Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

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Author: Robert I. Gal

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1 Executive Summary

The two keywords of social protection reforms introduced by the Orbán-government, which took office in 2010 with an unusually strong mandate, are centralisation and the increasing role of the state.

In the *pension* system, the funded pillar was renationalised and to a large part defunded. In order to absorb the savings returning to the public fund, equivalent to 10.2% of GDP, the Pension Reform and Debt Reduction Fund was established. Roughly half of the portfolio, equal to about 4.8% of GDP, was held in government bonds and revoked reducing the public debt directly. In addition, real returns of the funds, making up to 0.9% of GDP, were paid out to former fund members. A further amount, an equivalent of 1.8% of GDP was liquidated in order to finance the deficit of the NPIF. The remaining assets will cover further debt reductions or specific current budgetary purposes.

The government sent another strong message to the pension field by dealing simultaneously with the alternative routes of early retirement. Nearly 30% of beneficiaries, younger than the standard retirement age, 62 years, take up 25% of benefits. Their routes to leave the labour market are various. Previous efforts to keep them from retiring early failed because once the administration closed one exit route another opened wider. The new regulations will lock many of these ways and narrow those that still remain open making retirement below the standard retirement age more difficult. Nevertheless, most of current recipients will keep their benefits albeit under a different name. Estimations on how many current below-retirement-age beneficiaries will lose their benefits range between 5% to 15%. It also remains to be seen how many of the older workers who used to retire early can keep their job and how much of the problems of the pension system will be exported to the unemployment or social assistance schemes.

In the *health care* system the government opted for a systematic move on the way to a national health service by further centralising the allocation of capacities and making steps towards replacing contributions by taxes. The new programme, the Semmelweis Plan, was accepted by the government in June 2011. The focus of the reform is the establishment of a new system of actively managed patient routes. On the local level outpatient centres will take on this responsibility. At a higher level the newly established Regional Health Management Centres (RHMCs) will be in charge of the management of patient routes within their territorial responsibility. RHMCs will be supervised by the National Health Management Centre (NHMC), which will also organise services beyond the competence of RHMCs.

The *long-term care* system has so far been left out of major restructuring. In December 2010 the Ministry of National Resources invited an expert team to prepare a concept paper. The Concept Paper on Social Policy 2011-2020 was released in January 2012 not yet as an official document but one that represents the views of the authors. The Concept Paper would rearrange the division of labour between central and local government. Currently, local governments have a double act as an authority and as a service provider. The law orders them to evaluate the need for LTC services and also to meet them by maintaining facilities and programmes. The Concept Paper would redistribute the primary responsibility to the new, unified system of government offices and make service providers, among them local governments, to compete for their purchases.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The economic crisis in Hungary started before the international downturn and left the country particularly vulnerable to the consequences of the fiscal turmoil. At the time when its neighbours still enjoyed robust growth Hungary‘s economy came to a halt as early as the first quarter of 2007 due partly to the notorious overspending of the general government in 2001-2006, which resulted in a growth of consolidated gross public debt from below 52% of GDP in the second quarter of 2001 to 82% by 2010, and partly to the rapidly growing indebtedness of the household sector. Savings being inadequate both government and local governments as well as households took up loans denominated in foreign currencies blocking the way out of the crisis through sharp devaluation and inflation. Instead, the economy is still stagnating and current growth prospects are grim.

The effects are rather concentrated in social terms. The most hardly hit groups are two young generations, one, which is facing increasing difficulties to service their mortgage and the even younger cohorts who cannot find a job after leaving school. This is reflected in fertility rates. The Hungarian population tree would suggest a baby boom born at the turn of the millennium. Demographers at the time expected a postponement due to increasing age of mothers at first birth. However, the growing uncertainties of the second half of the 2010s will likely shave off the expected hump. Unless this would be compensated by increased savings in physical capital in the next two decades, the social protection system will face serious financial problems in the late 2030s.

As first corrective measures, the government raised taxes and halted public investment projects in 2006. Only in the second phase of austerity, in 2007-2008 were social protection expenditures cut back. The government introduced cost containment measures in health care and reduced the public spending on this chapter altogether. The ever deepening crisis forced the minority government and, after its resignation, a care-taker government to cut further, this time in pension expenditures as well. The 13th month bonus pension, introduced in 2003 had to be withdrawn, the retirement age was raised and the index rule went thEUrough a revision, all in 2009.

The new government, elected in 2010 with an unusually strong mandate, went on to further re-shape the social protection system, by regulating access through more thoroughly managed care (health) and reducing the inactive period by blocking routes of early retirement (pensions). The two keywords of these reforms are centralisation and the increasing role of the state.

The formerly separate portfolios of social protection were centralised in one large unit, the Ministry of National Resources (MNR). Indeed, the new ministry covers the entire life-cycle financing system including family and child welfare, education, health care and pensions. All of these were affected by the two overarching developments although each of them in their own way.

The pension administration, by nature, is highly centralised. The funded pillar of the system was renationalised and to a large part defunded. The health administration went through a major reorganisation in which the State Secretariat for Health care of the Ministry and its background institutions got a central position as manager of patient routes, supervisor of regional health management centres and operator of inpatient facilities, which were taken over

from county-level municipalities. The least centralised sector in social protection is long-term care where the MNR does not operate or control facilities. Control is left to the county-units of the Ministry of Public Administration and Justice whereas operation is decentralised.

2.2 Pensions

2.2.1 The system's characteristics and reforms

By 1975 the Hungarian mandatory pension system developed into a universal, national pay-as-you-go scheme covering all segments of society and offering uniform conditions with some minor exceptions. Benefits paid by the scheme became and still are the exclusive or nearly exclusive revenue for a large majority of the elderly population. Capital income, other than the imputed rent of owner-occupied house, is marginal and labour income above the age of 60 years is limited. Occupational schemes are practically non-existent and voluntary supplementary funds are also unimportant.

Benefits in the first pillar are established by a formula based on length of service[1] and the average indexed net monthly wage earned after 1988. The rate with which the entry pension replaces the calculated net monthly life-time wage is a function of accepted service years. This scale is non-linear favouring people with short and with long service periods at the cost of people with medium service length.[2] Service years include non-contributory periods (university studies before 1998, mandatory military service) and periods when the government paid contributions on behalf of the insured person (maternity leave, years in lower vocational school). Pensions are tax exempt since they are calculated from net wages.

The average total monthly benefit of an old-age pensioner was 73% of the average monthly wage in January 2011 (EUR 370 and EUR 510, respectively). The raw gender gap of old-age pensions is 16%: the average monthly benefit for women was EUR 340 and EUR 405 for men.

Those who did not collect the required length of service receive the benefit for the elderly (*időskorúak járadéka*), a means-tested benefit to the amount of EUR 80-120 depending on age and household structure.

As set out by the 1997 reform, the benefit formula has to change in 2013. The scale of replacement should be set linear (1.65% replacement of average indexed monthly wage for each service year). In addition, the benefit calculation should be based on gross wages. The law indicates the abolishment of tax exemption for pensions but it is unclear how pensions already in payment, which were calculated from net wages, should be treated. These rules are expected to be cleared out later this year.

Until 2012 contributions were shared between the employee, who paid 10% of his/her gross wage to the National Pension Insurance Fund (NPIF), and the employer, who paid an additional 24%. Since January 2012, employer contributions were renamed social contribution tax (*szociális hozzájárulási adó*). Its rate, 27%, is the same as before (pension, health and labour market contributions combined) but it falls under the legislation on taxes, not contributions. This has no direct consequence on eligibilities for the benefit formula is based on length of service and net wages but it signals a weaker earmarking of individual payments and makes more difficult to introduce individual accounts in the future.

[1] Throughout this report I use "length of service" and "contributory period" or "contributory years" as synonyms. In fact, the benefit formula includes non-contributory periods as spelled out in the body text.

[2] 15 service years give eligibility to 43% of average life-time net wage. This increases by two percentage points between 15 and 25 service years. Between 26 and 36 service years the increase is only one percentage point, which grows to 1.5 percentage point between 36 and 40 years of service. Above 40 years every additional year is worth of two percentage points.

The pension system got under severe pressure in the early 1990s when it lost a significant part of its contribution base. The 1997 reform targeted both this financial instability (by increasing the retirement age to 62 years and by reducing the wage index to the half-wage-half-price Swiss index) as well as the looming demographic deficit (by complementing the main pay-as-you-go pillar with a funded pillar).

However, both ambitions failed. Due to tax competition that resulted in a cut of contribution rate and the frequent misuse of the system for short-term political gains the implicit debt started to rapidly increase again in 2002 and by 2004-2006 it exceeded its pre-reform level measured in real terms. In addition, the transition costs, emanating from the accumulation of funds while pensions still had to be paid, were mostly financed from debt. These two failures led to ad hoc adaptations in 2007-2008, a new parametric reform package in 2009, the nearly complete defunding/re-nationalisation of the second pillar in 2010-2011 and even further parametric corrections in 2011-2012. I will present further details in the next section.

