Annual National Report 2009

Pensions, Health and Long-term Care

Hungary

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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 2008 and early 2009. 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.

2008 and 2009 are the years of restrictions in the Hungarian social protection system.

Health care and pensions were in the centre of political debates over the last years. Measures introduced in order to keep costs in health care under control and the failed attempt to privatise parts of health insurance led to the collapse of the ruling coalition in 2008 and the pressure for further cuts in cash benefits, pensions in particular, forced the prime minister of the minority government to resign a year later.

Rules of early retirement were severed and the retirement age was raised from 62 years to 65 years. 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. The benefit formula of entry pensions was rewritten and made less favourable. Indexation of already established pensions was also tied to GDP growth; the resulting mix of wage growth and inflation will result in lower indices. Some of the new rules are still in the legislative process but by the time the Commission reads this report will have most likely been accepted by Parliament.

In health care, the Government introduced a number of smaller but effective cost containing measures. Some of them, most notably user charges, had to be withdrawn under the pressure of a national referendum, which forced the Government to undo most of its reform steps. Some other measures remained intact. The threat of taxing the supply of pharmaceutics in case of overspending effectively controlled prices. The revised system of selecting the benchmark product successfully induced price competition among generic distributors.

In long-term care, new, restrictive rules of eligibility were introduced. Whereas before 2008 all residents above the age of 62 years were entitled to services, the new rules include a complex test of needs of the applicant.

The financial crisis hit mandatory pension funds, the second pillar of the pension system seriously. However, this does not translate directly to lower pensions. The funds are still in the accumulation period. They will start paying pensions in 2013 but the first large pre-funded cohorts will retire only in the late 2010s or early 2020s.

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

2008 and early 2009 were a busy period in the Hungarian social protection system. 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 73% by the fourth quarter of 2008, ended in abrupt corrective measures. In the first phase in 2006, the Government raised taxes and halted public investment projects freezing the economy long before the international downturn started. By the time the global recession began, the space of manoeuvring of the Government shrank to a minimum under the conditions of a revised convergence programme. Due to this and some other factors, most notably the large share of foreign denominated loans in household portfolios, the Government found it difficult to sell its bonds in the midst of the international financial turmoil. The country had to turn to a joint rescue package of the EU and the IMF in order to avoid a currency crisis accepting even stricter conditions than those of the convergence plan. This led to the second phase of the austerity measures, when not only taxes were raised but also social protection expenditures were cut back. Even that cannot protect a small open economy from the consequences of accelerating recession in its main export markets. The resulting downward modifications of prospects for output and public revenues force the Government to continuously revise its spending plans for the year of 2009 and introduce new restrictions one after the other.

Both pensions and health care were in the centre of public debate on the crisis. To start with, the political business cycle is rather strong in Hungary, and, in contrast to other New Member States (NMSs), it increased, not decreased in the 2000s. To a large extent, it is run by the social protection system. Since the pensioner society is an important constituency of the current Government, extra payments, such as a 13th month bonus were introduced driving the pension fund to deficit. In order to restore the balance, the Government tried to make savings and raise extra funds in health care. However, by the end, the health care reform led to the collapse of the socialist-liberal coalition in May 2008, and the unavoidability of large scale cuts in cash benefits forced the prime minister of the minority socialist government, Ferenc Gyurcsány, to resign in April 2009.

2.1 Pensions

2.1.1 Overview of the system's characteristics

Since the 1997 comprehensive reform, the mandatory pension system has been built in two pillars, a pay-as-you-go pillar with long tradition, and a new funded pillar, still in the process of maturation. There were many minor parametric corrections in the first pillar in 2008 and 2009 all with the aim of restoring the immediate and medium-term balance of the budget. Since the next years will see exceptionally large cohorts reaching the retirement age, much effort was made in order to keep the costs under control. Below this section, I will first list the many small restrictions. In the second pillar, the poor performance of the financial markets and the resulting loss of funds in the private accounts made reactions from the authorities necessary. Under the second subheading of this section, I will describe these provisions.

