening in the last two years.

Source: OECD Health Statistics 2023 (based on national programme data)

New plans to expand cancer screening services are underway

In 2022, the screening system in Hungary was reviewed. Areas identified for improvement included expanding eligible populations, changes to frequency in screening and using an electronic invitation system; these are currently being adopted under the guidance of the Ministry of the Interior. Furthermore, in 2023, the National Public Health Centre commissioned a working group of experts to review the current organisation of screening services and to formulate proposals to improve efficiency and outcomes in cancer prevention. The working group's proposals call for changes in existing strategies and for the national scale-up of pilot projects. It envisages inviting women over the age of 30 years for HPV-based testing every five years. Plans also include the organisation of preventive screening for lung tumours and stomach and prostate cancer and the introduction of stomato-oncology screening.

Reducing avoidable hospital admissions is on the agenda

Hospital admissions for chronic obstructive pulmonary disease (COPD), congestive heart failure, asthma or diabetes are considered avoidable as patients with these diseases can effectively be managed in an outpatient setting. National

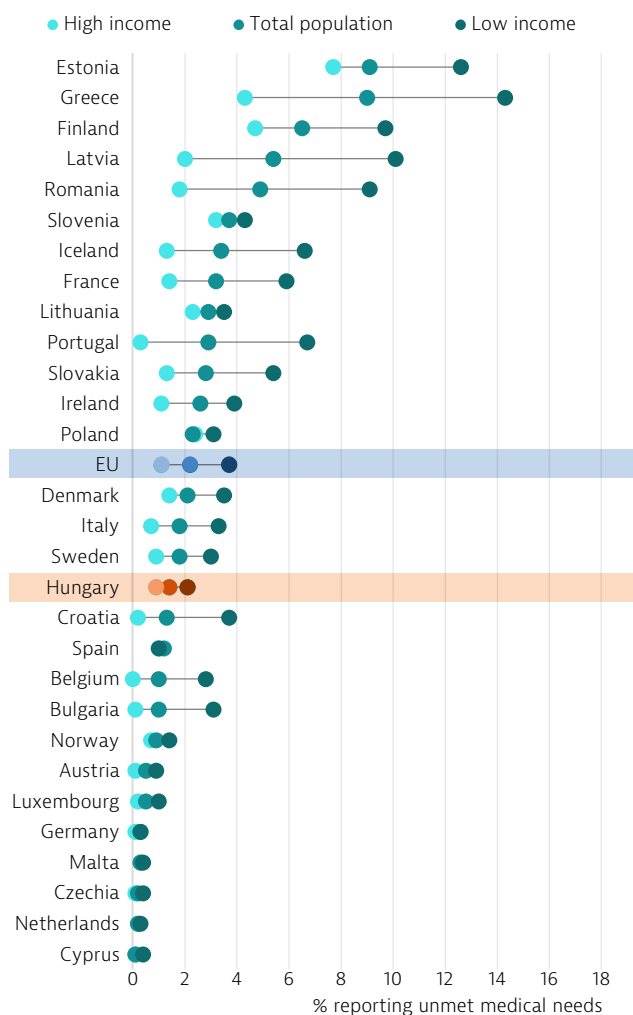
concerns over the high number of avoidable hospital admissions have led to efforts to reduce hospital stays for COPD patients. With the support of the EU's Technical Support Instrument, Hungary is in the process of creating a new financial and clinical governance model involving bundled payments through pilot projects. These have not yet been rolled out to the whole system. The efforts to reorganise primary care from single to group practices also aim to increase the effectiveness of keeping patients out of hospitals (see Section 4).

5.2 Accessibility

Unmet medical needs are comparatively low

In 2022, in the EU-SILC survey, only 1.4 % of the Hungarian population reported unmet medical needs for a medical examination or treatment due to costs, travel distance or waiting times (Figure 12), despite the high OOP payments for certain services (see Section 4). As in other EU countries, self-reported levels of unmet medical needs vary among people with low (2.1 %) and high (0.9 %) incomes, although the difference in Hungary is generally much smaller and both groups' averages are below their respective EU averages. Unmet needs for dental care show a wider gap between income groups with 2.6 % of people on low incomes reporting forgone care compared to just 0.6 % among the those with high incomes.

Figure 12. Hungarians with low incomes are more likely to report unmet medical needs



Notes: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

Higher levels of unmet medical were reported during the COVID-19 pandemic

Despite low numbers of self-reported unmet medical needs in general, evidence suggests that unmet needs increased significantly during the COVID-19 pandemic. A set of Eurofound surveys⁴ found that in spring 2021, 35 % of Hungarians reported unmet medical care needs during the first 12 months of the pandemic, considerably higher than the EU average of 17 %. However, contrasting with the EU trend of increasing unmet needs in the following year, the rate in Hungary decreased to 28 %, albeit remaining higher than the EU average (18 %) (Eurofound, 2022). The temporary suspension of elective surgeries that was in place between November 2020 and May 2021 and the restricted supply of available hospital beds during certain

waves of the pandemic may explain, at least in part, these rates of unmet medical needs reported by Hungarians.

Despite near universal population coverage, small gaps remain

NEAK provides near universal coverage for 95 % of the population. The insurance status for the remaining 5 % is unclear. These are citizens living abroad with access to healthcare within their country of residence and those living in Hungary without a permanent address (see Section 4). In 2019, the government introduced the Act on Entitlements to Social Security Benefits and on Funding These Services. Under this legislation, non-insured patients must pay for treatment out of pocket or forgo care, except in cases of emergency treatment.

