Annual National Report 2010

Pensions, Health and Long-term Care

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Author: Robert Gál

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1 Executive Summary

This report is a comprehensive summary of developments in the Hungarian social protection sector in 2009 and early 2010. It contains separate sections on pensions, health care and long-term care as well as a special theme section on the impact of the financial and economic crisis in these fields.

The economic crisis hit Hungary particularly severely. GDP fell by 6.3% in 2009. Unemployment, which stood at 7.6% in the third quarter of 2008, grew to 11.3% by the first quarter of 2010. Gross wages, which still grew by 1.2% in real terms in 2008, decreased by 3.6% in 2009. This made the contributions and membership fees for the social insurance funds and mandatory private pension funds more difficult to collect.

The various chapters of social protection took opposite courses in 2009. It was a relatively silent and eventless year in health care compared to the turbulences of 2006-2008. By contrast, the pension issue gained momentum after the financial turmoil in 2008 and became subject of public debates and a major re-parameterisation.

Rules of early retirement were tightened and the retirement age will be raised from 62 years to 65 years by 2022. The extra bonus on pensions, the so called 13th month benefit, which was phased in between 2003 and 2006, was replaced by a pension premium, which is a smaller amount and is tied to GDP growth set at a relatively high level. Indexation of already established pensions was also tied to GDP growth; the resulting mix of wage growth and inflation will produce lower indices.

The mandatory private pension funds mostly recovered from the losses of 2008. However, they also lost membership contributions due to the troubles in the labour market. In addition, they lost some of their old members (73,800 people, about 2.5% of the total) and reserves (about HUF 100 billion, an estimated 3.5-4.0% of total reserves) in a return-to-PAYG option. In order to protect older fund members from absorbing the loss of their reserves, the Government allowed fund members born in 1956 or earlier to restore their full eligibilities in the pay-as-you-go pillar.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the previous Year

Introduction: Social protection in general politics

After two relatively close elections in 2002 and 2006, both of which were won by a coalition of socialists and liberals, the recent polls in April 2010 led to a landslide victory of the centre-right opposition. Unusually for a Hungarian election, social protection issues played a secondary role in the campaign; the exceptions will be discussed below more in detail. Nevertheless, the botched health care reform of 2006-2007, which had to be withdrawn after a referendum in March 2008, significantly added to the erosion of the government. Not long after and for a cause closely related to the lost referendum, the liberals left the ruling coalition forcing the Socialist Party to govern in minority. In addition, plans of downsizing the pension system, which came to the fore once the economic crisis forced Hungary to apply for a stand-by loan of the EU and the IMF, largely added to the resignation of the Prime Minister, Ferenc Gyurcsany, in April 2009. Since then a quasi-caretaker government led the country through a series of severe austerity measures, which stabilised the budget against a surprisingly weak public resistance.

Over these years the various chapters of social protection took opposite courses. The first period of the government cycle saw efforts to restrict long-term care, cut back, reorganise and partly privatise public health care whereas pension expenditures still grew. The referendum halted and rolled back the health care reform although the budget cuts were not reversed. In general, not much has happened in this field since then. In contrast, the pension issue gained momentum after the financial turmoil in 2008 and became subject of a major parametric reform in 2009.

2.1 Pensions

2.1.1 Overview of the system's characteristics and reforms

Building on a long tradition of social insurance, the pension system gained its current shape in 1997 when a comprehensive reform downsized the pay-as-you-go pillar and introduced a new, privately managed, pre-funded pillar. However, the notorious political business cycle of Hungarian public finances, including pensions, undermined hard-won long-term financial stability. Over the 2000s, an unsustainable cut in the contribution rate and additional pension increases, most importantly the instigation of a 13th month benefit, destabilised the system, which required increasingly large transfers from the state budget. Despite the growing pressure, the ruling socialist-liberal coalition and later the socialist minority cabinet, for which the pensioner society is a particularly important constituency, tried to postpone the correction as long as possible. After the financial crisis hit the country, however, the Government was left with no choice but to re-parameterise the pension system. The extra month of benefit was withdrawn, the retirement age was increased and the indexation rule was clamped down.

Deficit

The 1997 reforms invited stability to the system but, due to politically motivated interventions stability did not last long. In the Hungarian context this meant growing government transfers

and eventually changing parameters. The total sum of such transfers is a subject of an on-going debate in the public discourse on pensions so, in Table 1 I will show some of its details.

Table 1: Government transfers to the National Pension Insurance Fund, in million Euros

	Special contributions and compensations	Direct transfers	*Sum excluding compensation for private funds*	Compensation for private funds	**Total sum**
2001	141	202	*343*	317	**659**
2002	155	762	*918*	365	**1 282**
2003	169	457	*626*	515	**1 141**
2004	193	573	*766*	668	**1 434**
2005	194	755	*949*	852	**1 800**
2006	212	1 215	*1 427*	911	**2 338**
2007	329	551	*880*	1 184	**2 064**
2008	488	571	*1 058*	1 315	**2 373**
2010 1st quarter	104	182	*286*	343	**630**

Source: Budget legislation; 2010: preliminary figures from the Central Administration of NPIF (CANPI).
Note: Special contributions and compensations: contributions paid from maternity leave transfers; special contributions paid after early retirees from hazardous jobs and the preferential retirement of the armed forces; compensation for the preferential contribution rate of new entrants to the labour market. Some special contributions are not included in the table (see the text surrounding the table).
No such specifications are available yet for 2009.

The table does not include contributions paid by various branches of the general government in capacity of a regular employer but only special contributions and compensations. Maternity leave transfers, financed by the central government, function in effect as paid household work and as such are subject to paying contributions. Ministries and other government agencies also pay supplements to the National Pension Insurance Fund (NPIF) for the preferential retirement of armed forces personnel. Since 2007, employers pay additional contributions if their employees are allowed to participate in a special early retirement scheme for people in hazardous jobs (*korkedvezményes nyugdíj*). In 2007, the total amount of this special contribution was taken over by Government. In 2008, only 75%, in 2009 50%, and in 2010 25% was taken over. From 2011 on, the entire early retirement contribution (*korkedvezmény-biztosítási járulék*) will be borne by employers who employ eligible people.

Also, government compensates the NPIF for contributions lost in the preferential tax-treatment of new entrants to the labour market, the so-called START-card holders. Some other smaller government transfers (such as contributions paid after the unemployment benefits and some social assistance type of benefits) are missing from the table since official documents do not allow a consistent time series. In this respect, the sums presented above are slightly underestimated.

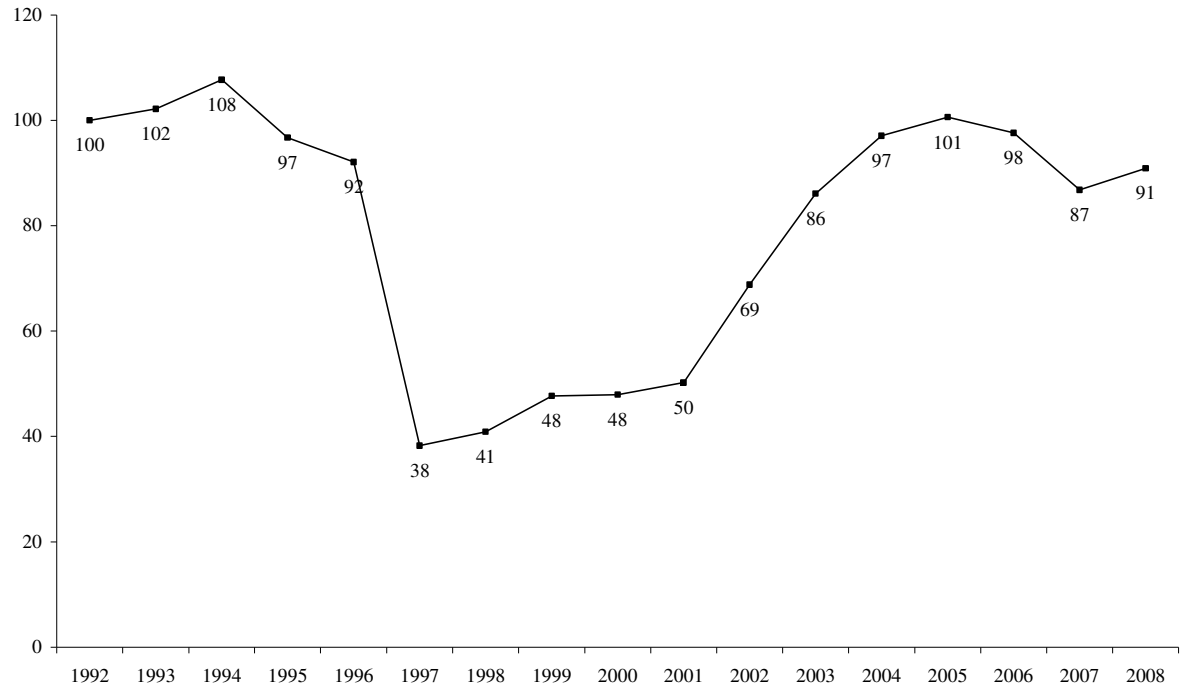
The Government also pays compensation for the contributions lost to the mandatory private funds (MPFs). Whether this item should or should not be considered a deficit in pension finances was a subject of a particularly intensive scholarly as well as public debate.