Although some of the adjustments (namely downward corrections of the pension index) put burden on current pensioners the replacement rate is still favourable. The average benefit (including supplements) of an old-age pensioner (including all types of old-age pensioners) is 72% of the average net wage (which is the relevant base of comparison as pensions are tax-exempt). In general, consecutive governments proved more successful in rising the effective retirement age (still low in cross-country comparison) than reducing the replacement rate. That said, the effective retirement age is still low. New measures introduced on 1 January 2012 target various early retirement channels. This again will be detailed below.

The 2009 parametric corrections and their further modifications in 2011

The increasing current deficit and the accumulating implicit debt of NPIF forced the government to revise the basic parameters of the first pillar in 2009. However, some of the new measures were revised in a second wave of adjustments even before they could have taken into effect.

The half-wage-half-price index was replaced by a new combination of the price-index and the wage-index conditioned by a complex system on GDP-growth. Due to the macroeconomic environment it functioned as a pure price index for two years, when it finally got replaced with the unconditional price index. This ended a two-decade struggle of consecutive governments to reduce the full wage index to a price-index.

In principle, retirement age has been 62 years for both genders since 2009. However, a service-length-based early retirement scheme (*előrehozott nyugdíj*), which offered a benefit with no or moderate reduction made over 90% of new pensioners retire below this age. The reform package of 2009 rose the standard retirement age from 62 years to 65 years by 2022. It also would have closed the above early retirement option with no reduction of benefit altogether and would have stricken conditions for early retirement with reduced benefit. Again, before these changes would have taken into effect they were overwritten in 2011. The new government, which came to office in 2010, closed down all options for early retirement. I will return to this issue below.

The third main measure of the 2009 package was the final abolition of a controversial boon to pensioners, the 13th month of extra benefit, which was gradually introduced between 2003 and 2006, reduced in 2008 and finally withdrawn in 2009. This episode revealed the severe lack of insulation of the public pension scheme from political short-termism in Hungary.

The 2010 defunding/re-nationalisation of the mandatory private funds

Taking office in May 2010 with an unusually strong support (more than half of the popular vote, over two thirds of seats in Parliament, enough to change the constitution) the new government introduced a macroeconomic policy diametrically opposing that of the previous government. Under the combined pressure of deficit reduction and electoral promises to decrease taxes imposed on labour and to make no further cuts in benefits or public services the government decided first to give up financing the transition costs of the partial pension privatisation and later opted for rolling back the whole pre-funding process altogether.

In order to paint a background to this decision we have to go back to the start of the 1997 reform, which established mandatory private pension funds (MPPFs). The maturation of this pillar was to create a limited double-burden problem: while pensions in payment had to be financed all along a part of contributions was saved in order for pre-funding future pensions. The resulting deficit of the NPIF had to be financed by government. This transition cost was to be covered from reduced public spending on other chapters of the budget rather than debt.

This could have been achieved at a relatively low social cost. The period between the late 1990s and mid-2010, that is the original, later extended, maturation phase of the funds, coincided with an exceptionally favourable demographic background. The current Hungarian age-tree has two large humps, two relatively big generations, those who were born in the mid-1950s and their children born twenty years later in the mid-1970s. The entry of the latter, in the late 1990s, to the labour market resulted in two large taxpayer generations and no similarly large cohorts in dependent age.

This opportunity, however, was not exploited. Although no special pensions-related flows were earmarked, so the exact extent of debt-financing cannot be determined, it is safe to say that the transition was not based on current but future revenues. The trends of public spending on other chapters and the rapid increase of government debt over this period all imply a debt-financed transition.

In order to obtain initial resources for the macroeconomic turn the administration tried to make the European Commission accept the transition burden as not part of the budget deficit. After this effort, supported by administrations of eight other member states, collapsed, in October 2010 the government announced to suspend the flow of contributions to the MPPFs for 14 months between 1 November 2010 and 31 December 2011. In parallel to that, the option of going back to the full pay-as-you-go pillar was reopened once again, which meant absorbing the accumulated savings on the individual accounts by the government in exchange for the restoration of accruals lost at the time of opting out to the MPPFs. The government made this option more attractive by offering the take-up of real returns as a lump sum. With this move the administration went beyond the original aim of temporarily easing the transition burden and made an effort to redirect the accumulated savings to the public wealth account.

As a third step conditions of remaining in the MPPFs and indeed the entire structure of the mandatory pension system were redefined in December 2010. The combination of a full pay-as-you-go scheme and a mixed scheme consisting of a majority pay-as-you-go pillar and a smaller, privately managed pre-funded pillar would have been replaced by a new combination of a pure pay-as-you-go pillar and a pure pre-funded pillar. Those who decided to stay in the MPPFs would have collected no further entitlements in the first pillar so participation in both pillars was to be excluded as an option. The mixed system would have been terminated.

Since this solution raised constitutional concerns, the government introduced even further changes before the last measures would have taken into effect. Accordingly, MPPF members will have to pay their full contributions to the public fund, for which they will receive benefits.

In addition, they can retain their accounts in the MPPF and pay in further amounts on a voluntary basis.

In order to absorb the savings returning to the public fund, equivalent to 10.2% of GDP, the Pension Reform and Debt Reduction Fund (PRDRF; *Nyugdíjreform és Adósságcsökkentő Alap* in the original) was established. The managing board of the Fund is presided over by a representative of the Ministry for the National Economy (MNE), and the MNE delegates one further member. Other institutions represented in the board by one-one members are the Ministry of National Resources (holding the culture, education, health care and social affairs portfolios), the Ministry of Public Administration and Justice, and the Central Administration of the NPIF.

Roughly half of the portfolio, equal to about 4.8% of GDP, was held in government bonds and revoked reducing the public debt directly. In addition following the promise, real returns, making up to 0.9% of GDP, were paid out to former fund members. A further amount, an equivalent of 1.8% of GDP was liquidated in order to finance the deficit of the NPIF. The remaining assets will cover further debt reductions or specific current budgetary purposes.

2011: Closing the routes to early retirement

As shown in Table 1, nearly 30% of beneficiaries, younger than the official retirement age, 62 years, take up 25% of benefits. Their routes to leave the labour market are various. The new regulations will lock many of these ways and narrow those that still remain open making retirement below the standard retirement age more difficult. The government even wanted to send a symbolic message by renaming all such benefits and withdrawing the word "pension" from the new forms. Nevertheless, most of current recipients will keep their benefits. Estimations on how many current below-retirement-age beneficiaries will lose their benefits range between 5 to 15%. It also remains to be seen how many of the older workers who used to retire early can keep to their job and how much of the problems of the pension system will be exported to the unemployment or social assistance schemes. Empirical studies on exit from the labour market usually focus on the supply side (Cseres-Gergely 2007, Kátay 2009).

Table 1: Pensions and other retirement benefits below retirement age, January 2011

	Beneficiaries ('000)	Monthly payments, million €
Total, below retirement age	839.2	232.9
old-age	238.4	104.2
employer financed, miner	15.6	7.6
disability	337.5	89.5
rehabilitation	24.6	6.5
survivor[1]	21.2	2.5
other[2]	201.9	22.5
	Below retirement age / all ages[1] (%)	
	29.8	25.0

Source: Central Administration of National Pension Fund.
[1] Excl. provisional widower and orphan benefits.
[2] Accident benefit, health damage benefit, disability benefit.

The largest group, 338,000 people, is disability pensioners (the system differentiates between disability pension (*rokkantsági nyugdíj*), which is a large chapter of the pension budget and disability benefit (*rokkantsági járadék*), which is a small supplement, put here in the "other" category). They make up 11.6% of recipients and collect 9.6% of all benefits – these figures are among the highest in the European Union or the OECD. Around 70,000 people, 17% of total disability pensioners, have 100% level of disability.

Starting from 1 January 2012 disability ceased to be part of the pension system. It was rearranged from the NPIF to the NHIF (National Health Insurance Fund), and the disability

pension was transformed to disability provision (*rokkantsági ellátás*) and rehabilitation provision (*rehabilitációs ellátás*), the latter being different from the former rehabilitation benefit, which was also withdrawn. The disability provision will function in effect in the same way as the disability pension. People belonging to disability class 1 and 2 (both include people with 100% disability) will receive this new provision. The same applies to people classified to the 3rd category[3] (at least 50% disabled) provided they were born in 1954 or before. The rest will obtain rehabilitation provision till 1 May 2012. At this point eligibility for the provision will cease to exist unless the beneficiary requests a complex review of his/her health conditions. Depending on the result of this re-checking the rehabilitation provision will be transformed to disability provision (if the client cannot be rehabilitated) or reduced (if he/she can be rehabilitated) or withdrawn (if health conditions allow the client to work).