Population groups who do not have access to Hungary's social health insurance (SHI) scheme – such as non-EU students – can purchase insurance from NEAK for an annual premium set at 50 % of the minimum monthly wage for adults and 30 % for children and full-time students. However, the benefits package is limited compared to that offered to the SHI insured population as it excludes dental care and cross-border treatment services.

Hungary's benefits package is broad, but dental care and medicines are not fully covered

Hungarian citizens can access a broad range of services in the statutory benefits package, covering all levels of healthcare and medicines. However, the proportion of publicly covered costs for outpatient medical care and pharmaceuticals are below the EU averages of public spending on health, while it is roughly the same for dental care. In 2021, dental care accounted for 12 % of OOP spending in Hungary. One explanation for this is the fact that dental services have not been maintained to the same extent as other service areas, and more emphasis has been placed on individual responsibility to cover these needs.

Hungary's benefits package includes a positive list of pharmaceutical products and in 2023 there are approximately 4 050 medicines on this list. Policies to boost consumption of generic over branded products aim to reduce costs and improve access to medicines. The two major policies in this area are generic substitution and generic prescribing, both voluntary in Hungary, although policies are in place to incentivise generic use. For example, NEAK provides pharmacies with financial incentives to use generics.

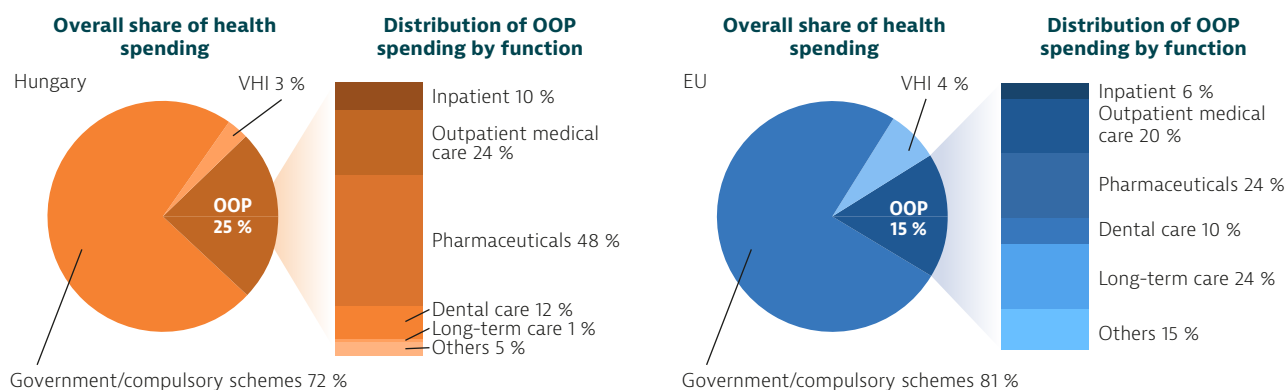
⁴ The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

Out-of-pocket spending is primarily on pharmaceuticals and outpatient medical care

OOP payments accounted for 25 % of Hungary's total health spending in 2021, much higher than the EU average of 15 % (Figure 13). The OOP health expenditure rate in 2021 was lower than in the previous two years, in part reflecting disruptions in non-COVID-19-related care and changes in

patients' healthcare-seeking behaviour during the pandemic. The largest share of OOP spending goes on outpatient pharmaceuticals (48 %), a result of high copayment rates. Another sizeable share of OOP spending in Hungary is on outpatient medical care (24 %), which reflects the increased usage of private healthcare services.

Figure 13. Out-of-pocket expenditure on outpatient pharmaceuticals is the highest in the EU



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.

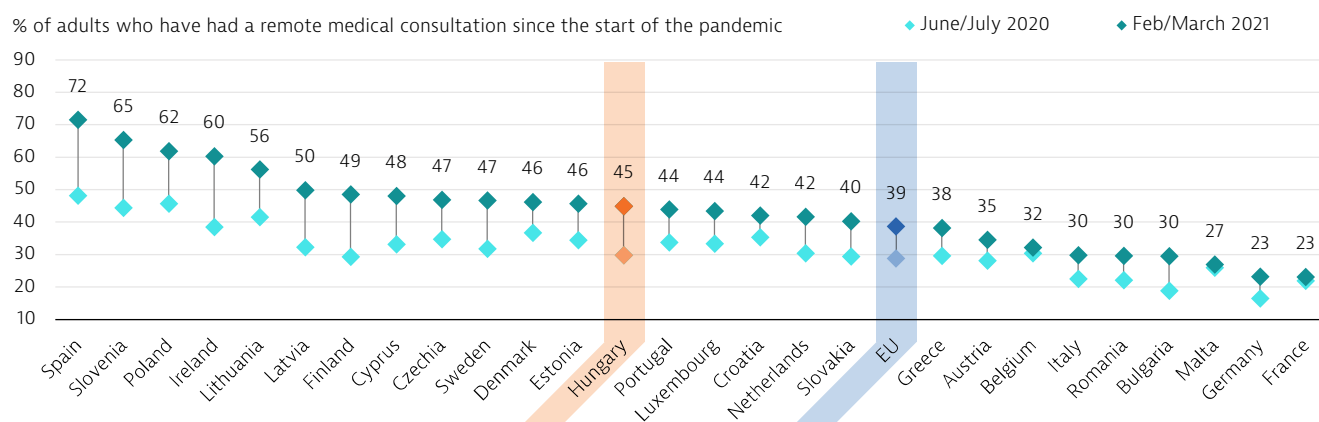
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

The number of teleconsultations continued to increase during the pandemic

As a response to mobility restrictions during the COVID-19 pandemic, the requirement that medical consultations only be performed in a patient's physical presence was lifted to allow remote care. This was intended to maintain levels of patient care while minimising the risk of infection. Furthermore, the range of healthcare workers allowed to perform teleconsultations

was expanded from doctors to nurses (OECD/EU, 2022). These changes are reflected in the number of teleconsultations during the first two years of the pandemic. A Eurofound survey highlights that in June/July 2020, 30 % of surveyed adults reported having had a teleconsultation online or over the telephone since the start of the pandemic. By February/March 2021, this had increased to 45 % (Figure 14).