The total sum of this nearly complete list of government transfers shows a rapidly growing trend. Over the course of seven years it almost quadrupled in Euro terms. Even if we remove the total of the compensation for private fund contributions the curve steeply increases from EUR 343 million to over EUR 1 billion. The table also reveals a clear political cycle in the

two election years covered, 2002, and 2006. However, 2010 is likely to be an exception in this respect.

Long-term instability also grew rapidly. In Figure 1, I present an estimation of the implicit pension debt (IPD) over the period of 1992-2008. For the sake of comparability, IPD figures are calculated in 2009 prices and, in order to filter out the effect of the discount rate and other assumptions on levels, they are expressed as a percentage of the 1992 IPD value. The estimation does not take into account the general and widely used service-length-based early retirement (*előrehozott nyugdíj*) so it overestimates the stabilising effect of the 1997 reform.[1]

Figure 1: Implicit pension debt in 2009 prices, 1992=100.



Own calculation.
Note: including the NPIF and the mandatory private pension funds.

The figure reveals a major, if, due to the above effect, somewhat exaggerated, decrease of the IPD in 1997. According to these figures, the reduction most likely fell below the optimal level in this correction. More importantly, in the course of a mere three years between 2001 and 2004 it grew back to the same level it had been before and stayed there until 2009. This happened in a period that was more favourable for the pension system in terms of demography and labour market than the preceding and the following decades.

A debate on the need for a new correction started as early as in autumn 2006, and a Pension and Old-age Roundtable of experts was convened by the Prime Minister in January 2007 with the explicit aim of advising the Government on potential reform scenarios.

[1] In addition, the estimation referred to here covers the entire pension system including the MPFs instead of focusing only on the NPIF and comprises both the revenue and expenditure side instead of being limited to the latter; so, the trends in Figure 1 do not fully correspond to those in Table 1.

Revenues, expenditures, reserves and coverage

Against this background the country was particularly severely hit by the 2008-2009 economic crisis, which reduced revenues, diminished the reserves of private funds and forced the Government to cut back on expenditures.

Table 2 shows the consequences on revenues. The table contains contributions (paid by employers and employees) and total revenues of the NPIF in comparative (2010 1st quarter) prices in two panels. The upper panel includes annual figures compared to previous year's data; the lower panel contains quarterly figures and compares these to the first quarter of 2009.

Table 2: Contributions and total revenues of the National Pension Insurance Fund, 2010 prices, in % of previous year or starting period

	contributions	**total revenues**
full year; previous year=100		
2008	100.0	101.9
2009	91.7	96.0
first quarter; 2009 1st quarter=100		
2009	100.0	100.0
2010	94.9	90.7

Source: 2007, 2008: budget legislation; 2009, 2010: preliminary figures from CANPI.
Notes: Including revenues transferred from the NHIF. Contributions: paid by employers and employees.

Contributions collected by the NPIF decreased by over 8% in 2009 in real terms due to declining employment, lower wages and deferred contribution payment by enterprises. This continued even further in the first months of 2010. The amount of contributions collected in the first quarter of 2010 were 5% lower in comparative prices than in the corresponding period in 2009.

Contribution payment reflects labour market trends more closely, whereas the rest of total revenues, which come mostly, though not exclusively from the state budget, signal the stress in public finance. Total revenues of the NPIF decreased by 4% from 2008 to 2009. This decline was unevenly distributed with acceleration after the first quarter of 2009. The quasi care-taker government took office in April 2009.

Table 3, which contains the planned and realised budget, reveals a similar picture. The NPIF started the year of 2009 with a legislated budget that did not materialise due to the crisis. Total revenues remained below target by nearly 5%; contributions by 6%.

Table 3: Planned vs. realised budget of the NPIF, 2009, in %.

Contributions		94.0
	employers and employees	94.0
	Other	96.0
Government transfers		99.9
Other revenues		107.2
Total		95.3

Source: preliminary figures from CANPI.

The MPFs also faced declining revenues. In nominal terms, the funds collected 3.6% less contributions in the first half of 2009 than in the corresponding period in 2008 (FSA 2009, 115). In real terms this is equivalent to a decrease of 7.9%. However, this is partly due to organisational factors. The regulation of the administration of contributions changed in 2007 and many funds responded by delaying the registering of some of the 2007 contributions in the first half of 2008. This rendered the 2008 base artificially high.

Decreasing revenues are mirrored in benefits. In Table 4, I present the trends of various benefit types. I start the time series in 2007 for comparison with the health budget data in the following section. The aggregate spending on old-age pensions was still growing in 2007 and 2008 in the years of financial restriction in health care, long-term care and disability. Old-age pensioners are a particular important constituency for the Socialist Party so the Government tried to protect their cash benefits from the austerity measures which started already in 2006, although services in-kind, most notably health care services, which are also consumed disproportionately by the elderly, were not shielded in the same way.

In 2009, there was no longer the chance to postpone the adjustment of pensions. The Government paid out the first half of the already reduced extra month benefit and eliminated it altogether before the second instalment. In real terms, the total amount of benefits paid by the NPIF decreased by nearly 6% in the course of one year. Since the GDP declined at almost the same speed, the relative share of NPIF benefits in GDP hardly changed. 2010 figures are also presented in the table projected from preliminary data on the first quarter of the year. If the Central Administration of the NPIF (CANPI) will not correct the figures and first quarter trends will prevail over the year, 2010 will see a further slight decrease in total benefits in real terms.

Table 4: Benefits paid by the National Pension Insurance Fund,
in 2010 prices and as % of GDP.

	old-age	**disability**	**survivors**	**13th month**	**total**
% of change to previous year; comparative prices					
2007	4.1	-5.9	5.0	15.7	2.5
2008	6.3	1.6	-0.5	5.7	4.4
2009	-0.4	-2.8	-2.7	-63.7	-5.9
2010	*2.8*	*1.7*	*0.9*	*-100.0*	*-0.7*
% of GDP					
2007	6.0	2.3	1.2	0.8	10.3
2008	6.5	2.4	1.2	0.8	10.9
2009	6.8	2.4	1.3	0.3	10.9

Source: 2007, 2008: budget legislation; 2009, 2010: preliminary figures from CANPI; 2010: projected from 1st quarter data.
Notes: Disability includes all types formerly funded by the NHIF as well as the rehabilitation allowance. The total includes the four benefit types of the table. Benefits paid by the central government and operating costs are not covered here.

The NPIF has no buffer fund but the MPFs have reserves. After a loss of about 20% in 2008 the funds largely recovered in 2009. According to the Financial Supervisory Authority (FSA), the three portfolios offered by the funds produced the following average returns:

growth portfolio: 25.6%
balanced portfolio: 17.4%
classic portfolio: 11.5%.

In nominal terms, the funds' aggregate loss was HUF 422 billion or 1.59% of the GDP in 2008, but in 2009 they gained HUF 458 billion or 1.75% of the (nominally lower) 2009 GDP (FSA 2010).

The financial crisis induced various provisional measures, which I will discuss in more detail in Section 3. Here, I mention only one: permission to return to the first pillar.

MPF membership is mandatory for new entrants of the labour market but it was optional for those with accrued rights established before 1998. In principle, since the period of optional switching terminated in 1999, fund members cannot return to full pay-as-you-go, although the option has been re-opened and closed again over time.