The other large group of early retirees includes regular old-age beneficiaries consisting of several subgroups. One of them are beneficiaries of service-length-based early retirement (*előrehozott nyugdíj*) discussed above. This channel of early retirement was closed down altogether. No new such benefits will be established in the future. The benefit of current recipients (that is old-age pensioners younger than the retirement age) is transformed to the new below-retirement-age provision (*korhatár előtti ellátás*), which will function the same way as the previous allotment and be converted back to the regular old-age pension upon reaching the retirement age. However, as mentioned above no new benefits of this type will be established in the future.

Another subgroup of old-age pensioners below retirement age worked as members of the armed forces or had dangerous and hazardous jobs (*szolgálati nyugdíj* and *korkedvezményes nyugdíj*, respectively). Here again, those who are close enough to the retirement age (born in 1954 or before) will see their circumstances practically unchanged. Younger beneficiaries of this group will be offered government jobs or they have to accept a 16% lower benefit.

It has to be noted that the administration's efforts to rise the effective retirement age are not consistent. Before the municipal elections held in October 2010 the government opened up a new retirement channel for women independent of age but based exclusively on working years. In order to meet an electoral promise, women are allowed to retire after 40 years of work (including periods on maternal leave).

2.2.2 Debates and political discourse

Two pension-related issues made constant headlines in 2011, the re-nationalisation/defunding of the MPPFs and the withdrawal of below-retirement-age benefits. Unlike the health care reform, discussed in the next section, both were heated.

As for the MPPFs, those who remained in the second pillar, and many who did not, considered it a confiscation of private property. Indeed, the move was unpopular. Around 1 million people, one third of total membership signed declarations released by the funds stating that should the Constitution Court abolish the re-nationalisation law they would restore their fund membership. Nevertheless, the government was able to neutralise the resistance, which was led by non-Parliamentary actors, more specifically Stabilitas, the largest association of the pension funds, relatively easily. After weeks of a vehement campaign to torpedo re-nationalisation, the association became more muted and withdrew key figures. The opposition in the Parliament, in

[3] The three disability categories are defined as:
category III: at least 67% reduced working ability, 50-79% health damage
category II: 100% reduced working ability, at least 79% health damage, self-care
category I: 100% reduced working ability, at least 79% health damage, need for care.

particular the Socialist Party, also criticised the move heavily and promised a return to partial pre-funding if re-elected.

The second pillar debate produced an outburst of populist language exceptional even by Hungarian standards both from the government and its opposition. The government blamed the funds of losing pension reserves by playing murky games in the stock exchange (but nevertheless thought it attractive for fund members to offer the take-up of real returns in case of returning to the first pillar). The opposition called the defunding/re-nationalisation manoeuvre "theft" and "predatory" (as if the ruling coalition and their supporters pocketed the reserves). The language of the debate certainly did not help anchoring the image of the pension system as part of life-cycle finances, and that of pension benefit as depending on life-time savings and human capital investments.

Soon after the heated debate winded down the administration opened a new front by announcing the withdrawal of pensions below the retirement age. The declared aim of redirecting 100-150,000 people out of the over 800,000 detailed in Table 1 is considered too ambitious by most experts but the government's attempts can prove efficient in blocking the way of new entries. So the average age of retirement is expected to grow in the years to come. However, remains to be seen whether this improvement will be realised in increasing employment or it will only amplify unemployment among older workers.

The political discourse on pensions is typically inconsistent and cross-sectional. Trusting the short time horizon and memory of voters political forces represent frequently changing positions depending on whether they are in government or in opposition or even whether they are near to elections or can still wait some years. General trust in political institutions eroded over the last two decades, which hinders long-run thinking.

In European comparison that is in terms of absolute poverty the Hungarian elderly are among the poorest. 14% of older people, both among the 65 years old and older and in the oldest old (75 years old and older) age group, face severe material deprivation. This rate is somewhat lower than the average of the twelve new member states but significantly higher than the overall average of the European Union. The Hungarian rates are the 6th highest in this comparison.

The Hungarian pattern of absolute poverty has two distinct features. First, poverty does not become more severe by age; second, the gap between men and women seems to be more explicit than in the NMS12 group or among the EU27.

Table 2: Selected indicators of social inclusion of the elderly, 2010

	Hungary	NMS12	EU27	HU rank
at-risk-of-poverty, 65-	13.8	16.0	16.5	11th lowest
at-risk-of-poverty, 65+, total	4.1	17.8	16.8	lowest
at-risk-of-poverty, 75+, total	3.3	20.7	19.8	lowest
at-risk-of-poverty, 65+, males	2.8	13.1	13.2	2nd lowest
at-risk-of-poverty, 65+, females	4.8	20.7	19.3	lowest
severe material deprivation, 65+	14.1	16.7	9.2	6th highest
severe material deprivation, 75+	14.0	18.0	9.7	6th highest
severe material deprivation, 65+, males	10.1	14.2	7.8	6th highest
severe material deprivation, 65+, females	16.4	18.2	10.1	6th highest
relative median income ratio 65+	101.0	83.3	88.0	2nd highest

Source: Eurostat.
Note: rank: position of Hungary among the EU27 countries.

However, the Hungarian elderly are poor in the European context because Hungary is poor in general. In relative terms, that is, in the national context, older people are doing quite well. Indeed, the relative income position of Hungarian elderly is the most favourable in the EU. The

at-risk-of-poverty measure is the lowest both in the 65+ and the 75+ population. Although the figures reflect a modest gender gap, older women, too, rarely fall below the 60% of median income threshold.

The relative median income ratio (persons aged 65 years and over compared to persons aged less than 65 years) is the second highest among the member states. Its value is above one meaning that the elderly in fact have a higher median income than those younger than 65 years. This is largely due to the generosity of the pension system. The aggregate replacement ratio (the ratio of income from pensions of persons aged between 65 and 74 years and income from work of persons aged between 50 and 59 years) is 60%, well above the European average (the 6th-8th highest). It is notable though that a year before, in 2009, the Hungarian replacement rate was still 62% and the 3rd highest in the EU.

Table 3: Current and projected theoretical replacement rates, 2010 and 2050

	Net 2010	Net 2050	Diff.	Net 2010	Net 2050	Diff.	Net 2010	Net 2050	Diff.
38 years career: average income	83.3	65.5	-17.8	63.0	53.4	-9.6	61.2	56.7	-6.9
40 years career									
Average income	93.0	75.0	-18.0	69.2	58.5	-10.7	66.4	62.0	-6.9
Low income	83.0	75.0	-8.0	75.9	64.5	-11.4	72.6	67.4	-7.9
High income	88.2	56.3	-31.9	54.2	41.4	-12.9	53.7	45.3	-10.5
42 years career: average income	111.5	87.2	-24.3	76.1	67.1	-9.0	71.8	68.7	-5.7
10 years after retirement	109.3	59.2	-50.1	64.9	51.1	-13.8	62.3	56.0	-8.4

Source: AWG.

This picture is supported by the simulation exercise of the Ageing Working Group. As shown in Table 3, net replacement rates are significantly higher in Hungary by all career types compared to either the NMS12 or the EU27. Benefits are particularly attractive in that not only entry pensions offer a high replacement but their value is well preserved as reflected in the exceptionally high replacement rate, the highest among the member states, 10 years after retirement. All these are expected to change by 2050. Although the replacement rates would still be higher than average especially for average earners, they will decline faster than in the reference groups. The decrease will be particularly sharp for workers with longer careers and after retirement.

2.2.3 Impact of EU social policies on the national level

The European context changed public debates significantly in recent years. It became common to talk about Hungarian developments in international comparison. The main reference points are the Visegrad countries, Slovakia in particular.

Until recently the Hungarian administration tried to catch up with European developments. The Hungarian Presidency of the European Union might have boosted this process. The presidential position forced the administration to rethink their preferences and try to formulate them in a European context. In the end the Central Administration of the National Pension Insurance Fund organised two presidential conferences, one on child-related pensions and another one on the administration of portable pensions.

The former addressed a key objective of sustainable pensions from a special, demographic perspective. The underlining argument of the presentations was based on a pair of empirical evidence. First, the extension and maturation process of pay-as-you-go pension systems

contribute to the declining trend of fertility. Second, the collectable amount of contributions depends on past investments in the number and human capital of children of the past, that is, current contributors. A conclusion of the conference was that the consequences of the ageing process cannot be avoided any longer and have to be absorbed by currently living generations but a system of child-related pension, which makes benefit dependent on individual child-raising efforts, can help to avoid the re-emergence of similar problems on the long-run.

The other conference discussed the issue of how can pension systems be made more European by removing barriers for the mobility of workers, in particular how national pension administrations can promote mobility by improved cooperation.