Figure 14. The number of teleconsultations in Hungary was higher than the EU average at the beginning of 2021



Notes: The EU average is weighted. Low reliability for 2021 data from Cyprus, Latvia and Malta, and for 2021 and 2020 data from Luxembourg because of low sample sizes.

Source: Eurofound (2022).

Policies have aimed to alleviate health workforce shortages and improve retention rates

Workforce shortages in Hungary are partly tied to emigration to other European countries. In response, the government has introduced several policies to bolster retention rates and the number of doctors applying for an official certificate to have their professional qualifications recognised abroad has decreased. Since 2011, medical residents can also apply for a scholarship if they agree to work in Hungary for 10 years after graduating. Healthcare professionals have also received several wage increases, most recently under the new public sector health employment contract of 2020, which provides doctors, dentists and pharmacists with gradual pay rises over a three-year period (between 2021 and 2023). A 2022 amendment introduced options to reward good performance by doctors with a raise of up to 40 % and to lower salaries of those not performing well by up to 20 %, although this has not yet been implemented (see Section 4).

The explicit prohibition of informal payments, now punishable by a gaol term, is an important part of the legislation that underwrites the new remuneration package. The density of doctors within Hungary also varies greatly between urban and rural areas.

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,⁵ improve critical areas of the health sector, and fortify their preparedness for future shocks.

Hospital activity slowed during the pandemic

Mindful of its excessive reliance on hospital-based care, Hungary has been gradually reducing its total number of hospital beds since 2000. However, with a density of 6.8 total beds per 1 000 population in 2021, it is still well above the EU average of 4.8 per 1 000. During the COVID-19 pandemic, the occupancy rate of available beds dropped sharply

due to postponed care – from 63.8 % in 2019 to just 51.5 % in 2021. The rates in both years were well below EU averages. Hospital discharges, similarly, saw a large drop in 2020, as Hungary recorded 35 % fewer inpatient care discharges per 100 000 population in 2021 compared to 2019, now below the EU average after years of having far more discharges in inpatient care.

When looking at surgical activity in the context of the pandemic, volumes in Hungary decreased as they did across the EU. Similar trends can be seen, for example, for hip and knee replacements and breast surgeries, although Hungary, before and during the pandemic, registered fewer operations for each of these categories. However, in contrast to the EU averages, the surgical activity continued to decline in 2021.

Elective surgeries for cataracts, hips and knees continue to deal with backlog issues

Due to the suspension of many non-emergency services as part of the health system response to COVID-19, waiting times for cataract, hip and knee replacement surgery increased. The largest increase was for cataract surgery: 42.2 % of patients in 2020 had to wait three months or longer for their procedure (up from 6.7 % in 2019). This rate fell to 32.7 % in 2022. More patients also had to wait longer for hip and knee replacements and waiting times for both were still higher in 2022 than 2019 (Figure 15).

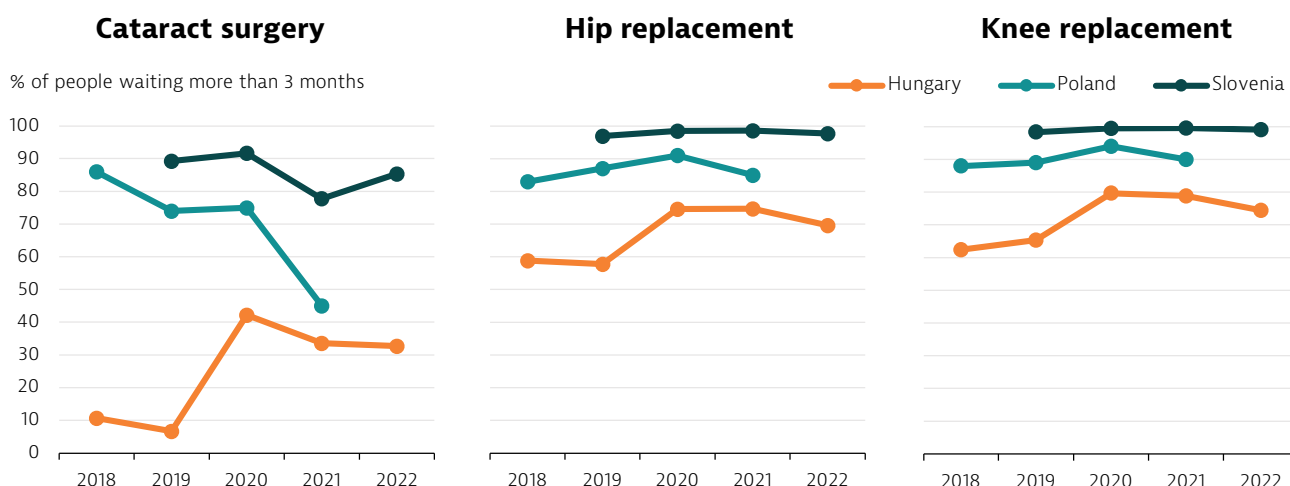
COVID-19 booster vaccination uptake among those aged 60 and over has been relatively low

Hungary's initial rollout of its COVID-19 vaccination programme in 2021 was successful, maintaining high rates of uptake for the primary course of inoculations that kept pace with the EU average for most of the year, and reaching 70 % of the adult population in December 2021. However, sustaining good vaccination coverage has proved challenging, particularly among the more vulnerable older age groups: coverage of second booster vaccinations among those aged 60 and over is very low, reaching only 12 % at the end of 2022 (the EU-wide average was 36 %).