At the end of 2009, the MPFs had just over 3 million members, i.e. about 80% of employees. These people still pay the majority of their contributions to the pay-as-you-go pillar. Currently 24% is paid by the employer and 1.5% by the employee to the first pillar and 8% to the MPF; all percentages are given in terms of gross wages. Returning to the first pillar implies redirection of the 8% contribution to the pay-as-you-go scheme.

Due in a smaller part to overselling at the time of the establishment of private funds, but mostly to the unexpectedly (and unsustainably) high pensions paid by the pay-as-you-go pillar in the 2000s, estimations by the Ministry of Finance found an alarmingly high number of fund members who would have come out with higher pensions should they have remained in the pay-as-you-go pillar with their full contributions. The employment and financial crisis made the outlook even grimmer. In order to prevent tensions arising from this cause, the Government opened the way to return to the first pillar for those born in 1956 or before (and the very few people who have already retired from the private funds) to restore their eligibilities as if they had never switched to the MPFs. Altogether 123,000 people met these conditions, out of whom 73,800 people decided to return (FSA 2010). The market value of the accounts of returnees is HUF 100.2 billion (EUR 370 million); the funds have transferred HUF 74.3 billion (EUR 274 million) to the Government Debt Management Agency, HUF 13.2 billion (EUR 49 million) to the State Treasury and HUF 1.4 billion (EUR 5 million) to the NPIF.

2.1.2 Overview of debates/political discourse

2009 and the first quarter of 2010 saw three pension-related debates; one in early 2009 preceding the re-parameterisation of the pay-as-you-go pillar; one during autumn 2009 concerning the property rights structure of the MPFs and the annuities they should pay in the future; and finally another one at around the end of the year and early 2010, when the Pension and Old-age Roundtable (NYIKA by its Hungarian acronym) presented their report.

Debate on parametric corrections

Under the pressure of the strict budget control by the IMF, the Government submitted a package of parametric changes. Below, I will refer to this as the Gyurcsany programme, named after the then ruling Prime Minister, and show its key parameters in Table 5. Before it could come into effect, however, the Prime Minister resigned. The new Bajnai Government instead passed an even stricter variant.

In addition to these two proposals, I also present the pension recommendations of the Reform Alliance, an ad hoc association established by the leaders of various employers' organisations and former and current presidents of the Hungarian Academy of Sciences. The Alliance invited distinguished experts, including academics, consultants and specialists to write its

programme. Since the new government introduced measures which the reformers found close enough to their concept, the Alliance was dissolved.

Table 5: Proposals for parametric changes, 2009.

	Reform Alliance	**Gyurcsany Government**	**Bajnai Government**
retirement age	65 after a 3 year transition starting in 2010	65 after an 11 year transition starting in 2016	65 after an 8 year transition starting in 2014
early retirement		2013 tightening introduced in 2011-2013	2013 tightening introduced in 2011-2013
indexation	price indexation	special indexation rule	stricter Gyurcsany-indexation
13th month benefit	immediately abolished	no benefit for new retirees from 2010	immediately abolished + pension premium

Note: The Bajnai-proposal has been passed by Parliament.

Indeed, neither government proposals fully met the corrections demanded, but they were clearly close in the end. The Gyurcsany programme aimed at a higher retirement age, 65 years, phased in by 2027. The Bajnai programme shortened the transition period to closing by 2022, still not the 2012 date required by the Alliance, but closer to it. Instead of price indexation, the Gyurcsany Government intended to apply a complex growth-dependent index. As shown in Table 6, the former Swiss index, i.e. the 50-50% combination of price and wage growth, would have fully applied only if the annual growth of the GDP had reached 4%. Below 2% pensions would have increased only by the consumer price index (CPI). Between 2% and 4%, the share of the CPI decreased from 100% to 80% and then to 60%. I also show the Bajnai modification, which kept the price/wage shares but raised the growth brackets.

Table 6: Changing government proposals for a new indexation, March and April, 2009.

Gyurcsany	**Bajnai**		
Programme		Share of component in index (%)	
GDP growth (%)		CPI	Wage growth
<2	<3	100	0
2.0 - 2.9	3.0 - 3.9	80	20
3.0 - 3.9	4.0 - 4.9	60	40
4.0<	5.0<	50	50

Note: The Bajnai proposal has been passed by Parliament.

Finally, the abolishment of the extra month bonus went through similar changes within a short period. The Gyurcsany Government, four months after it limited the payment to people above the age of 62, excluded everyone who will retire in 2010 and beyond. One month later, the new government abolished the bonus altogether but introduced a pension premium which is conditional to GDP growth (3.5% a year) and the financial stability of the budget of the general government.

The parametric reforms affect various groups differently. The pension premium, which is by and large equivalent to the withdrawal of the 13th month benefit, cuts annual benefits by 8.3% for a pensioner in real terms. It affects both current and future beneficiaries.

The impact of the higher retirement age depends on life expectancies (LEXP). Currently, about 5% of those who reach the age of 62 years die before they turn 65. By the time the gradual increase of the retirement age will reach 65 years this proportion is expected to

decrease to 4%. These people will lose their entire lifetime pension. Those who reach 65 years have a gender-specific LEXP of 13.6 years (men) and 17.5 years (women), respectively. By 2022, this will be about 1-1.5 years longer. Consequently, the lifetime pension of a new male retiree will decrease by some 15%-16%; that of a new female retiree will decrease somewhat less. Here, the affected group is only future pensioners.

Despite the complex formula, the new pension index is effectively a price index. Calculated on the basis of 15 years in retirement and a 3% real wage growth, the new index results in about 11% of further loss in lifetime benefits. Here, men and people with low education lose less; women and people with higher education lose more. The new index also affects current pensioners.

These are consequences calculated on theoretical "typical" careers. No more cohort-specific analyses have been published. However, the estimated aggregate effects stabilise the system for the next three decades according to the Ministry of Finance (see next subsection).

Debate on the property rights status of the MPFs and annuities

Hungarian MPFs have a peculiar property rights structure. In contrast to their counterparts elsewhere, they look like mutual savings associations. Members are not clients but co-owners of the fund holding non-tradable property rights. This leads to managerial control over the funds. However, managements are frequently selected by sponsor institutions, usually insurance companies or savings banks, sometimes employers, which the funds are named after. This, in turn, has a consequence on the costs charged on the members. Most notably, asset management fees used to be significantly higher in funds with a financial institution in the background than in employer funds or independent funds. The Government has made steps since 2006 to cap those costs, such as setting a minimum of the reserve rate and limiting the asset management fee to a percentage of the annual average assets.

In addition, the 1997 law enacted a new benefit formula and indirectly made pensions subject to income taxation. The details, however, are being awaited. Also, the way accumulated savings in MPFs will be translated to annuities is unclear. The legal background of annuity providers is not yet ready.

In order to solve these problems the Government submitted a proposal to Parliament in October 2009, which was passed in December. The new law was to establish pension institutions functioning as corporations as from 2013. The old association-type funds were to merge into these new corporations. Fund members would have lost their nominal non-tradable property rights. The law also aimed to regulate annuity provision.

The opposition, playing on widely held anti-privatisation sentiments, vehemently attacked the proposal blaming the Government of putting future pensions at risk. The President of the Republic, Laszlo Solyom, refused to sign legislation and referred it to the Constitution Court. The Court President found the proposal unconstitutional on grounds of limiting property rights of fund members without compensation.

Debate on the adoption of the Swedish NDC system in Hungary

The third debate, which shaped the public discourse and slightly affected the recent election campaign but has not materialised in policies, followed the release of the Report of the Pension and Old-age Roundtable (NYIKA), which was published both in Hungarian and

English (Holtzer 2010).[2] The Roundtable, an expert panel convened by the Prime Minister in 2007, published its first report as well as its base case model in 2008. It developed a dynamic microsimulation model, which simulates life events such as entry to the labour market (with transition from school to labour), marital status, labour market positions (such as full time employed, part time employed, unemployed, inactive below retirement age), and retirement. The simulation is based on large administrative datasets of the NPIF and the FSA.

The NYIKA microsimulation model developed by Deloitte, an international consultancy, is a major improvement in the administrative capacities of the authorities. According to PENMICRO, an EU-wide inventory of pension projection tools commissioned by the European Commission, the NYIKA model is the only dynamic microsimulation model available for a government in the new Member States for the moment, offering analytical capabilities unavailable to standard cohort models. After the Roundtable completed its mandate the tool was deployed at the Secretariat of the newly established Fiscal Council, which will use it for more general budget projections.