In February 2011, the administration released the Széll Kálmán Plan of growing out public debt by a series of complex reforms, which established the National Reform Programme published in April. With frequent references to EU 2020 strategy the government wants to shape an environment that in turn would raise the employment rate to 75% by 2020 in the 20-64 population (66.3 - 69.1% by 2015 from 60.4% in 2010) and create 1 million new tax paying jobs over the ten-year period. The comprehensive package includes a review of active labour market policy objectives and instruments; modification of passive policies in order to provide stronger work incentives by shortening the maximum length of benefit for job search and by reorganising the benefit structure; a better way of reconciling work and family. The programme also promises to improve the efficiency of the institutional framework of employment and reduce the employment-related administration of enterprises. The aim is partly to reduce the idle workforce and partly to whiten the informal sector of the labour market.

A further point in the programme is the introduction of the new Labour Code with the aim of making the labour market more flexible. The Code, which was passed in January 2012, re-regulated the atypical forms of employment, labour contracts, paid holidays, working hours and probation work. For unskilled labour, new public work projects were initiated by the government and social assistance was tied to participation in such projects. This is a shift from previous efforts, which focused on local governments.

The programme also addressed the "pull" effects, which make the pension system all too attractive. The main target as it was detailed above was the alternative routes of early exit from the labour market.

The frequent references of the National Programme to the EU 2020 strategies, the European context which shaped the programme and the obvious ambition of the government to make Hungary catch up with its neighbours and return to the path of convergence, which it left in 2007, are in sharp contrast with the fiercely anti-European remarks by government members.

2.2.4 Impact assessment

The two major changes described above, defunding/re-nationalisation of the second pillar and fighting back early retirement are very recent, indeed the latter is still unfolding, and were not preceded by analysis. Since no research results, administrative or academic, have been published since the announcements of these measures here I have to restrain myself to just a general assessment.

As for abolishing the pre-funded pillar, what seems to be certain is a relief of the government budget for the rest of decade and a sudden jump in the implicit pension debt, which will be due mostly from the early 2020s. The relief is a consequence of quitting the payment of the transition burden, which would have cost around 1.5% of GDP per annum. This would have been diminished by the decreasing pension outlays once the first cohorts started to retire and complete their old age income from the MPPFs. A note may be necessary here. By the original

design, this maturation process would have started to wind down in the mid-2010s. However, as described in previous Annual National Reports, the 2008 downturn of the capital market forced the administration to let older cohorts born in or before 1956 return to full pay-as-you-go in order to protect them from absorbing their losses. Since about 60% of the cohorts involved opted for return voluntarily the MPPFs would not have started paying out annuities in large before 2020.

The other side of the provisional relief is the increase in the implicit pension debt, which will surface in higher pensions after 2020. The administration does not publish official estimations on IPD and the new practice, starting from 2014, to make such calculations in a comparative manner will not change this. The European effort to extend statistics on explicit debt with implicit debt will be based on accrued-to-date liabilities, a method that does not allow estimations on expected future revenues and outflows of the system.

Based on earlier estimations and the official projections of the cross-section balance of the pension budget published in the convergence report it seems to be safe to say that the IPD increased by about 20-25% due to the defunding/re-nationalisation of the MPPFs.

2.2.5 Critical assessment of reforms, discussions and research carried out

The defunding/re-nationalisation of the second pillar was deemed unconstitutional by critics. It was asserted that the balance of the individual accounts embodied private property, which was confiscated by the authorities without compensation. I do not share this view. Since accruals in the first pillar were fully restored the "no compensation" argument does not hold. In addition, and more importantly, I would be hesitant to call the balances of the individual accounts private property knowing that every forint of "private" savings was paralleled by one forint and a bit more for administrative costs in public debt. Should the accumulation period created a net wealth the "private property" argument would be stronger, and possibly the government's appetite to defund it would have been weaker.

Taking this into account I still find the paradigmatic changes critical for three reasons.

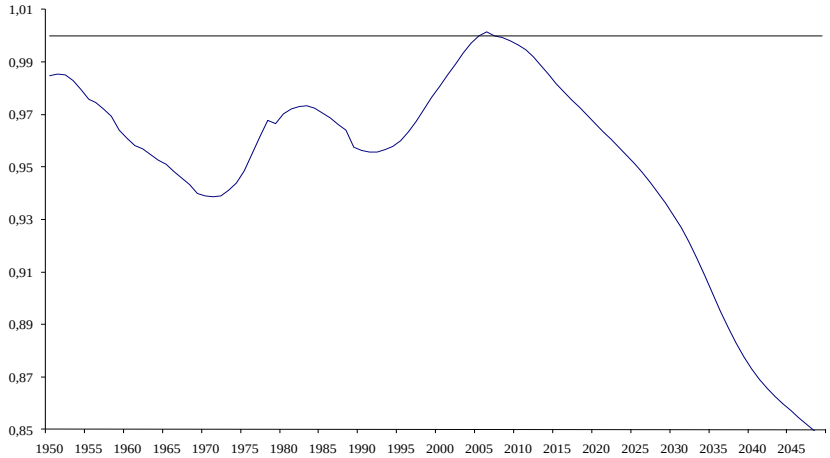
First, the government will not use all the accumulated wealth to repay debt. As spelled out above, real returns were paid out to former fund members increasing current household consumption or household savings. In addition, a significant amount was absorbed by current government spending in 2011 and it is still unclear how much of the remaining assets will eventually finance current deficits or reduce debt. The exact proportions depend on future decisions. At any rate, the sum of explicit and implicit debt will increase. This may not emerge immediately in the official figures of implicit debt to be published from 2014, which, as mentioned above, will include only to-date accruals and no present values of future flows of contributions and pensions.

Second, the 1997 pension reform was based on the assumption that returns on savings will be higher than returns in the pay-as-you-go pillar. Although developments during the 2010s provisionally falsified these expectations it could happen only at the cost of unsustainable tendencies that had to be corrected. In the light of the 2009 parametric adjustment, partial pre-funding still could have offered higher old-age income to the young cohorts on the long run. Now, their chance for this potential extra gain has been abolished.

Third, the demographic future of the pension system is gloomy, which is frequently demonstrated by the support ratio. The support ratio is usually defined in simple demographic terms as the number of people in their active age over the number of people in their inactive age. However, Cutler et al (1990) give a richer meaning to the concept by weighting the demographic numbers with the age-profiles of labour income and consumption. By projecting

detailed age-patterns and not only population totals a clearer picture can be gained about the sustainability of current labour careers and consumption patterns. As a demonstration, in Figure 1, I show the rate of total labour income of total consumption if the given (or projected) demographic patterns are weighted by the 2005 age profiles of labour income and consumption, respectively. In order to abstract away of levels, I use 2005 as a point of reference.

Figure 1: Support ratio in Hungary, 1950-2050, 2005=1



Source: Author's calculation.
Note: support ratio: total labour income over total consumption using the 2005 age-profiles of labour income and consumption and the actual demographic age-pattern in a given year.

In years of increasing support ratio it is easier to accumulate wealth without extensively changing the age patterns of labour and consumption; in downhill years, it is the other way around.

The figure has two uphill sections over a period of a century. The first one occurred between 1970 and 1985, when a large generation entered the labour market. They are called the Ratko-children named after the then-minister of welfare who was responsible for an anti-abortion campaign, which raised fertility to high levels for a short period. The other ascending section of the curve is between 1995 and 2010, when the Ratko-generation and their echo, sometimes called the Ratko-grandchildren, were in their active age and no other large generation was among the dependents. The second growing period climbs higher than the preceding one although the echo-generation is smaller than that of their parents. This seeming contradiction is due to the much lower fertility of the echo-generation. The first and the second large humps in the age-tree are not followed by a third one. The Ratko-grandchildren have not produced their own echo. So the period between 1995 and 2010 combines two factors in the improvement of the support ratio: many young people entering the labour market and only a few leaving for maternity. Such circumstances are ideal for capital accumulation for a relatively modest sacrifice of consumption. This demographic window coincides with the maturation of the mandatory pension funds.

However, this development will turn negative, when the Ratko-grandchildren will retire in the late 2030s and there will be no large cohorts any longer to pay for their pension. The only option left is to save from their consumption and accumulate it for their old age. Unfortunately, by all accounts voluntary savings are usually inadequate. This is the point, where mandatory pre-funding would have given a great service to this generation. In short, the critical point is that turning back on the way toward pre-funding undermined the credibility of any future mandatory savings programme. Upcoming administrations will face difficulties to convince people of the merits and reliability of mandatory pre-funding programmes.

As for the measures against early retirement, the government took the brave effort to approach all exit routes at once. They engaged in a collision with trade unions of the armed forces and took up the conflict with disability pensioners in order to drive back 100,000 to 150,000 people from the retirement system and discourage people to take them as potential escape routes from the labour market. However, the measures are inconsistent. The same administration opened a new gate of early retirement for women having a working career (including time spent on maternity leave) of 40 years without any estimation of the present value of its costs and indeed without any real political pressure.

