2.3 THE DISTRIBUTION OF INFORMAL PAYMENTS, OF THE USE OF PRIVATE HEALTH CARE AND OF UNMET HEALTHCARE NEEDS ALONG THE AXIS OF SOCIO-ECONOMIC STATUS

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The majority of the subchapters of *In Focus* examines the distribution of the state of health and the use of health care services along the axis of labour market status and socioeconomic status using administrative data. However, this naturally results in less attention on informal payments, on the use of private health care and on unmet health care needs – to name a few examples – which do not appear in the databases used. The following is a short summary of the results – related to inequalities based on social and economic status – of a few studies that explore these subjects.

According to an earlier, representative survey (*Baji et al,* 2014), nearly 80 percent of respondents visited a doctor during the year preceding the survey, and 21 percent of them made informal payments. 21 percent of respondents stayed in a hospital, and nearly half of them (44 percent) made such a payment. Controlling for the number of visits to the doctor and for the state of health – in the case of visits to the doctor – the elderly, those living in the capital, and those with a higher income were more likely to make informal payments, while those with a bigger household were significantly less likely to do so. In the case of hospital stays, income status and the size of the household had a significant effect on whether informal payments were made.

Informal payments are the most prevalent in obstetrics. Here we found that it was primarily the fact of having a doctor of choice that had an influence on the paying of an informal payment, and not the quality of the service (*Baji et al,* 2017). In a representative sample of 600, two-thirds of the women had a doctor of choice, and 79 of those did make informal payments; in contrast to only 17 percent of those without a doctor of choice. Having a doctor of choice was more frequent among older mothers and mothers with higher educational attainment, but controlling for the fact of having a doctor of choice, socio-demographic variables did not have a significant effect on the occurrence of informal payments. At the same time, those with a higher income, those living in Budapest, and those living in a marriage or partner relationship paid significantly higher amounts of informal payment. An important finding is that the quality of care was different for those with, and without a doctor of choice: medical interventions (Cesarean sections, induction of labour) were more frequent among those with a doctor of choice, but these mothers were also treated with more respect.

In one of our related studies (*Baji et al,* 2012) we examined the regressivity of household healthcare expenditure in the period between 2005–2008 (which is comprised of the expenditures (own contribution) spent on medications and medical aids, usage fees and informal payments). Informal payments totalled only 4–9 percent of healthcare-related expenditure in the period examined, which was approximately 0.2–0.3 percent of the total income of households. (In comparison: households spent the largest amount on medications and medical aids; these comprised 78–85 percent of the healthcare-related expenditure of households.) The annual informal payment expenditure was regressive, that is, poorer households belonging to the bottom income fifths spent a higher percentage of their income on informal payments than did wealthier households belonging to the top income fifth. Consequently, informal payments meant a greater burden for poorer households. However, it also emerged that in 2007, through the (temporary) introduction of the "visit fee", informal payments became proportionate to the income. This may have been for two reasons: poorer households either paid less informal payments, or did not even visit doctors.

Examining the healthcare-related expenditure of households, another detail that becomes clear is that the (official) expenditures of households spent on healthcare service fees comprised 11–15 percent of the total healthcare-related expenditure of the household, and 0.5–0.6 percent of the household income between 2005–2008. These expenditures were proportionate to the income (*Baji et al,* 2012), that is, households belonging to the top income fifths spent more money on usage fees in real terms. This can be explained mainly by the more frequent use of private healthcare services. According to the data of a representative survey we conducted in 2019 (*Lucevic et al,* 2019; *Zrubka et al,* 2020), 11 percent of the latest visits to doctors occurred at private healthcare providers during the year preceding the survey (*Zrubka et al,* 2020). In the age group of 25–44, among those with a paid job and among those with higher education as their attainment level, having had the latest visit to the doctor at a private healthcare provider was a more frequent occurrence.

Another frequent phenomenon is that the population chooses rather not to use the healthcare treatment otherwise needed, due to its cost or due to travel inconvenience. According to our representative survey conducted in 2019, 27 percent of respondents had postponed a visit to the doctor due to travel inconvenience; at the same time, 24 percent did not purchase the medication prescribed, 21 percent postponed a visit to the doctor, and 17 percent postponed a diagnostic test or a prescribed medical treatment due to costs, during the year preceding the survey (*Lucevic et al,* 2019). Regression analyses showed that women, younger individuals, and those with a lower income (1st and 2nd income fifths) gave the response that they had some kind of unmet healthcare need a significantly higher number of times. Those with a lower

educational attainment level (those who had the completion of elementary or secondary school as their educational attainment level) were more likely not to purchase the medications prescribed, and to postpone medical care due to travel inconvenience. At the same time, labour market status did not have a significant influence on the results. These results regarding unmet healthcare needs correspond, to the most part, to the statistics published by the Eurostat broken down by educational attainment level and income fifths, based on the EU-SILC survey.

Overall, it can be said that informal payments, the use of private healthcare services, and the presence of unmet healthcare needs are closely correlated to income status, which may compromise equal access to healthcare services.

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