The Roundtable made projections of the "current system" and five alternatives. The word "current system" was put in inverted commas since the base case kept changing over the entire modelling exercise. Finally, the released results were made obsolete at the moment of publication of the Bajnai reform; fortunately, this does not affect most of the conclusions. The alternatives the panel modelled are a point system with marginal minimum pension guarantees; a point system combined with an extended minimum pension; a non-financial defined contribution (NDC) system in two versions; and a fully funded system. The two versions of the NDC model differ in that one keeps the current proportions of the public-private mix whereas the other calculates with a gradual full privatisation. All proposals implied the introduction of an individual account system. The full point system focused on a clear feedback of contributions in benefits. It worked with long transitions. The combined point system and extended minimum pension was developed so as to minimise old-age poverty. The mixed system NDC had self-sustainability as its main emphasis. Finally, the two privatisation proposals were based on expectations on higher return in a funded system and a sceptical view on the social sustainability of the pay-as-you-go pillar.

The alternatives that have been elaborated are not detailed reform proposals. The mandate of the expert team was to analyse the consequences of various institutional settings on pension levels, budget deficits and sustainability. The alternatives are proposals by academics, except for the mixed system NDC, which was submitted to Parliament by a smaller opposition party, the Christian Democrats who, as part of the centre right alliance, came to power in 2010. This is the reason why the final report of the Roundtable attracted unexpected attention. During the election campaign the Socialist Party tried to convince the pensioners and older workers that the centre right alliance is preparing a reform that would cut pensions and raise retirement age. However, the alliance made it clear that they do not want to adopt the Swedish system in Hungary.

2.1.3 Impact assessment

The Government published the estimated long-term effects of the 2009 parametric corrections on the total public pension budget. This calculation includes all public pension expenses, i.e. benefits paid by NPIF as well as the central government and the related operating costs.

The estimated effects are indeed significant (see Table 7). Total public spending on pensions are expected to be 0.8% lower in terms of GDP already in the first year of implementation

[2] The author of this report was a member of the Roundtable and took part in the modeling project.

mostly due to the abolition of the 13th month benefit. By 2020, the difference between the two expenditure paths will be 2.4% of GDP; by 2060 as much as 3.2%. The most important improvement is made by the new indexation rule. After 2040, pension spending is expected to be lower by 1.5% of GDP due to the price index. The higher retirement age makes about another 1 percentage point improvement and the abolition of the 13th month benefit cuts annual spending by 0.7%-0.8% of GDP.

Table 7: Consequences of the 2009 re-parameterisation on total public pension expenditures, in % of GDP.

	2007	2010	2020	2030	2040	2050	2060
Total public pension expenditures							
- prior to 2009 re-parameterisation	10.9	11.3	10.7	10.5	11.4	12.2	13.2
- after 2009 re-parameterisation	10.9	10.5	8.3	7.6	8.3	9.4	10.0
Decrease							
	0	-0.8	-2.4	-2.9	-3.1	-2.8	-3.2
of which							
higher retirement age	0	na	-0.9	-0.9	-1.1	-0.9	-0.9
new indexation rule	0	na	-0.8	-1.4	-1.5	-1.5	-1.5
abolition of 13th month benefit	0	na	-0.7	-0.7	-0.7	-0.8	-0.8

Source: Government of Hungary (2010).
Note: Separate effects are different from the total effect since the latter includes the impact of tightening the rules of early retirement (the Malus Effect) as well as the abolition of correction of disability pensions in 2010.

The mix of the 2009 re-parameterisation does not score well in several of the Open Method of Cooperation (OMC) objectives in that it enhances sustainability mostly at the cost of adequacy. Pension cuts, due to the loss of the extra month of benefit and the new indexation rule, which hits older pensioners in particular, are much more significant in the restoration of long-term stability than longer working careers.

In general, the mix of the small-step corrections in 2007-2008 was more input-based (longer contributory period) than output-based (less pensions), although both components are present. This improves the achievements of the system.

2.1.4 Critical assessment of reforms, discussions and research carried out

The introduction of a pension analysis usually starts with the demographic and labour market background. However, the Hungarian pension scene cannot be understood without a constant reference to the electoral cycle. In general, public investment activity, wages, social spending, and the consequent budget deficit all show a strong four-year cycle; pensions are no exception to this.

The recent parametric reforms have to be judged against this background. Most importantly, the series of small-step corrections in 2007-2008 and the more comprehensive Bajnai reform in 2009 has likely restored the long-term financial stability of the system. 2010, though an election year, saw neither a new pension cycle nor unfounded promises for future spending. Pensions played a secondary role in the campaign and even when they were mentioned it was used to scare pensioners away from the opposition stating that they would cut benefits in the future.

However, a number of issues remained unresolved. No effort was made to build in guarantees that would insulate the pension system from short term politics even though this vulnerability

has proved to be the most prominent feature of the Hungarian system over the past two decades. No elements of automatic governance, i.e. built-in algorithms or balancing mechanisms were designed for the new system. To the contrary, the pension and indexation formulae were made even more complicated calling for manipulation of the rules whenever the short-term financial situation would allow. The 13th month benefit was in practice withdrawn but in fact it was replaced by the pension premium. The price index was not substituted by the Swiss indexation but a rather complex and arbitrary weighting mechanism was introduced. The current form invites renewed interventions once the budget pressure alleviates, much the same way as it happened in the early 2000s.

Also, the Government has not finally solved the problem of annuities in MPFs, nor the taxation of benefits after 2013 as indirectly indicated (though not stated clearly) by law. Both issues have to be settled within two years by the new government.

2.2 Health

2.2.1 Overview of the system's characteristics and reforms

The Hungarian public health care was built up as a system of integrated state socialist health services, which was shifted during the 1990s to a split purchaser/provider contract model controlled by a self-government body, only to be taken back to effectively 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 fails to meet some important characteristics of the classical social health insurance systems. The rate of contributions is set by Parliament, that is to say, by the Government, which has a priority of tax competition with neighbouring countries over health expenditures. Collection of contributions was delegated to the Tax and Financial Control Administration (Tax Office in short) supervised by the Ministry of Finance in 1999, which took over the function from the National Health Insurance Fund Administration (NHIFA). The professional associations such as the Hungarian Medical Chamber, which has been functioning on a voluntary basis since 2007, and the Hungarian Hospital Association do not have any defined rights and roles in determining the benefit package or delegated regulatory role in health financing issues. The various financing methods, such as the price per patient for general practitioners (GPs), value of diagnosis-related groups (DRGs)[3] for hospitals, etc. are regulated by the Government, and the NHIFA has essential decision right only with respect to the reimbursement decisions about pharmaceutical expenses.

A comprehensive reform plan of the Government in 2006-2007 aimed at decentralising the NHIF into NUTS2[4] level regional funds, which, in the final version of the plan that went to legislation, would have been open for partial privatisation up to 49%, including important points of control for the minority private shareholder, such as a veto right in the modification of the benefit package financed by the NHIF and the right to appoint the CEOs of regional funds. The reform went in parallel with an effort to control costs. Public expenditures on health care were cut back; co-payment for GP visits and hospital stay was introduced.

[3] Diagnoses-related groups or DRGs is a system of classification of hospital cases developed for the purposes of the American Medicare programme but widely used internationally.

[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 three statistical large regions (NUTS1), seven planning and statistical regions (NUTS2), and 20 counties plus Budapest (NUTS3).

However, by the end of 2008, the structural elements of these policy objectives disintegrated. Between December 2007 and June 2008 the same Parliament approved twice and then revoked practically the same bill. The legislation process brought about the intervention of the President of the Republic, who sent the first version back to Parliament for reconsideration, and finally, after the co-payment components of the health reform package were rejected by a referendum and the law was withdrawn, it led to the collapse of the ruling coalition.

Revenues, expenditures and coverage

In 2007, 70.6% of total health expenditure was financed from public sources; the remaining 29.4% was private (24.9% out-of-pocket; OECD 2010). About 85% of public finance comes from the NHIF. Services are delivered predominantly by local government-owned public providers, who contract with the NHIFA. The central government is the dominant regulator of health services, exercising statutory supervision over the NHIF and controlling the NHIFA. In addition, it provides capital grants and delivers public health and some tertiary care services.