Finally, I would repeat another critical component, the gloomy prospect of resurfacing poverty in old age. This issue emerged partly as a consequence of the 2009 correction of indexation of pensions in payment. Calculated on the basis of 15 years in retirement and 3% real wage growth, the new index results in about 11% loss of lifetime benefits. Due the gender-specific and education-specific survival rates men and people with low education lose less; women and people with higher education lose more. The new index also affects current pensioners.

In addition, in the near future cohorts, who suffered most from the employment crisis of the early 1990s, will reach retirement age. The collapse of the centrally managed economy in 1989 led, as expected, to a transitional crisis including a very rapid growth of unemployment and inactivity. However, against expectations, the fast recovery, which started in 1993, induced only a minor growth in employment and labour force participation. In addition, the proportion of unreported and underreported economic activities also grew fast. These adverse effects shaped the life cycle of subsequent cohorts rather differently. The most severely hit year-groups are about to reach retirement age including a large number of people who, according to the current rules, will not be eligible for any benefit. The estimated number of effected people varied between 250,000 and 500,000 but the most recent estimations go even higher.

These two still unaddressed developments are critical to the OMC objective of adequate retirement incomes.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The system's characteristics

The Hungarian public health care was built up as a system of integrated health services, which was rearranged during the 1990s as a split purchaser-provider contract model controlled by a self-government body, only to be taken back in effect to government control again. In the late 1990s, the organisational autonomy of the National Health Insurance Fund (NHIF) was restricted and finally eliminated, resulting in a system that does not meet some important characteristics of the classical social health insurance systems. In 2006-2007, the sector saw a renewed decentralisation attempt in social insurance, this time combined with the aim of privatisation. However, the reform package was challenged by a referendum and had to be withdrawn before implementation leaving behind a still hybrid system with some inconsistencies.

The new government elected in 2010 opted for a systematic move on the way to a national health service by further centralising the allocation of capacities and making steps towards replacing contributions by taxes. The new programme, the Semmelweis Plan, was announced in October 2010 and after an active public debate it was accepted by the government in June 2011. The focus of the reform is the establishment of a new system of actively managed patient routes. On the local level outpatient centres will take on this responsibility. At higher level the newly established Regional Health Management Centres (RHMCs, *Térségi Egészségszervezési*

Központ) will be in charge of the management of patient routes within their territorial responsibility. Altogether eight RHMDs were formed each covering 1.2 million people on average. The RHMD would

- register, optimise and monitor patient routes in their respective region,
- plan capacities,
- prepare implementation plans, management systems and cooperation models of regional actors,
- prepare contracts, set up project organisations and other forms of cooperation of regional actors,
- organise joint use of diagnostic capacities, laboratories, etc.,
- organise regional business management,
- monitor and supervise the activity of regional actors and
- organise trainings for the personnel.

RHMCs will be supervised by the National Health Management Centre (NHMC, *Állami Egészségszervezési Központ*), which will also organise services beyond the competence of RHMCs. Details of the division of labour and the extent of independence of RHMCs from the NHMC are still subject of debates. The current version of the organisational plan suggests stricter supervision and limited degree of freedom for the regional level.

As a preparatory step in May 2011 the government merged five separate health research institutes into one organisation, the Institute of Pharmaceutical and Medical Quality Control and Organisational Development (IPMQCOD, *Gyógyszerészeti és Egészségügyi Minőség- és Szervezetfejlesztési Intézet*). IPMQCOD is a background institution of the State Secretariat for Health care of the Ministry of National Resources, a large ministry holding the culture, education, health care and social, family and youth affairs portfolios. IPMQCOD will establish the NHMC, create the national health strategy, set up a central health care database and manage the special EU projects of the sector.

In February 2012, IPMQCOD is expected to deliver the final version of its plan for capacity distribution in inpatient care. By 31 March new licenses will be released. By 30 April the National Health Insurance Fund Administration (NHIFA, *Országos Egészségbiztosítási Pénztár*) will sign the contracts with service providers. The NHIFA in practice will function as a financial administrator.

Revenues and expenditures

The process of replacing contributions with taxes and government transfers continued in 2011 and will continue in 2012. As mentioned in the Pensions section, the employers' part of the social security contributions (*társadalombiztosítási járulék*) were replaced by a tax, the new social contribution tax (*szociális hozzájárulási adó*). Like in the case of pensions this has no direct consequence on the access to health services for it is established by the employee's contribution.

In 2009, contribution revenues made up to 70% of the public health budget against 25% of government transfers (3.45% and 1.22% of GDP, respectively, see Table 4). This changed to 49% and 46% respectively by 2011. The 2012 budget for the first time includes higher tax revenues and government transfers than contributions if the social contribution tax is classified, as it should be, a tax. Indeed, if the balance between expenditures total and revenues total is assumed to be covered by further government transfers the rates already reversed in 2010.

Table 4: Revenues and expenditures of the NHIF (% of GDP)

	2009	2010	2011	2012
REVENUES				
contributions	3.45	2.53	2.43	2.42
taxes and government transfers	1.22	2.31	2.26	2.51
other revenues	0.20	0.34	0.24	0.91
total	4.87	5.18	4.94	5.84
EXPENDITURES				
cash benefits	0.95	0.83	0.71	1.91
in kind	4.31	4.52	4.39	4.01
curative-preventive care	2.76	2.96	2.84	2.83
pharmaceutics	1.32	1.34	1.33	0.95
medical aids	0.18	0.17	0.18	0.15
other expenses	0.06	0.06	0.05	0.05
total	5.45	5.52	5.23	5.96

Source: NHIFA. Notes: 2011: preliminary data, 2012: planned budget and GDP. Revenues total: planned balance included in government transfers. 2012: social contribution tax classified as tax, transfers from the NPIF classified as other revenues.

The 2012 health budget seems larger than that of 2011. The increase is mostly due to the rearrangement of taxes, to the amount of 1.18% of GDP, financing disability and rehabilitation benefits, from the government and the NPIF to NHIF. In addition, two new smaller taxes, the accident tax (*baleseti adó*) paid by automobile owners and the public health tax (*népegészségügyi termékadó*) levied on consumers of unhealthy food (such as chips, soda and similar products) were introduced in order to extend the tax base of the health care system. In the 2012 budget they make up to 0.15% of the expected GDP.

Disability and rehabilitation benefits also appear among the cash benefits on the expenditure side. Otherwise the planned share of curative-preventive care is the same as in the previous year whereas the 2012 budget for pharmaceutics is significantly lower.

Out-of-pocket payments are estimated to reach nearly one quarter (23.7% in 2009) of total health expenditures (Gaál et al 2011, 84). A bigger half (56-57%) was spent on pharmaceutics and other outpatient medical goods, 43-44% on health services. The latter figure also includes informal payments, a persistent phenomenon of the Hungarian health care system.

Coverage and health status

The coverage is nearly universal. Indeed, if measured by self-reported unmet needs the access to examination or treatment is easier in Hungary than the EU27 average, and it is also more equal (see Table 5). Only 3% of people in the 1st income quintile of the SILC reported unmet needs compared to 5% in the European Union in general. The same survey, however, finds Hungarians in poorer self-reported health conditions: 16% reported on very good health against 23% in the EU.

Table 5: Access to health care and health status in Hungary and the European Union, 2010

self-reported unmet need for medical examination or treatment				self-perceived health status			
		HU	EU27			HU	EU27
income quintile	1	3,0	5,2	health status	very good	15,8	22,7
	2	1,4	2,4		good	39,0	45,6
	3	0,7	1,4		fair	28,5	22,4
	4	0,7	0,8		bad	12,6	7,5
	5	0,4	0,3		very bad	4,1	1,8
	total	1,2	2,0				

Source: Eurostat statistics based on SILC; Administration

The Semmelweis Plan includes a reorganisation of health care administration. The new organisational structure keeps the administrative functions and system management centralised in the hands of the State Secretariat for Health care of the Ministry of National Resources and its background institutions, IPMQCOD, the National Centre for Patient Rights and Documentation (NCPRD, *Országos Betegjogi és Dokumentációs Központ*) and the Office of Health Authorisation and Administrative Procedures (OHAAP, *Egészségügyi Engedélyzési és Közigazgatási Hivatal*). Epidemiological and other public health issues belong to the Public Health and Medical Officer Service (NPHMOS, *Állami Népegészségügyi és Tisztiorvosi Szolgálat*) and its affiliates.

The management of patient routes and service provision is fully separated at the level of NUTS3 administrative units[4] and above, at the level of health-regions and nationally. At lower levels patient routes are managed by service providers, more specifically by outpatient and care centres.