The incremental growth in public funding for healthcare experienced a boost during the pandemic

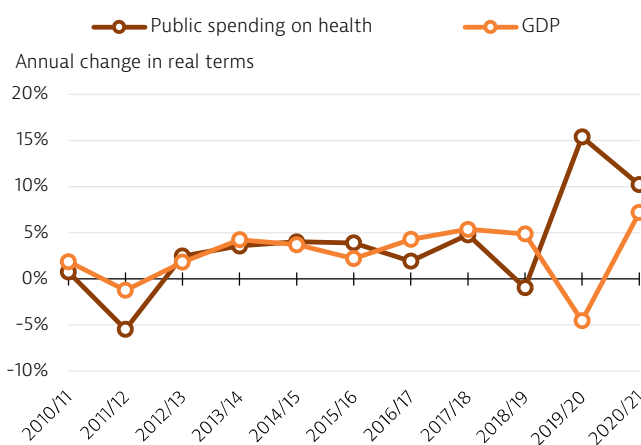
Public spending on health in Hungary has grown every year since 2012 except for 2018/2019. It increased substantially between 2019 and 2020,

⁵ In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessments, 2020).

Figure 15. Waiting times for elective surgeries increased in Hungary during the COVID-19 pandemic

Source: OECD Health Statistics 2023.

by 15.4 %, as the government quickly made public funding available for health to respond to the COVID-19 pandemic. At the same time, the downturn in economic activity due to the impact of lockdowns and other pandemic measures saw a contraction in GDP of 4.5 % (Figure 16). In 2020/2021 public spending on health once again outgrew GDP, although economic activity rebounded, and the gap was much smaller.

Figure 16. Public spending on health jumped in 2020 to equip the health system to fight the outbreak of COVID-19

Source: OECD Health Statistics 2023.

Funding from the Recovery and Resilience Facility provides Hungary with significant resources to modernise the health system

Under its Recovery and Resilience Plan, Hungary is scheduled to receive EUR 5.8 billion (equivalent to just under 4 % of GDP). It intends to dedicate just over one fifth of these funds (22 %), totalling

EUR 1.3 billion, to healthcare investments. The digitalisation of the healthcare sector is a major priority under the plan (Figure 17), and involves financing development of information technology infrastructure in healthcare institutions, development of telemedicine solutions, the rollout of enhanced mobile health applications and a remote health monitoring system for older people. Other areas of investment focus on upgrading healthcare infrastructure and equipment, bolstering the provision of services under the hospital network and strengthening the integration of primary and preventive care through the establishment of GP group practices (European Commission, 2022b). Currently, the disbursement of funds is pending the implementation of 27 “super milestones”, many of which focus on anti-corruption measures, public procurement, judicial independence and the rule of law (European Parliament, 2023).

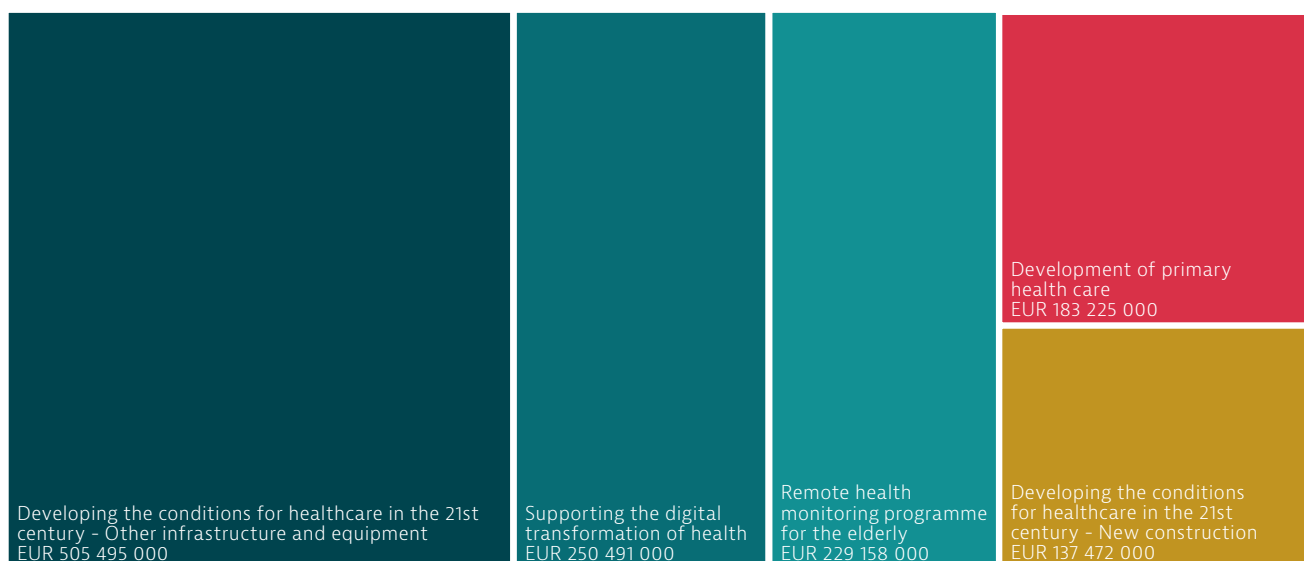
These investments will be complemented by the rollout of the EU Cohesion Policy 2021-27 programming, through which Hungary is set to invest a total of EUR 154 million in its healthcare system. The EU will co-finance a significant amount (85 %), via the European Regional Development Fund (ERDF), with a view to improving service quality through modern infrastructure development, so that adequate provision becomes accessible to inhabitants in targeted areas.⁶