Table 8: Contributions and total revenues of the NHIF,
2010 prices, in % of previous year or starting period

	contributions	**total revenues**
full year; previous year=100		
2007	100.6	99.3
2008	98.4	96.5
2009	85.9	85.8
first quarter; 2009 1st quarter=100		
2009	100.0	100.0
2010	70.7	100.8

Source: NHIFA.
Notes: Total: excluding contributions collected on behalf of and transferred to NPIF in 2007 and 2008. Contribution rates decreased in 2009 and 2010 (see text surrounding the table).

Contributions to social insurance and health care in particular are subject to frequent adjustments. Subsequent governments feel forced by international tax competition to make efforts in cutting total labour costs. As a consequence, the total rate of health contributions decreased from 23.5% to 8% of gross wages between 1994 and 2010. In 2007, some of the responsibilities of the NHIF, more specifically the financing of lower levels (3rd category) disabilities, were transferred to the NPIF. The corresponding contributions, 4% of gross wages, were also relocated to the pension fund. Even taking this into consideration means an effective cut in half of the health contribution rate. Declining health contributions have been slightly compensated by a fixed-amount contribution, which lost much of its real value over the years.

The employment crisis added to the financial problems of the system. Total revenues decreased by 0.7% in 2007 and another 3.5% in 2008 in real terms (see Table 8). This was equivalent to a decrease from 6.7% of GDP in 2006 to 5.7% in 2008. In 2009, when contribution rules changed during the fiscal year, a further 14% drop followed due partly to the first step of the cut in the contribution rate, and partly to the employment crisis. This decline came to a halt in 2010, judging by first quarter data, but a rearrangement in the composition of revenues continued. The NHIF collected slightly more revenues in the first quarter of 2010 than in the corresponding period of 2009, but its contribution revenues decreased by nearly 30% due to the second step of lowering the contribution rate.

As Table 9 reveals, realised contributions and government transfers lagged behind the budget plans by practically the same rate in 2009. The former is partly also a consequence of government decisions: the health contribution rate, as mentioned above, decreased during the fiscal year. By 2010 the budget plans adjusted to the changing rules. The Tax Office could collect nearly 7% more contributions in the 1st quarter of the year than the time-proportionate share of the annual budget.

Table 9: Planned vs. realised budget of the NHIF, in %.

		2009	**2010 - 1st quarter**
Contributions		86.0	106.8
	proportional contribution, employers	75.8	105.4
	proportional contribution, employees	90.7	
	other proportional contributions	122.1	117.7
	fixed contribution	92.2	
	fees and fines	86.7	
Government transfers		100.0	100.0
Other revenues		113.8	142.2
Total		90.1	105.5

Source: NHIFA. 2010: Realised budget in 1st quarter compared to time-proportionate planned budget. Notes: Contribution rates decreased in 2009 during the fiscal year.

Due to the austerity measures, expenditures of the NHIF decreased by 6% between 2007 and 2009 (see Table 10). In particular, spending on curative-preventive care decreased by 10% and on pharmaceutics by 4% in the course of two years. This is quite significant, but less than the drop in revenues (see Table 8). After two years of near balance, the NHIF was running a large deficit again in 2009.

Table 10: Expenditures of NHIF.

		in 2010 prices; 2007=100				**as % of GDP**		
		2007	2008	2009	*2010*	2007	2008	2009
cash benefits		100	101	103	*93*	0.86	0.88	0.95
in kind		100	98	93	*103*	4.29	4.28	4.30
	curative-preventive care	100	99	90	*110*	2.83	2.85	2.76
	pharmaceutics	100	95	96	*90*	1.27	1.23	1.32
	medical aids	100	108	114	*94*	0.14	0.16	0.18
	other	100	97	118	*107*	0.04	0.04	0.06
other expenses		100	91	83	*85*	0.21	0.19	0.19
total		100	98	94	*101*	5.35	5.35	5.44

Source: NHIFA. 2010: projected from 1st quarter data.

Potential consequences on the access to health services and on health conditions may be revealed by a new data source, the European Health Survey (ELEF by its Hungarian acronym). I will return to this in a subsequent subsection on impact assessment.

2.2.2 Overview of debates/political discourse

The health care reform was a major political issue in 2006-2008. However, once some minor components of the reform package (more specifically small amounts of co-payment for GP-visits and in hospitals) were rejected by a referendum in March 2008, the entire project was

halted. The ruling coalition fell apart; the minority government withdrew the proposals. Since then, (around summer 2008), health care is mostly in the shadows. No new ambitious programmes have been announced. The Government returned to the strategy of small steps such as setting up new health care protocols and putting more emphasis on the National Health Programme (*Népegészségügyi* Programme). Health care played no role in the recent election campaign, which circulated mostly around political corruption and the rise of a radical right-wing party.

2.2.3 Overview of 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 in health care.

The lack of impact assessment was one of the main reasons for the President of the Republic to return the first version of the law on competing health insurance funds to Parliament for reconsideration. The Ministry of Health (MoH) and the NHIF do not publish performance reports on the health care system, but the WHO initiated a project on this topic in cooperation with different bodies of the Government.

An indirect indicator of impact of the reform measures could be a recent general survey on health conditions. Similar surveys were conducted by the Central Statistical Office (CSO) in 1994 and the National Epidemiology Centre (NEC) in 2000 and 2003. During autumn 2009, the CSO collected data again on health conditions as part of a European Health Survey representing a large sample of the 15 years old and above population living in private households. Due to the time gap between the surveys as well as to some methodological issues the effect of the botched 2007-2008 health care reform and austerity measures cannot be captured by these surveys; the more general trends however can.

The CSO will publish a volume later this year but preliminary results were already published in April 2010. As Table 11 shows, weight is a major issue in the context of Hungarian health conditions. A high and growing rate of men in the 35-64 age bracket is either overweight or obese. About 70% of men above the age of 35 face this health risk. Except for younger cohorts the trends are growing in both sexes and age-groups.

Table 11: Rate of the overweight and the obese by sex and age, 2000-2009, in %.

	18-34	35-64	65-
Men			
2000	42.0	64.8	61.3
2003	42.1	66.1	68.7
2009	41.1	69.8	69.8
Women			
2000	22.5	56.4	59.4
2003	22.4	57.3	61.1
2009	21.3	57.3	65.9

Source: CSO (2010).

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

The other main health risk shows a more positive trend. As against obesity, which can and frequently does start in senior ages, smoking develops at a young age. Non-smokers usually do not start smoking above the age of 30 or 35 years. So the growing smoking rates among the elderly (see Table 12), in particular among women, are the consequence of the ageing of cohorts that started smoking before. In this respect it is good news that smoking, though still all too frequent by international comparison, generally decreased among young adults in the last decade. As in the case of obesity, women are less exposed to this health risk than men.

Table 12: Rate of regular smokers by sex and age, 2000-2009, in %.

	18-34	35-64	65+
Men			
2000	44.4	41.0	13.7
2003	43.1	39.0	15.9
2009	36.3	36.4	14.1
Women			
2000	29.0	28.2	3.4
2003	32.5	28.5	5.3
2009	25.6	28.8	7.0

Source: CSO (2010).

The ever tightening budget, and the growing private share in finances can affect OMC objectives, such as access to services as well as the quality of health care. Responding to the OMC objectives of ensuring access to and quality of health care services, a supervisory agency, the Health Insurance Supervisory Authority (HISA) was established in 2007 with the task of monitoring the waiting lists of providers and publishing monthly reports on access to health services. At the end of December 2009, there were about 22,000 patients on hospital waiting lists, up from 11,000 in December 2008. Hospitals are obliged to publish waiting lists of 18 various treatments, out of which 10 saw the waiting time grow over 2009. There is a large variation across institutes in terms of the waiting time, reflecting regional differences. The longest queues are for spinal stabilisation surgery, in some hospitals more than three years, whereas some other institutes have a waiting time shorter than one month for the same type of treatment. Waiting times are also longer on average in outpatient centres than a year ago.

There are regional inequalities in the geographic accessibility of health care services despite the high coverage. Facilities are concentrated in cities, and there is a lack of GPs and specialists in some rural areas.