All actors are connected to NHIFA, which manages the finances of the system. The emergence of the new institutional actors in patient route management will likely reduce the importance of NHIFA. A further organisational change to diminish the former role of NHIFA is the redistribution of responsibilities between them and a new network of NUTS3-level administrative centres, the government offices (frequently referred to as government windows). As part of the general reorganisation of public administration, the government united 29 tasks of formerly separate institutions from family benefits to permissions for constructions to social assistance and other assignments. The aim is to merge parallel territorial networks. In the first step of this reform the administration of in kind benefits and services remained the responsibility of NHIFA but cash benefits were reassigned to the new general network.

Market structure and property rights

From January 2012, the government took over the property rights as well as the debt of hospitals owned by the county (NUTS3-level units) municipalities and the capital, Budapest. The agency acting on behalf of the state as owner is the IPMQCOD, the background institute of the Ministry mentioned above. Remaining inpatient centres are expected to be renationalised in 2013.

Centralisation of public property rights counterpoints the crawling functional privatisation of medical facilities, ongoing for years, and the underregulated cohabitation of public and private units. This field to my knowledge is underresearched and there is not much information available other than anecdotic evidence.

The government also intervened in the pharmacy market. Stricter procedures were introduced in establishing new pharmacies. Soon after the 2010 elections licensing of new pharmacies were suspended in settlements already having a public pharmacy. In December 2010 a new regulation was accepted by Parliament with the aim of maintaining or restoring the market position of pharmacies owned by pharmacists. Accordingly, in order to hold up their licenses pharmacies have to have a majority (over 50%) of property rights in the hands of a pharmacist from 2017 (over 25% by 2014). Also the size of chains has been limited and wholesale traders as well as pharmaceutical producers have been excluded from potential owners.

4 The Nomenclature of Territorial Units for Statistics (NUTS by its French acronym) is a hierarchical system of subdivisions of countries for statistical purposes established by Eurostat. Hungary is divided into 3 statistical large regions (NUTS1), 7 planning and statistical regions (NUTS2) and 20 counties plus Budapest (NUTS3). The new health regions, which are larger than NUTS3 but smaller than NUTS2 units do not fit in this classification.

2.3.2 Debates and political discourse

The announcement of the Semmelweis Plan in October 2010 brought on numerous reactions. In the final version of the plan, which was accepted by the government, the authors acknowledged 148 responses (34 from individuals and 114 from organisations). Yet, compared to the fierce debates surrounding the privatisation of health insurance and co-payment plans in 2006-2007 and the defunding of the pension system in 2010-2011 the dispute was muted.

The open wage-fight of residents was more heated. The Hungarian Association of Residents collected notices to quit and threatened to submit them collectively if their work conditions and wages are not improved. Their movement got support from the Hungarian Physician League (*Magyar Orvosok Szövetsége*), a union, and the Hungarian Medical Chamber (*Magyar Orvosi Kamara*), a guild-like organisation based on mandatory membership. Health authorities are in continuous talks with the representatives of residents.

The public forms a generally negative opinion on the quality of health care. On a four-item scale (very good, fairly good, fairly bad, very bad) 28% of Hungarian respondents evaluate the system as good (the first two categories combined) and 72% as bad (categories 3 and 4 combined). The European averages are 70% and 30% respectively. Only Bulgarian, Romanian and Greek respondents hold more negative view on the quality of their health care system (European Opinion Research Group 2010).

2.3.3 Impact of EU social policies on the national level

The National Reform Programme briefly mentioned health issues subordinated to employment. The NRP referred to the poor health conditions of the population especially among older middle-aged cohorts. According to figures of the European Health Survey self-assessed health is much worse among Hungarians than the European average. Whereas 14.7% of Hungarian respondents find their health bad or very bad, the corresponding average in the 27 member states of the European Union is 9.5%. The NRP found these conditions an impediment of achieving the ambitious employment rates.

2.3.4 Impact assessment

Although the law (Act XI/1987 on legislation) and other regulations (Government Resolution 1082/2005 on impact assessment; Communication 8001/2006 IM by the Ministry of Justice on the methodology of impact assessment)[5] define the role, the need and the methodology of impact assessment, the government bodies frequently neglect this obligation or make it formal in health care.

The Semmelweis Plan explicitly targets this issue and devotes an entire section on necessary developments of the IT background of the health care system and utilisation of data this system generates.

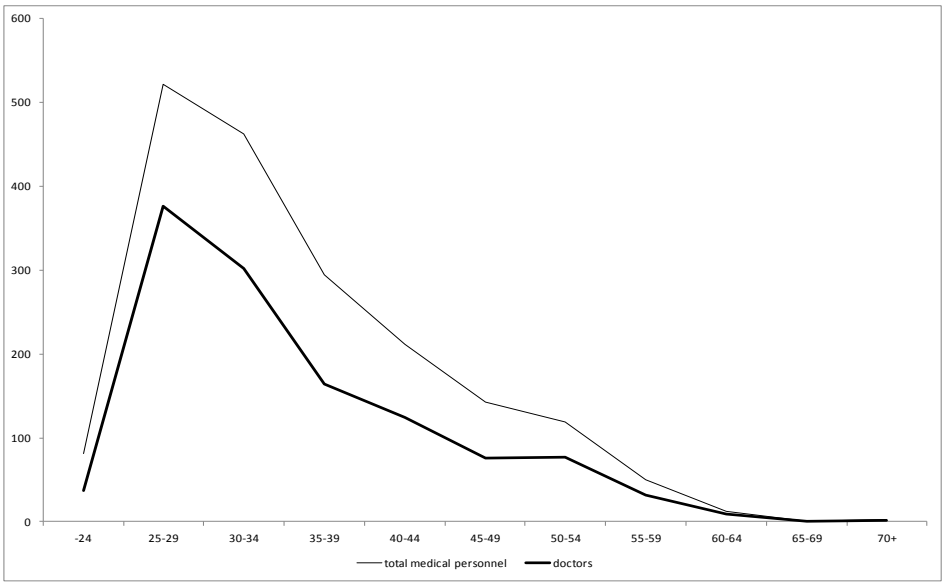
2.3.5 Critical assessment of reforms, discussions and research carried out

The effects of brain drain, due to the wage differential between richer EU member states and Hungary, are becoming increasingly serious. The authorities do not have reliable figures of actual emigration but the OHAAP register requests for official licenses needed for employment in abroad, which is a close proxy. Accordingly, 1,200 doctors requested such license in 2011 compared to 1,111 a year before. The number of total medical personnel submitting such requests, including dentists, nurses and other related professions was 1901 in 2011. Not only

[5] These and other laws and regulations can be searched at https://kereses.magyarorszag.hu/jogszabalykereso (in Hungarian only).

are the numbers alarming but also the age composition of emigrants. In Figure 2, I demonstrate that the brain drain as usual affects the young disproportionately. This creates a cumulative effect: for a period the consequences of emigration are not directly felt but eventually when older cohorts retire the shortage of expertise become all of a sudden acute.

Figure 2: Age-composition of medical personnel requesting licenses for working abroad, 2011



Source: OHAAP (2012.)

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

LTC services are administered in the health care system and the social care system separately. Both systems have their own distinct legislation, financing mechanism and services. The two systems maintain parallel institutional networks. This applies to institutional care as well as home care. Cooperation between the two branches, although still requires improvement, enhanced over the last two years due to the contraction of the health care and social affairs portfolios in one authority, the Ministry of National Resources (MNR). The MNR set up a permanent committee dealing with the "frontier" issues.

Services provided in health care are nursing care in nursing departments of hospitals and home nursing care; the three main types of services in social care are home care (including "meals on wheels" services), day care and residential care. Key figures of the system are presented in Table 6. Data of 2011 are not yet available.

Universal coverage, based on the principle of social equity, is an expressed policy goal. Until 2008 age was the only prerequisite for entitlement. Anybody reaching the age of 62 years, the retirement age, was entitled. No means test was required and the extent of lost physical or mental capabilities was not checked. Personal insurance history was not controlled until 2006. As a major change, in 2008 an eligibility test was introduced, which evaluates the physical and social conditions of applicants.

Table 6: Key figures of the LTC-system in Hungary, 2010

acute beds	44 388
chronic beds	27 149
of which lasting care	2 606
home nursing care cases	49 821
of which 65+	34 578
home care recipients	75 054
home care nurses	8 625
meal on wheels recipients	146 443
alarm system-based home assistance	25 242
attendees of day-care for elderly	37 905
residents in elderly homes	51 736

Source: CSO 2011a, b.

The LTC-system does not offer benefits for recipients to ease access to services. There is only one type of social allowance for relatives who provide for a disabled family member. The nursing fee (*ápolási díj*) is a social allowance; applications, based on the expert opinion of the GP, can be submitted to the local authority. The nursing fee can also be claimed by relatives caring for a severely disabled or a permanently ill young (<18) family member. That is, the nursing fee is not specifically targeted to long-term care of the elderly. Additionally, the social legislation provides an opportunity for local governments to give financial help to relatives caring for a family member aged over 18.