Greater centralisation of governance is seen as key to enhancing health system efficiency

Responsibility for the health system in Hungary was recently moved to the purview of the Ministry of the Interior (see Section 4). With this competency

⁶ These EU Cohesion Policy figures reflect the status as of September 2023.

Figure 17. A large proportion of Recovery and Resilience Plan funding will flow into the upgrading of infrastructure and digitalisation of the health sector



Notes: These figures refer to the original Recovery and Resilience Plan. The ongoing revision of the Plan might affect its size and composition. Some elements have been grouped together to improve the chart's readability.

Sources: European Commission – Recovery and Resilience Scoreboard; Eurostat Database.

change, enhancing health system efficiency is posited as a major policy priority in the years to come. In December 2022, the Hungarian Parliament adopted several measures to reorganise the health system and centralise governance. These included plans to centralise decision making in primary care, transfer LTC departments within hospitals to the social care system, use the state ambulance service to provide emergency out-of-hours services, centralise decision making to the county level and confer stronger management powers to county hospitals and centralise the management of mother and child health services (health visitor) services.

Not everyone supports the current reform package. In particular, the Hungarian Medical Chamber has objected to further centralisation of the health system and in January 2023 put forward an alternative set of policy mandates focused on strengthening primary care and dental services, easing working conditions for specialist doctors and increasing the salaries of allied health professionals. Mandatory membership in the Hungarian Medical Chamber was abolished by the government in February 2023.

The reform of primary care is wide-ranging

Under the 2022 reform package, the government gained the authority to close practices with less than 1 200 registered adult or 600 paediatric patients (to be implemented by 2028) and to redefine the boundaries of primary care practices, which was previously overseen by local governments. These developments follow

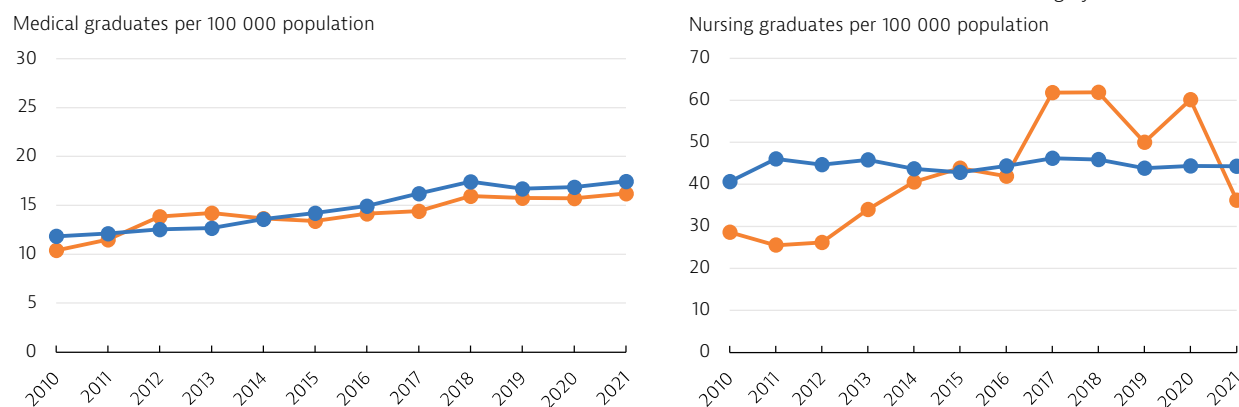
other measures introduced in 2021 to encourage the establishment of group practices through additional direct payments to GPs and to enhance their role. Primary care group practices can involve the co-operation of several GPs, paediatricians and primary care dentists to enhance integrated care for patients with chronic conditions, and can increasingly involve other professionals, such as dietitians, physiotherapists, health visitors and psychologists, as well as the provision of specialist care and community-level health promotion and preventive services, such as screening.

The number of medical graduates has increased gradually

The growth in the number of nursing graduates in Hungary has varied over the last decade and generally outpaced the EU average after 2016. The steep decline in 2021 shown in Figure 18 represents a change in reporting and since then excludes ambulatory nurses and those in programmes shorter than three years. Thus, at 36 nursing graduates per 100 000 population in 2021, Hungary's latest rate was below the EU average (44 per 100 000).

The number of medical graduates has gradually increased in Hungary since 2010, and at 16 per 100 000 population in 2021 this rate was close to the EU average (18 per 100 000). One issue is whether new medical graduates will opt to work in the public sector or choose to practice in the private sector or abroad.