2.2.4 Critical assessment of reforms, discussions and research carried out

2009 was a relatively silent and uneventful year in Hungarian health care compared to the turbulences of 2006-2008. The general balance of the reform battle is mostly negative. Restrictive budgets reduced the resources available to the system. Since the country was deeply hit by the economic crisis and had to apply for an EU-IMF stand-by loan, it is difficult to see where the new government would find the ways and means to avoid further down-sizing. Privatisation of social insurance failed. The unregulated and uncontrolled process of service privatisation in outpatient care and hospitals, which anyway met with the general suspicion of the public, seems to be halted. Cheap and efficient cost control measures, such as co-payment for hospital use and GP visits were withdrawn. In the light of the major efforts, the current system is not so different from what it was in 2005, except for fewer resources and

various reform alternatives that have become impractical for the years to follow due to heated political debates.

2.3 Long-term care

2.3.1 Overview of the system's characteristics and reforms

The Hungarian LTC system still bears some 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. A further feature of central planning, which, in principle, assumes the planner to be better informed than regulators of a market, that the planning process is biased towards sectors that are easier to measure. Since the efficiency and output of human capital investments and life-cycle financing in general is more difficult to measure, and, in addition, its time horizon is much longer than the five-year plan, these fields are residual for the planner compared to sectors such as heavy industry.

This structure is still recognisable although it has changed significantly since 1990. New providers, in particular charities, entered the scene; public administration became more decentralised; many of formerly informal activities became formal; and much of the demand that used to remain unmet now is met by supply.

LTC services are administrated 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 to home care. There is no cooperation between the two systems and none of them applies, let alone coordinates, a system of case management.

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. Universal coverage, based on the principle of social equity, is an expressed policy goal. Up to 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. Although the NHIF introduced personal health accounts from 2007, it was not meant to restrict entitlement but to increase revenues from the active-aged population. As a major change, in 2008 an eligibility test was introduced, which evaluates the physical and social conditions of applicants. According to expert estimates these restrictions diminished utilisation by about 10% among new applicants, which has a clear effect on an OMC objective in long-term care: accessibility.

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 care for a disabled family member. All other expenses finance services in-kind.

Data on demand for and access to LTC are outdated. As mentioned in the previous subsection, the last National Health Survey (NHS), which includes information on dependency and access to public long-term care services, was conducted in 2003. Table 13

summarises the main findings in this regard. The new ELEF data offer a chance to make new estimations later in 2010.

The NHS defined dependency in three levels: not dependent, dependent, severely dependent. The upper panel of Table 13 shows how many of those severely dependent have an access to residential care. The table reveals that even in the 80+ cohorts the access to residential care of people living with severe dependence is limited to a minority. The rate is higher among women than among men, in particular above the age of 70, due to household composition. Women are more likely than men to remain alone. The lower panel of the table displays the access of a wider group, those living with dependence in general, to home care. The figures reflect an even wider gap of unmet needs.

Table 13: Access to LTC services by level of dependency, sex and age, 2003, in %.

	Women				**Men**			
	60-69	70-79	80+	*60+*	60-69	70-79	80+	*60+*
Access of severely dependent people to residential care								
Residential home (social care)	13	32	41	*32*	13	13	28	*16*
Chronic nursing care (health care)	27	29	21	*42*	23	15	19	*19*
Access of dependent people to home care								
home care	3	6	10	*6*	2	5	10	*4*
meal on wheels	7	10	14	*10*	8	10	18	*11*
home care with signalling system	1	3	4	*3*	1	2	3	*1*
home nursing care	2	5	13	*6*	3	5	9	*5*

Source: Baji (2009).

Data on supply are more recent. The supply of residential care for elderly people has increased significantly over the past two decades. At the beginning of the 1990s around 30,000 beds were maintained in social institutions (1993: 28,000; data from CSO, 2009). By the year 2000 this had grown to 38,000 despite the rapidly diminishing government subsidies. A significant growth in subsidies between 1999 and 2003 led to a further increase in the number of beds, which was accelerated by development programmes by the central government. In 2006, the number of beds provided in residential homes reached 47,000, which was completed by a further 3,000 beds in care centres, which gave temporary residential care for up to one year. In effect, these numbers remained unchanged by 2008.

The average quality of the infrastructure in residential homes is rather low. Three quarters of rooms harbour three or more clients and have no separate bathroom.

The number of nursing beds in hospitals was 4,000-5,000 until the 2006 health care reform. The reform doubled the number of beds due to reclassification of beds (and related costs) from active to chronic. At the beginning of the 1990s, 27,000 people profited from these beds annually; and 45,000 in 2006. After the reform, the number of clients increased to 67,000.

2.3.2 Overview of debates/political discourse

Long-term care hardly attracts attention in national politics. Political debates on social protection are dominated by pensions and health care. In particular, similarly to health care, the LTC front was quiet in 2009 after a relatively active (and restrictive) 2007-2008. I found two events that may be of interest.

First, the Vienna-based European Centre for Social Welfare Policy and Research (ECV) and the Hungarian Institute for Social Policy and Labour held a large-scale public presentation of the newly released *Facts and Figures on Long-term Care – Europe and North America* of the ECV. This provided attention to LTC that the field rarely gets. The two-day conference covered a wide range of issues from cost projection and informality all the way through to labour force and migrant workers in LTC. It also gave an opportunity to compare Hungarian findings with international results.

The other related issue is the National Strategy for the Elderly (*Idősügyi Nemzeti Stratégia*), which was passed by Parliament in September 2009.[6] The strategy covers many age-related subjects such as active ageing, intergenerational relations, employability of the elderly, health conditions and others; the LTC system is an integral part. Passing the strategy as a Parliament resolution is an important step in the political institutionalisation of care for the elderly, which began with the establishment of the National Council on Ageing and Older People (*Idősügyi Tanács*), an umbrella organisation of various pensioners' associations, and its Secretariat at the Ministry of Social Affairs and Labour.

2.3.3 Impact assessment

For the moment, the available studies, mostly by the public administration and barely in academia, focus on institutions and use macro data. The last time budget survey, which is the primary source of estimation on informal care, is nearly ten years old. Results of the health survey mentioned above will be published later this year; the previous round dates back to 2003. The latest efforts by the administration to build up more specific datasets will contribute to the improvement of analysis.

2.3.4 Critical assessment of reforms, discussions and research carried out

There are clear signs of increasing standards in decision making in the administration of LTC. Efforts were made in order to build more effective capacities, such as administrative datasets and improved tools of analysis, which will result in more accurate mapping of needs, cost planning and cost projections for the coming years. Nevertheless, these small-step improvements still leave some key questions unanswered. In particular, the Hungarian LTC system has a dual structure. The health care system and the social care system hardly communicate with each other. Division of labour between the two branches is unplanned and frequently inefficient. The recent measures do not target this issue. The National Strategy for the Elderly can help in this respect.

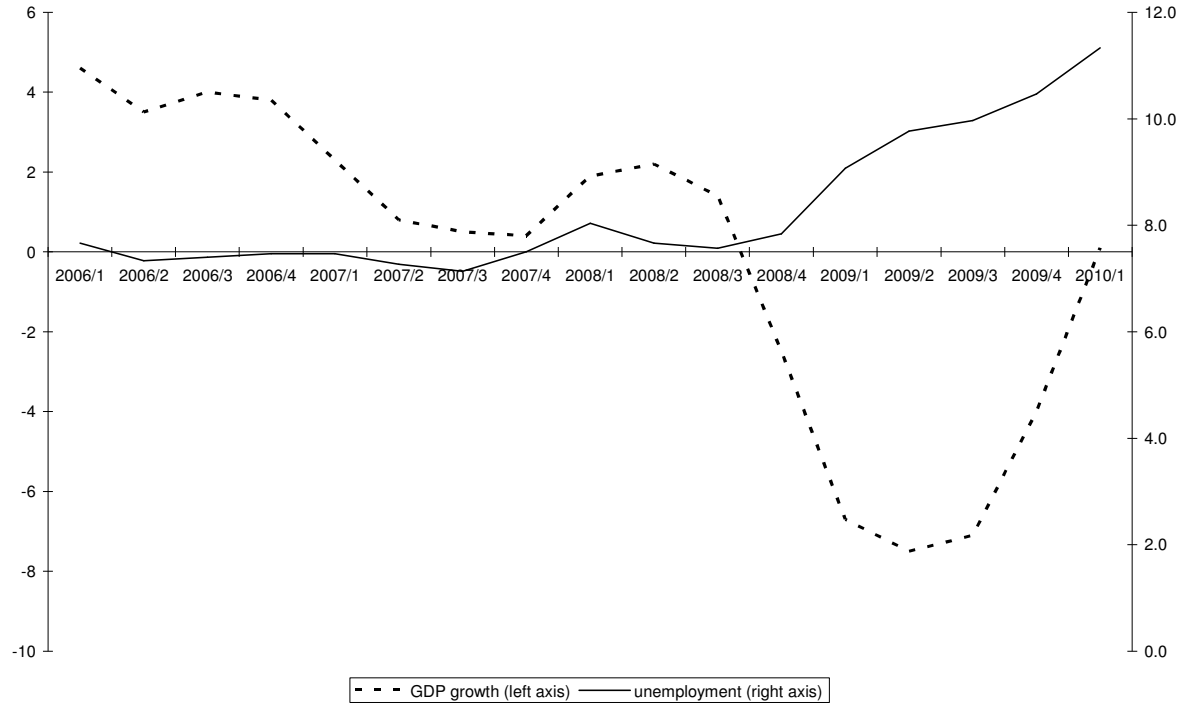
3 Impact of the Financial and Economic Crisis on Social Protection