All other expenses finance in-kind services.

The bulk of LTC activities are left to households or an informal market. This problem is further aggravated by the fact that the majority of elderly people live in households either alone or with another elderly person.

In 2010 a number of smaller adjustments made the operation of the sector easier without increasing government subsidies and indeed without major structural changes. The improving relationship between the social sector and the health care sector has been mentioned above. In addition, some administrative burdens were eliminated. The upper limit of the fee that an LTC institution can charge was increased, which in effect gave help to the LTC sector at the cost of households. Mandatory auditing was abolished, which again saves some of the resources in the short run but increases the chances of losses later. The compulsory public procurement in purchases of e.g. food was also eliminated, which, according to experts, will decrease rather than increase prices. This reflects the frequent malfunctioning of procurement procedures and like the above measures raises concern for the future.

Property rights are on the changing in the sector in two ways. First, there is a tendency of privatisation mostly to the hands of religious charities. The grave financial situation of local governments forces many of them to get rid of LTC facilities. Since per capita subsidies are 95% higher for religious charities than for local governments or non-religious organisations, local governments offer their elderly homes to a church. In parallel to that, the nationalisation process, which rearranged property rights (as well as debts) from county-level municipalities to the state in health care, is also present in LTC.

A further development in health care will also likely affect the LTC system in the near future. The new patient route system will rationalise the distribution of inpatient capacities and will likely lead to re-specialisation of smaller centres as elderly homes or chronic centres with beds for lasting care.

2.4.2 Debates and political discourse

In December 2010 the State Secretariat for Social, Family and Youth Affairs of the MNR invited an expert team to prepare a concept paper. The Concept Paper on Social Policy 2011-2020 (*Nemzeti Szociálpolitikai Koncepció 2011-2020*) was released in January 2012 not as an official document yet but one that represents the views of the authors (Czibere et al 2011).

The Concept Paper would rearrange the division of labour between central and local government. Currently, local governments have a double act as an authority and as a service provider. The law order them to evaluate the need for LTC services and also to meet them by maintaining facilities and programmes. The Concept Paper would redistribute the primary responsibility to the new, unified system of government offices described above in section 2.3.1 and make service providers, among them local governments, to compete for their purchases. This would likely lead to the privatisation of service providers currently owned by local governments.

Government offices would also give a background for closer cooperation between the two branches of long-term care by establishing the system of case management.

2.4.3 Impact of EU social policies on the national level

The Concept Paper on Social Policy makes explicit reference to the EU 2020 strategy in that it aims at reorganising social assistance in a way that combines economic growth and social cohesion.

2.4.4 Impact assessment

In this respect there have been no changes since the last Annual National Report. The available studies, mostly by the public administration and barely in academia, focus on institutions and use macro data. Data of the 2010/2011 time-budget survey, which is the primary source of estimation on informal care, and the Hungarian set of the European Health Survey, 2009, which was released for research in 2010 will improve the capacities of the government to establish evidence-based policies.

2.4.5 Critical assessment of reforms, discussions and research carried out

The new structure of the government is highly centralised. The Ministry of National Resources holds the entire social protection system, and indeed the entire institutional structure of public life cycle financing, in one portfolio. This promises an improving coordination between health care and social care. Similar effects can be expected from the unified public administration service if they live up to their capabilities.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

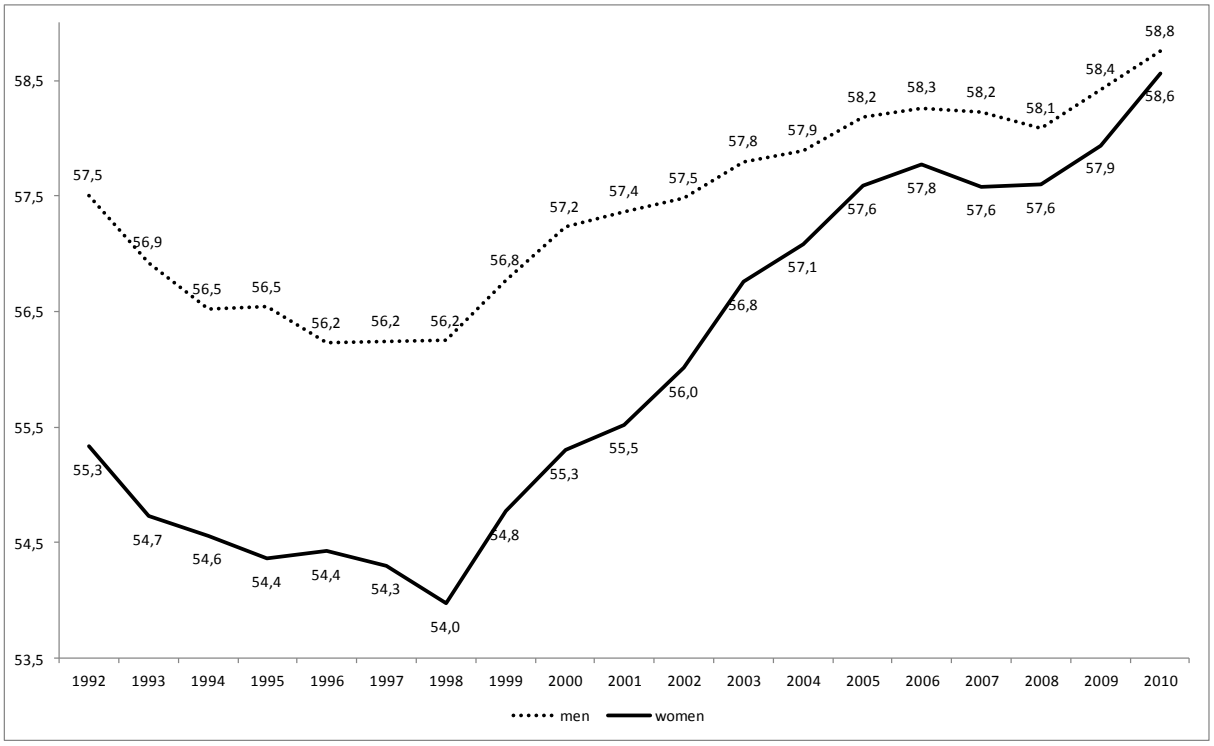
In Figure 3, I show the estimated effective retirement age over the period of 1992-2010. The estimation is based on 5-year age-group data of the OECD on population and labour force participation. The figure reveals that the increase of the official retirement age does affect retirement behaviour and it has a particularly strong impact at times of economic growth.

The standard retirement age was 60 for men and 55 for women till 1998. Over a transition period it increased to 62 by 2001 for men and by 2009 for women. However, as described in section 2.2.1, the transition was further cushioned by the introduction of a service-length-based early retirement scheme (*előrehozott nyugdíj*), which offered a benefit with no or moderate

reduction. At the start, the condition for the non-reduced variant was set at 37 contributory years for men and 34 contributory years for women. This condition was to gradually increase to 40 contributory years for both sexes by 2009. The actual increase observable in the figure was due to the hardening of this condition as well as a composition effect. By the end of the period discussed here, the cohorts reaching retirement age could collect less and less contributory years during the years of nearly full employment prior to the labour market crisis of the early 1990s so less and less people could meet the condition on service length.

The increase was particularly dramatic for women. Over the period of 12 years the effective retirement age grew by 4.6 years. The age-differential between the two sexes nearly disappeared.

Figure 3: Effective retirement age, 1992-2010



Source: Author's calculation from OECD labour statistics.

A further increase in the effective retirement age is expected now that the routes for early retirement were blocked. This may come from two sources. First, the share of a cohort leaving the labour market below retirement age will likely decrease and second, the retirement age will grow. Table 7 shows the transition of the retirement age from 62 years to 65 years.

Table 7: Retirement age and year of retirement in the transition period by birth cohorts

birth year	age at retirement	calendar year
1951	62,0	2013
1952	62,5	2014, 2015
1953	63,0	2016
1954	63,5	2017, 2018
1955	64,0	2019
1956	64,5	2020, 2021
1957	65,0	2022

Working beyond the retirement age is rewarded by the benefit formula. As discussed in Section 2.2.1 the current benefit formula is non-linear and rewards the early and the late years of the contributory period with higher replacement. Beyond 40 years of service each contributory year increases the entry pension by 2% of the net wage.

2.5.2 Participation in society

Measured by the European Quality of Life Survey participation in voluntary activities is less frequent in Hungary in European comparison (McCloughan, Batt, Costine and Scully 2011). With 20% of people reporting any participation Hungary is the 17th out of the 27 Member States and only the 21st if only people who participated at least once a week are considered. The social protection system leaves any voluntary or charitable work unnoticed.