Figure 18. Until recently, Hungary was able to increase its level of nursing graduates quicker than medical graduates



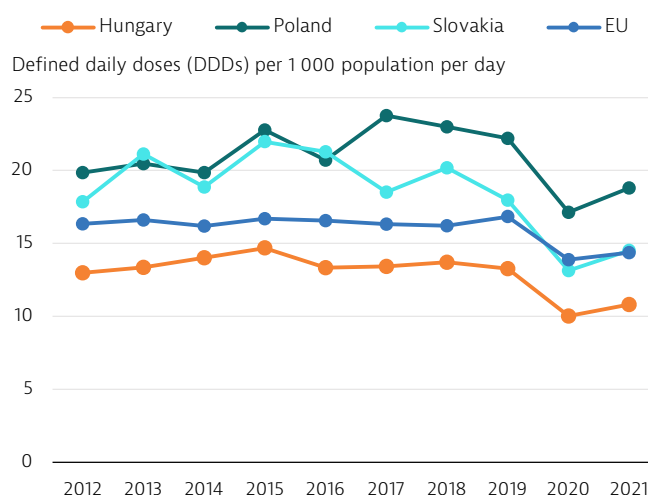
Note: There is a break in the 2021 data for nursing graduates in Hungary.
Sources: OECD Health Statistics 2023; Eurostat Database.

Antibiotic consumption levels in Hungary are relatively low

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths in the EU/EEA due to antibiotic-resistant infections (ECDC, 2022) and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

In 2021, antibiotic consumption in the community stood at 10.8 daily defined doses per 1 000 population per day in Hungary, which is below the EU average (14.4) (Figure 19), and half of that of countries such as Bulgaria and Romania. Broken down into the WHO antibiotics classifications of access, watch and reserve, consumption in Hungary for antibiotics reserved for a specific limited number of indications (watch) was roughly equal to the EU consumption average, while consumption of those that are first- and second-choice (access) antibiotics that should be widely available was much lower. The trend in antibiotic consumption in Hungary has decreased slowly but gradually over the past decade. However, as one indicator of antibiotic resistance highlights, Hungary had levels of registered bloodstream infections due to methicillin-resistant *Staphylococcus aureus* (MRSA) above the EU average among patients with tested blood samples in 2021.

Figure 19. Antibiotic consumption in Hungary is well below the EU average



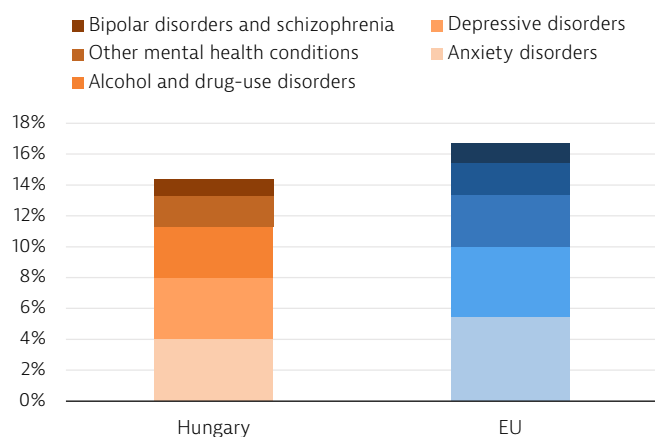
Notes: The EU average is unweighted. The data only cover consumption in the community (outpatient).
Source: ECDC ESAC-Net.

6 Spotlight on mental health

The burden of mental health in Hungary is comparatively low, yet many are struggling

According to estimates from the Institute for Health Metrics and Evaluation (IHME), 14 % of the Hungarian population had a mental health condition in 2019, compared to 17 % across the EU (Figure 20). The economic costs of mental ill-health are substantial, with direct and indirect costs estimated at 3.1 % of GDP in Hungary or nearly EUR 3.5 billion in 2015 (OECD/EU, 2018). The most common mental health conditions in Hungary are anxiety and depressive disorders (both estimated to impact 4 % of the population) and alcohol and drug use disorders (3 %).

Figure 20. Depressive and anxiety disorders are the largest shares of the mental health burden

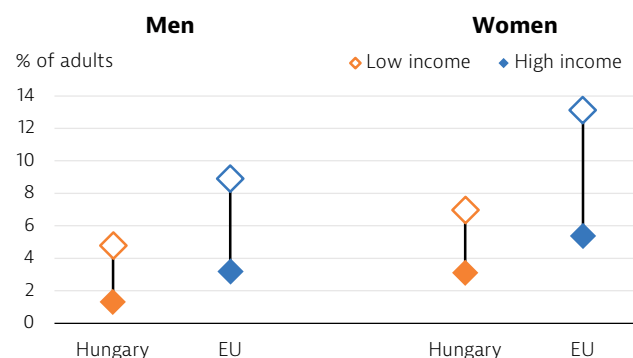


Source: IHME (data refer to 2019).

People in low-income groups report depression more often

Data from the 2019 European Health Survey show that depression was more frequently reported by those in the lowest income quintile (4.8 % of men and 7 % of women) than the highest quintile (just 1.3 % of men and 3.1 % of women) in Hungary. However, these differences between income groups for both Hungarian men and women are smaller than the EU average differences (Figure 21).