There are two peculiarities of the crisis in Hungary that distinguish it from the typical international pattern. First, in contrast to most other countries of similar size and vulnerability to foreign markets, the Hungarian crisis is at least partly home-grown. Long before the financial and subsequent real economy crisis shook the world, the Hungarian Government

[6] See the full text at http://www.parlament.hu/irom38/10500/10500.pdf (in Hungarian).

expenses became unsustainable and required correction. Long overdue austerity measures were introduced in 2006-2007 and marked a declining path of growth, which made adjustments to the international turmoil particularly difficult. Figure 2 demonstrates that after a long period of steady growth at around 4% a year the economy rapidly slowed down from the beginning of 2007 and after the first weak signs of recovery a year later, it was severely hit by the international downturn. The Government had to adjust to the convergence programme, and, after the market for government bonds was left without buyers and the country had to apply for an EU-IMF stand-by loan, the country had to comply with the even stricter requirements of the named financial institute.

Figure 2: Growth and unemployment, 2000-2009, quarterly data.



Source: National Bank of Hungary.

Secondly, the crisis started in the Government and not in finances nor in production. This is particularly important from the perspective of social protection. The domestic debate did not consider social protection as a means to tackle the crisis but rather as its cause. Consequently, the Hungarian economy is exposed to the downturn without any cushion of demand stimuli. To the contrary, the Government had to cut back expenses, in particular in social protection. In this respect, the various chapters of social protection scored differently. Whereas expenditures on public health care decreased in real terms, pensions as a share of GDP even grew in 2006-2007. However, once the Government, under a new Prime Minister, finally dared to touch pensions, it made a large scale re-parameterisation in 2009.

It is worth noting that the Hungarian crisis showed many symptoms of the current Greek calamities but for the moment its outcome seems to be quite different. Hungary, not being a member of the Euro area could let her currency, the forint, devalue. The public resistance was surprisingly modest. Neither large-scale demonstrations nor strikes were organised. The public anger, at least for now, was channelled into the regular democratic process: the public took revenge on their rulers at the ballot box.

Neither does the current crisis seem to repeat developments of the transition crisis of the early 1990s in that it is unemployment services and social assistance rather than the pension system that absorbs tensions in employment. To the contrary, early retirement paths have been narrowed. In spite of the fact that the economy seems to have passed the bottom of the downturn, there are no signs of the massive structural reconstruction, which made skills obsolete on a large scale at the time of transition. The chances are now better to recover the employment of people who lost their jobs and avoid their escape to the pension system.

Many of the consequences of the current crisis on social protection were mentioned in the previous sections. Most importantly, revenues decreased and benefits and services had to be cut back or, in the case of health care, debts were accumulated. Opening the gateway back from mandatory private funds to full pay-as-you-go, which was also discussed above, can be considered, too, as a means to mitigate the consequences of the crisis. Below I will list some further ad hoc measures.

1. A World Bank analysis (Impavido and Rocha 2006) of the performance of mandatory private funds found the MPFs particularly risk averse. One of the responses of the FSA was to oblige funds to raise the share of stocks in their portfolio and at the same time introduce life-cycling elements. Offering a portfolio choice for fund members was optional in 2008 but, following the original regulation, it was to be made mandatory as from 1 January 2009. The regulation defined three types of portfolios, classic, balanced and growth. Funds offer choices and members may or may not choose. For most funds if a member did not choose, they would get the classic package if they were five years or less from retirement, and a balanced package if they were 15 years or less from retirement age. If a member chose a portfolio there was only one limit: the oldest group (five years from retirement age) was not allowed to opt for a growth package. However, these age brackets would have forced a number of fund members to realise losses by exchanging stocks to bonds when stock prices were at the bottom. A provisional regulation postponed the mandatory portfolio change by a year. Also, the deadline for reaching the regulated levels of stocks in the balanced and growth portfolios, originally set to 30 June 2009, were postponed until 2011.

2. In March 2009, the Government submitted a bill to Parliament including the following measures:

- Further decrease of the employers' contribution rate for health care. The employer health insurance contribution rate was decreased from 5% to 2% of gross wages (0.5% for benefits in cash, 1.5% for benefits in kind), as from 1 July 2009. The rate for the proportion of wages above double of the minimum wage remained 5% in the second half of the year. From 1 January 2010 the lower rates applied to all Forints earned.
- The maximum period of entitlement to sick pay after termination of employment was reduced from 45 to 30 days.
- Eligibility criteria for Child Care Fee (GYED by its Hungarian acronym) was toughened (longer period of employment will be required).
- Health insurance subsidies to benefits in kind were cut. In the case of pharmaceuticals price subsidies decreased in certain cases. The subsidy category of 85% was lowered to80%, which meant a HUF 18 billion cut in subsidies. In total, a HUF 30 billion cut of expenditure was expected, equivalent to an estimated 0.11 percentage point decrease in public expenditure as a percentage of GDP in 2009.

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CANPI (Central Administration of the National Pension Insurance Fund): http://www.onyf.hu/index.php?module=news&fname=onyf_left_menu_statisztika_osszefoglalo&root=ONYF

NBH (National Bank of Hungary): http://www.mnb.hu/engine.aspx?page=mnbhu_statisztikai_idosorok

NHIFA (National Health Insurance Fund Administration):
http://www.oep.hu/portal/page?_pageid=34,35856,34_19365817,34_1668804&_dad=portal&_schema=PORTAL

4 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

[R1; R2; R3; R5] HOLTZER, Peter (ed.): "Report of the Pensions and Old-age Roundtable", 2010.
http://nyugdij.magyarorszagholnap.hu/wiki/A_Jelent%C3%A9s_angol_nyelven

The Pensions and Old-age Roundtable, an expert panel, was convened by the Prime Minister in January 2007. It oversaw the development of a dynamic microsimulation model, based on large administrative datasets of the NPIF and the FSA, which was used in the analysis of five alternative reform scenarios. The alternatives the panel modelled are a point system with marginal minimum pension guarantees; a point system combined with an extended minimum pension; a non-financial defined contribution (NDC) system in two versions; and a fully-funded system. The two versions of the NDC model differ in that one keeps the current proportions of the public-private mix whereas the other calculates with a gradual full privatisation.

[R1; R2; R3; R5] HOLZMANN, Robert and GUVEN, Ufuk: "Adequacy of Retirement Income after Pension Reforms in Central, Eastern, and Southern Europe", 2009.
http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/03/19/000333038_20090319032815/Rendered/PDF/478120PUB0Adeq101OFFICIAL0USE0ONLY1.pdf

The book offers a high quality comparison of motivations for pension reform, policy trends, and characteristics of the reform system and an assessment of the performance of pension systems in seven former communist countries, Bulgaria, Croatia, the Czech Republic, Hungary, Poland, Romania and Slovenia. The Hungary chapter gives a detailed description of the institutional design and an assessment of the current and expected future performance of the pension system in terms of replacement rates (adequacy) and sustainability. The overall conclusion is that the 1998 reform restored long-term financial stability; later developments undermined it but the recent new measures improved sustainability again. Large cohorts with poor labour market career behind them are approaching retirement, which raises concerns over the adequacy of their old-age income. In addition, the performance of the funded pillar is far from satisfactory.