2.5.3 Healthy and autonomous living

The LTC system still bears marks of central planning that was in effect in the country between 1950 and 1990. The organisational logic of the central planner dictates centralisation (for it is easier to control fewer institutions); a preference for institutionalised care compared to managing personal networks such as home-based care; and a kind of organisational blindness that does not notice needs beyond its sphere of operations. The consequence, as in other fields of activities, is a dual structure: a centralised system of institutions and a wide range of household activities by which people adjust to the situation. This structure is still recognisable although the system's tendency of institutionalisation has been changing over the last years. In Table 8, I display the dynamics of home care over the period of 2008-2010. The figures reveal a forceful increase in this part of the sector. The number of recipients and nurses grew by over 50%; the meal-on-wheels service reached more than 35% more people by 2010. Over the same period, the number of elderly home residents remained practically unchanged.

Table 8: Dynamics in home care, 2008-2010

	2008	2009	2010
home care recipients	48 120	63 392	75 054
home care nurses	5 571	7 442	8 625
meal on wheels recipients	107 803	124 693	146 443

Source: CSO 2011b.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R1] CANPI (Central Administration of the National Pension Insurance Fund), Lifecycles and pension systems. Conference proceedings, 2011, Budapest, CANPI.

As a key event of the Hungarian Presidency in social protection, the CANPI organised an international conference in May 2011 and published its proceedings. The conference focused on interrelations of demography and sustainability of pension schemes and discussed issues such as low fertility rate and the spread of atypical family models; inflexibility of family benefit systems; distortion of employment structure and unemployment; adverse changes of dependency ratio; capital markets and demography, etc.

[R1] VISZKIEVICZ, A., Egyéni számlás öregségi nyugdíjrendszer Magyarországon. A svéd modell alkalmazásának lehetőségei, Budapest, Századvég Gazdaságkutató Working Papers 2011/1, retrieved from:

http://www.szazadveg-eco.hu/files/muhelytanulmanyok/SzazadvegEco_Muhelytanulmany_2011_I..pdf .

"Old-age pension system in Hungary with individual accounts. Applicability of the Swedish model"

The paper gives a detailed account of the Swedish NDC system and discusses the potential introduction of such a system in Hungary. More specifically, the author analyses the consequences of differences between the two countries and finds that stability of NDC pension plans is largely determined by the country-specific factors and consequently the Swedish case should be introduced with caution.

[R1, R2, R3, R5] HIROSE, K, Hungary, In: Hirose, K. (ed.): Pension Reform in Central and Eastern Europe in times of crisis, austerity and beyond, 171-198, 2011, Budapest, ILO.

A concise and well-focused description of the Hungarian public pension scheme. Despite the recent release some sections, such as the detailed analysis of the second pillar, were made outdated by the speed of current reforms.

[R3] GOVERNMENT OF HUNGARY, Magyarország Nemzeti Reform Programja. Retrieved from:

http://www.kormany.hu/download/0/c3/30000/Nemzeti%20Reform%20Program.pdf

"National Reform Programme of Hungary"

An official programme of the government for sustainable growth with detailed national targets in the context of the EU 2020 strategy. The chapter on employment directly addresses issues related to early retirement. Several points of the plan have been legislated since its announcement in April 2011.

[H] Health

[H1, H2, H3, H4, H5, H6] GAÁL, P, SZIGETI, S, CSERE, M, GASKINS, M, PANTELI, D, Hungary: Health system review. Health Systems in Transition, 2011, 13(5), 1–266.

This comprehensive country study written within the framework of the European Observatory on Health Systems and Policies is likely to become a standard reference on the subject for some time.

[H1, H2, H3, H4, H5, H6, H7] State Secretariat for Health care of the Ministry of National Resources: Újraélesztett egészségügy - Gyógyuló Magyarország: Semmelweis Terv az egészségügy megmentésére, Budapest, retrieved from:

http://www.kormany.hu/download/3/c4/40000/Semmelweis%20Terv%20szakmai%20koncepci%C3%B3%202011.%20j%C3%BAnius%2027.pdf

"Resuscitated health care – Recovering Hungary: Semmelweis Plan for the rescue of health care"

As an official Concept Paper, accepted by the government in June 2011, it serves as the guide book for the ongoing reorganisation of the public health care system.

[L] Long-term care

[L] CZIBERE, K et al, 2011, Nemzeti Szociálpolitikai Koncepció, 2011-2020, Budapest, retrieved from:

http://www.szoszak.hu/adat/dokumentumtar/hu32_NSZK_2011_10.pdf.

"Concept Paper on National Social Policy, 2011-2020"

The Concept Paper was written by the invitation of the State Secretariat for Social, Family and Youth Affairs of the Ministry of National Resources but it is not an official document yet. The authors propose to rearrange the division of labour between central and local government by allocating authority to the new, unified system of government offices and make service providers, among them local governments, to compete for their purchases.

4 List of Important Institutions

Budapesti Corvinus Egyetem Egészséggazdaságtani és Technológiaelemzési Kutatóközpont – Corvinus University of Budapest Health Economics and Technology Assessment Research Centre

Contact person: László Gulácsi
Address: Fővám tér 8, 1093, Budapest, Hungary
Webpage: http://hecon.uni-corvinus.hu/corvinus.php?lng=en

Research fields: health economics and technology assessment

Budapesti Corvinus Egyetem, Közgazdaságtudományi Kar, Biztosítási Oktató és Kutató Csoport – Corvinus University of Budapest, Faculty of Economics, Actuary Training and Research Centre

Contact person: Erzsébet Kovács
Address: Veres Pálné u. 36, 1093, Budapest, Hungary
Webpage: http://portal.uni-corvinus.hu/index.php?id=5483

Research fields: actuarial calculations, pension reform

Debreceni Egyetem, Orvos- és Egészségtudományi Centrum, Népegészségügyi Kar, Egészségügyi Humán Tudományok Tanszék – University of Debrecen, Faculty of Public Health, Medical and Health Science Centre

Contact person: Róza Ádány
Address: Kassai út 26, 4028 Debrecen, Hungary
Webpage: http://www.ud-mhsc.org/index.php?option=com_content&task=view&id=112&Itemid=67

Research fields: public health

Egészségügyi Stratégiai Kutatóintézet – National Institute for Strategic Health Research (ESKI)

Contact person: György Surján
Address: Hold u. 1, 1054, Budapest, Hungary
Webpage: http://www.eski.hu/index_en.html

Research fields: health informatics, health system analysis, health technology assessment

Eötvös Loránd Tudományegyetem, Társadalomtudományi Kar, Egészségpolitika és Egészség-gazdaságtan Tanszék, Egészség-gazdaságtani Kutatóközpont – Eötvös Loránd University, Faculty for Social Sciences, Department of Health Policy and Health Economics, Centre for Health Economics

Contact person: Éva Orosz, professor
Address: Pázmány Péter sétány 1/a, 1117, Budapest, Hungary
Webpage: http://egk.tatk.elte.hu/index.php?option=com_content&task=blogcategory&id=42&Itemid=58

Research fields: health technology assessment, health system analysis

Magyar Tudományos Akadémia, Közgazdaságtudomámyi Intézet – Institute of Economics of the Hungarian Academy of Sciences

Contact person: András Simonovits
Address: Budaörsi út 45, 1112, Budapest, Hungary
Webpage: http://www.econ.core.hu/english/

Research fields: income and social conditions of older workers, voluntary pensions, early retirement, career projections by cohort

Pécsi Tudományegyetem, Egészségtudományi Kar, Egészségbiztosítási Intézet – University of Pécs, Faculty of Health Sciences, Institute of Health Insurance

Contact person: Imre Boncz
Address: Rét u. 4, Pécs, Hungary
Webpage: http://www.etk.pte.hu/menu/18

Research fields: health technology assessment

Semmelweis Egyetem, Egészségügyi Menedzserképző Központ – Semmelweis University, Health Services Management Training Centre

Contact person: Péter Gaál
Address: Kútvölgyi u. 2, 1125 Budapest, Hungary
Webpage: http://english.sote.hu/education-highlights/health-services-management-training-centre

Research fields: health system analysis, human resources, health management, quality research

Semmelweis University, Magatartástudományi Intézet – Semmelweis University, Institute of Behavioural Sciences

Contact person: Mária Kopp, professor
Address: Nagyvárad tér 4, 1089 Budapest, Hungary
Webpage: http://behsci.hu/

Research fields: health behaviour, mental health

TÁRKI Társadalomtudományi Kutatóintézet – TARKI Social Research Institute

Contact person: István György Tóth
Address: Budaörsi út 45, 1112, Budapest, Hungary
Webpage: http://www.tarki.hu/en/index.html

Research fields: sustainability projections, income and social conditions of older workers

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

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http://ec.europa.eu/social/main.jsp?catId=327&langId=en