Figure 21. Men and women in low-income groups are more likely to report depression



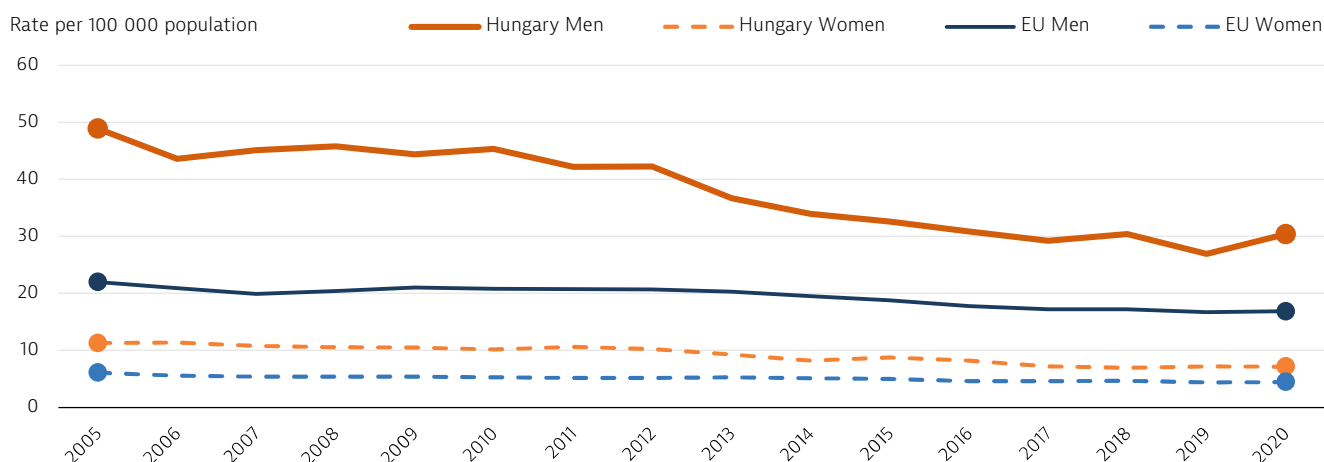
Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).

Source: Eurostat Database (based on EHIS 2019).

The link between low income and poor mental health persisted throughout the COVID-19 pandemic. Survey data showed that those in unstable financial circumstances had a higher risk of depression. According to Eurofound's Living, working and COVID-19 survey (Eurofound, 2021), 58.4 % of people in financially struggling households in Hungary were at risk of depression, compared to 29.7 % of those who were not. These proportions were lower than the EU averages.

Despite a reduction over time, Hungary has one of the highest suicide rates among men in the EU

Progress has been achieved in reducing historically high mortality rates from suicide in Hungary. The combined suicide rate for men and women has decreased significantly from 35.1 per 100 000 population in 2000 to 15.7 in 2019. However, it slightly increased again to 17.1 per 100 000 in 2020, potentially related to the toll that the COVID-19 pandemic had on mental health. Despite this progress, the suicide rate among men is far higher than among women and is the second highest among EU countries. The suicide rate for women has slowly decreased from 16.0 per 100 000 in 2000 to 7.2 per 100 000 in 2020 (Figure 22).

Figure 22. The suicide rate among Hungarian men has decreased but remains high

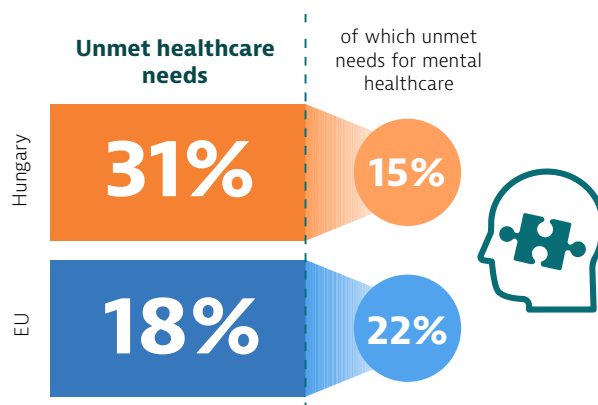
Source: Eurostat Database.

Hungarians reported unmet mental healthcare needs during the pandemic

Mental healthcare is integrated with the health and social care system, both organisationally and in terms of financing structures. Outpatient centres are available in almost all departments of psychiatry (or psychiatric dispensaries). In 2022, there were 130 psychiatric and 19 youth and child psychiatric public outpatient care providers in Hungary (Hungarian Central Statistical Office, 2023). Nevertheless, underfunding and lack of capacity result in postponed treatments and a shift to the private sector for those who can afford to pay for it.

Hotline services are maintained by non-governmental organisations, with limited (or no) support from the central healthcare budget. Currently, multiple hotline services are operating for the whole country, some of them organised as a service network. Well-trained professionals staff these telephone hotlines and form a fundamental part of mental health support, crisis intervention and suicide prevention. However, the hotline service has not been integrated into clinical practices (European Commission, 2013).

As in many other EU countries, many Hungarians reported unmet mental healthcare needs during the COVID-19 pandemic. According to a European-wide survey carried out in spring 2021 and spring 2022, 31 % of Hungarians reported unmet healthcare needs, of which nearly one sixth (15 %) were related to mental healthcare (Figure 23).

Figure 23. Nearly one sixth of unmet healthcare needs in Hungary during the pandemic were for mental healthcare

Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.

Sources: Eurofound (2021; 2022).

A new National Public Health Programme for 2030 is in development

In 2018, the Hungarian Government adopted the National Health Programmes and Related Policies for 2019-22. One of the five programmes was a dedicated National Mental Health Programme. With the programme, local governments received the autonomy to develop and implement plans for local health promotion. In 2021 there were 110 health promotion offices across the country. Hungary is currently in the process of developing a new National Public Health Programme, commissioned by the Ministry of the Interior. As with the previous national programmes, the new one is expected to include a strand of policies related to mental health, including mental health promotion (WHO Regional Office for Europe, forthcoming).