[R1; R4; R5] AUGUSZTINOVICS, Mária and KÖLLŐ, János: "Decreased employment and pensions: The case of Hungary", 2009.
In: Holzmann, R., MacKellar, L. and Repansek, J. (eds.): Pension reform in South-Eastern Europe. Washington DC: The World Bank, 89-104.
http://siteresources.worldbank.org/INTECA/Resources/pension_reform_in_see.pdf

The authors analyse the asymmetric effect of the transitional employment crisis of the early 1990s on various birth-cohorts. They find that nearly full employment of the 1970s and 1980s still protects currently retiring cohorts from exceptionally low pensions or the outright loss of eligibility but cohorts approaching the retirement age and soon reaching it will face this problem. In order to prevent this happening the authors list four potential solutions: reintroducing redistributive components to the system; delegating provision of minimum old-age income to other branches of the social assistance system; limiting social security to a flat basic old-age income system and make savings for old age voluntary; and finally providing a tax-financed basic pension and a contribution-financed earnings-related pension.

[R2] VITTAS, Dimitri, RUDOLPH, Heinz and POLLNER, John: "Designing the Payout Phase of Funded Pension Pillars in Central and Eastern European Countries", 2010.
http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2010/04/21/000158349_20100421103114/Rendered/PDF/WPS5276.pdf

This very recent publication by World Bank experts tackles the increasingly burning issue of the pay-out phase of privately managed mandatory pension funds established in the late 1990s and the 2000s throughout the entire region. After a phase of accumulation these funds are reaching maturation when they will start paying pensions on a large scale. The study discusses the key policy questions, the menu of potential retirement products and the crucial regulatory issues. In addition, it includes an inventory of the current plans for the pay-out phase in Estonia, Hungary, Lithuania and Poland.

[H] Health

[H1; H4; H7; L] «Idősügyi Nemzeti Stratégia» 2009
"National Strategy for the Elderly"
http://www.parlament.hu/irom38/10500/10500.pdf

The Strategy gives a detailed description of the demographic, health and labour market conditions and lifestyle of the elderly, and the social institutions that affect their daily life, such as the health care system and the long-term care system. In addition, it gives development targets in order to keep the older population in the labour market and in active life as long as possible.

[H1; H5] GRESZ, M. et al. (corresponding author: KRISZBACHER, Ildikó): "Acute care hospital bed occupancy rate in Hungary between 2000 and 2008" 2009

[H1; H5] VARGA, S. et al. (corresponding author: KRISZBACHER, Ildikó): "Bed occupancy rate of Hungarian intensive care units" 2009

[H1; H5] VAS, G. et al. (corresponding author: KRISZBACHER, Ildikó): "Regional differences in acute care hospital bed capacities following the 2006-2008 health care reform in Hungary" 2009
http://www3.interscience.wiley.com/journal/122522362/issue

These are three related posters presented at the 12th Annual European Congress of ISPOR (International Society of Pharmacoeconomics and Outcome Research) in October 2009, in Paris and published in the October 2009 issue of Value in Health, the scientific journal of ISPOR. They represent a new generation of research in the Hungarian health economics, which apply large micro datasets and high quality analytical tools and which can serve as the basis of evidence based policies.

[H2; H4] LACKÓ, Mária: «A rossz magyar egészségi állapot lehetséges magyarázó tényezői; összehasonlító makroelemzés magyar és osztrák adatok alapján, 1960-2004» 2010
"Explanatory factors of the poor health conditions in Hungary; Comparative macro analysis on Hungarian and Austrian data, 1960-2004"
http://econ.core.hu/file/download/mtdp/MTDP1007.pdf

Hungarian mortality statistics are poor in cross-national comparison but health conditions of working age men are particularly bad. The paper explains the trends of the mortality rate of working age (15-60) men in Austria and Hungary, two neighbouring countries of similar size and shared history. The two countries were at the same level in the 1960s but they started to diverge in the beginning of the 1970s. Explanatory variables of the model are indicators of life style (consumption of alcohol, smoking, supplementary working hours in the „second" (legal) and „hidden" (informal) economy), GDP per capita, health-care resources and labour market conditions (unemployment rate).

[L] Long-term care

[L] BUGARSZKI, Zsolt, ESZIK, Orsolya, SOLTÉSZ, Ágnes, SZIKLAI, István: «Egy lépés előre, két lépés hátra» 2010
"One step forward, two steps back"
http://www.tasz.hu/files/tasz/imce/NFU_jelentes.doc

The Hungarian LTC-system is highly institution-centred. This paper spells out a strategy of how to use structural funds of the European Union to build cheaper and more efficient home-based care networks. Its focus is not the elderly but people living with physical disabilities or mental problems. Based on evidence collected in European countries, in particular in the United Kingdom, the authors argue that a well-managed network of home-based care produces better results in terms of rehabilitation and integration from fewer resources than the traditional institutionalised care system.

5 List of Important Institutions

Corvinus University of Budapest, **Department of Economics, Health Economics and Technology Assessment Research Centre** (László Gulácsi)
Webpage: http://hecon.uni-corvinus.hu/corvinus.php?lng=en
Special research field: health technology assessment.

Egészségügyi Minisztérium – Ministry of Health
Address: 1051 Budapest, Arany János u. 6-8, Hungary
Webpage: http://www.eum.hu
The Ministry of Health is responsible for health issues like the health insurance, medical and pharmaceutical devices and public health.

ELTE University, Faculty for Social Sciences, **Centre for Health Policy and Health Economics** (Éva Orosz, Zoltán Kaló, Zoltán Vokó)
Webpage:
http://egk.tatk.elte.hu/index.php?option=com_content&task=blogcategory&id=42&Itemid=58
Special research fields: health technology assessment, health system analysis.

Semmelweis University, Health Services Management Training Centre (Péter Gaál, Éva Belicza, Miklós Szócska)
Webpage:
http://english.sote.hu/education-highlights/health-services-management-training-centre
Special research fields: health system analysis, human resources, health management, quality research.

Semmelweis University, Institute of Behavioural Sciences (Mária Kopp)
Webpage: http://www.usn.hu/english/content/info/?inst_id=18&page_id=2
Special research fields: health behaviour, mental health

Szociális és Munkaügyi Minisztérium – Ministry of Social Affairs and Labour
Address: 1054 Budapest, Alkotmány u. 3.
1373 Budapest, Postafiók 609
Webpage: http://www.szmm.gov.hu
The Ministy of Social Affairs and Labour is responsible for all tasks concerning the fields of Labour, e.g. employment programmes, and Social Affairs, e.g. human resources development operational programme.

University of Pécs, Faculty of Health Sciences (Imre Boncz)
Webpage: http://etk.pte.hu/html/intezetek.html
Special research field: health technology assessmen.t

University of Debrecen, Faculty of Public Health Medical and Health Science Centre (Róza Ádány)
Webpage: http://www.ud-mhsc.org/index.php?option=com_content&task=view&id=112&Itemid=67
Special research field: public health.

University of Szeged, Department of Clinical Chemistry (Andrea Horváth)
Special research field: health technology assessment.

National Institute for Strategic Health Research (ESKI) (György Surján, Márta Pékli)
Webpage: http://www.eski.hu/index_en.html
Special research fields: health informatics, health system analysis, health technology assessment.

TARKI Social Research Institute (TARKI) (István György Tóth, Róbert Iván Gál, Márton Medgyesi)
Webpage: http://www.tarki.hu/en/index.html
Special research fields: sustainability projections, income and social conditions of older workers.

Institute of Economics of the Hungarian Academy of Sciences (Mária Augusztinovics, András Simonovits, János Köllő, Zsombor Cseres-Gergely)
Webpage: http://www.econ.core.hu/english/
Special research fields: income and social conditions of older workers, voluntary pensions, early retirement, career projections by cohort.

The **Pension and Ageing Roundtable** collected practically all experts who work on pension research. The homepage of the roundtable is available only in Hungarian:
Webpage: http://nyugdij.magyarorszagholnap.hu/wiki/Kezd%C5%91lap

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(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.

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