7 Key findings

- The COVID-19 pandemic interrupted the gradual convergence of life expectancy in Hungary with the EU average, and the gap stood at 4.5 years in 2022. Pre-pandemic gains in life expectancy are attributed to reductions in mortality from circulatory diseases – the leading cause of death in Hungary – followed by cancer. Hungarian men are expected to live nearly 7 years less than women, which can largely be attributed to greater prevalence of risk factors among men.
- Hungary has a rapidly ageing population, with over one fifth of the country aged 65 and over in 2020, many of whom report suffering from multiple chronic conditions. In fact, Hungary has the highest share of older men and women reporting limitations in basic activities of daily living in the EU.
- Dietary risks and smoking are significant population health risks in Hungary: Hungarians were some of the heaviest smokers in the EU in 2019. There is a pronounced gender gap, as over a third of Hungarian men smoke daily, compared to over one fifth of women. Furthermore, measured obesity has increased from 29 % of adults in 2009 to 33 % in 2019, and is particularly a concern among adolescents: 25 % of 15-year-olds were overweight or obese in 2022. As in all EU countries, there are pronounced differences in the impact of risk factors between socioeconomic groups.
- Health expenditure in Hungary has risen in recent years, fuelled by spending related to the COVID-19 pandemic. Nevertheless, Hungary spent less than half the EU average per capita in 2021, ranking the sixth lowest among EU countries. Although out-of-pocket payments for healthcare decreased in 2021, at 25 % they were considerably higher than the EU average (15 %), as a result of only partial cost coverage for several health goods and services. Nearly half of all household out-of-pocket spending goes towards pharmaceuticals.
- Care provision in Hungary is heavily reliant on hospitals, with bed densities well above the EU average, and nearly one third of healthcare spending dedicated to inpatient care. The wide-ranging new health reform adopted in December 2022 plans to strengthen primary care and encourage group practices, particularly to enhance integrated care for patients with chronic conditions and to deliver improved preventive services.
- Hungary's Recovery and Resilience Plan forecasts approximately EUR 1.3 billion for health sector investment. This includes upgrading of infrastructure and equipment in health facilities and spearheading the drive for greater digitalisation, with a focus on transforming information technology frameworks, developing telemedicine and remote monitoring solutions, as well as rolling out mobile health applications. Support from the EU Cohesion Policy will also go towards infrastructure improvements.
- With a growing private care system in Hungary, many health professionals work multiple jobs within and across the public and private sectors. Furthermore, higher salaries and better working conditions abroad continue to be incentives for emigration to other countries. The government has partly addressed health workforce retention challenges through significant wage increases for doctors, dentists and pharmacists, implemented in stages over the last three years. Other measures to prevent doctors from working in the public and private sectors were also part of the legislation, although they have only partially been implemented so far.
- Depressive and anxiety disorders are the largest mental healthcare issues in Hungary, and have the greatest impact on lower-income groups. Hungary has one of the highest suicide rates among men in the EU. During the COVID-19 pandemic, around 15 % of reported unmet healthcare needs were related to mental healthcare. A new National Public Health Programme for 2030 is expected to include mental health policies, and is currently in development.

Key sources

Health Systems and Policy Monitor – Hungary (2023), European Observatory on Health Systems and Policies, <https://eurohealthobservatory.who.int/monitors/health-systems-monitor>.

OECD/EU (2022), Health at a Glance: Europe 2022 – State of Health in the EU Cycle. Paris, OECD Publishing.

References

ECDC (2022), Press Release: 35 000 annual deaths from antimicrobial resistance in the EU/EEA. Stockholm, <https://www.ecdc.europa.eu/en/news-events/eaad-2022-launch>.

EU Expert Group on Health Systems Performance Assessments (2020), Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement. Luxembourg.

Eurofound (2021), Living, working and COVID-19 survey, rounds one, two and three (spring 2020, summer 2020 and spring 2021). Dublin, <https://www.eurofound.europa.eu/surveys/living-working-and-covid-19-e-survey>.

European Commission (2013), Mental health systems in the European Union Member States: status of mental health in populations and benefits to be expected from investments into mental health. Brussels.

European Commission (2022a), Eurobarometer: Corruption. Brussels, <https://europa.eu/eurobarometer/surveys/detail/2658>.

European Commission (2022b), Laying the foundation for Hungary's recovery conditioned on rule of law reforms; Next Gen EU. Brussels.

European Parliament (2023), Briefing requested by the CONT committee: Rule of law-related "super milestones" in the recovery and resilience plans of Hungary and Poland. Brussels.

European Union (2021), Council Directive 2011/64/EU of 21 June 2011 on the structure and rates of excise duty applied to manufactured tobacco. Brussels.

Gaal P et al. (2021). The 2020 reform of the employment status of Hungarian health workers: will it eliminate informal payments and separate the public and private sectors from each other? Health Policy 125(7): 833–40.

Health Behaviour in School-aged Children study (2023), Data browser (findings from the 2021/22 international HBSC survey): <https://data-browser.hbsc.org>

Hungarian Central Statistical Office (2023), A pszichiátriai betegek gondozása [Care of psychiatry patients]. Budapest, https://www.ksh.hu/stadat_files/ege/hu/ege0016.html.

Joó et al. (forthcoming). The Impact of Regulatory Tightening of the Hungarian Tobacco Retail Market on Availability, Access and Cigarette Smoking Prevalence of Adolescents. BMJ Tobacco Control.

OECD/ECDC (2019), Antimicrobial resistance: tackling the burden in the European Union. Paris.

OECD/EU (2018), Health at a Glance: Europe 2018 – State of Health in the EU Cycle, OECD Publishing, Paris.

WHO Regional Office for Europe (forthcoming). WHO Mental Health Survey, 2023.

Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

State of Health in the EU

Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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