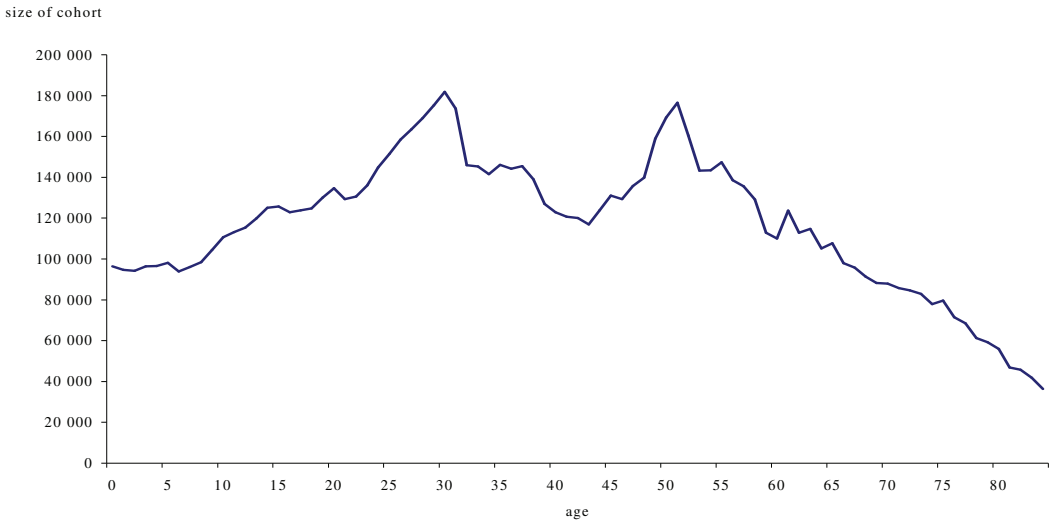
Changing rules in the first pillar

i) RETIREMENT AGE. For decades, the retirement age was 60 for men and 55 for women. After several postponements, it was raised to 62 to both genders in 1997. The transitory period ended in 1999 for men (the last male cohort retiring below the age of 62 was the 1939 year-group in 1998). For women the increase was sharper and it was phased in over a longer period. It ended in 2008 (the last female cohort to retire below the age of 62 was the 1946 year-group in 2007).

ii) EARLY RETIREMENT. Since a mere 6% (OECD 2008, 94) of the relevant cohorts retire at the official retirement age, the age related rules of eligibility to early retirement are more relevant. The 1997 rules separated early retirement without and with reductions in benefit (hereafter ER/o and ER/w, respectively) depending on the length of the contributory period. The extent of the reduction is a function of the number of missing years from the contributory period. From 2008, the eligible age to ER/o was 57 years for women and 60 years for men with the related required service period of 38 years. In 2009, the age of eligibility for women grew to 59 years. This was combined with an increase in the required service period to 40 years for both genders. Since the share of people with broken and fragmented labour force career is growing in the cohorts currently approaching retirement, these stricter rules will filter out a growing number of candidates.

Raising the effective retirement age is considered particularly urgent under Hungarian circumstances due to the pressure of demographics. As shown in Figure 1, an outstanding generation, the so-called Ratko-generation, named for a minister who oversaw the abortion ban of 1953-1956, is reaching the eligibility age of ER/o in the near future. The obvious effect of the stricter conditions for retirement is longer working careers and shorter retired careers or lower pensions for a sizeable age-group.

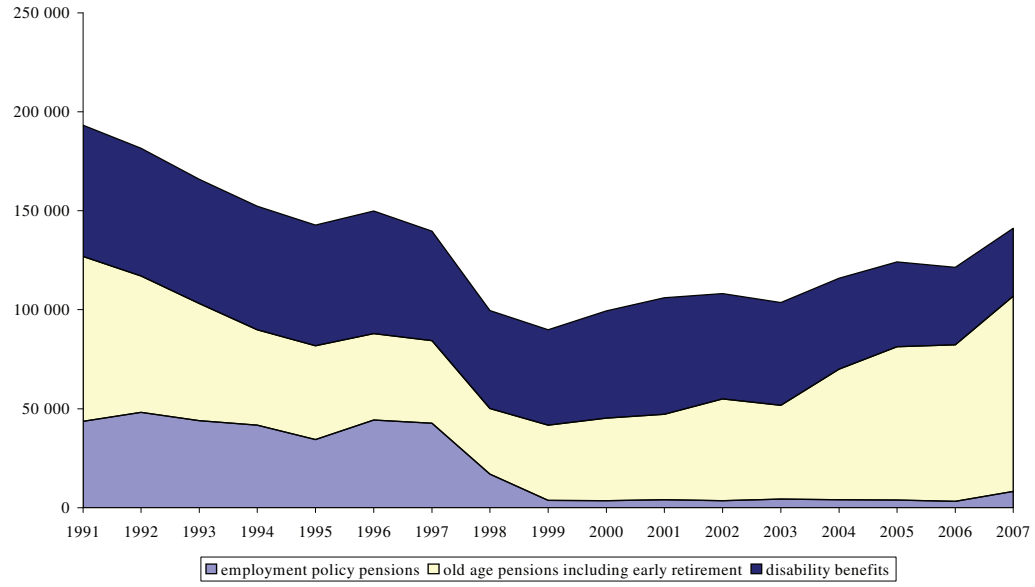
Figure 1: Age distribution of the Hungarian population, end of 2005



Those who meet the age condition but collected less service years can also retire below the official retirement age. The malus is defined by the length of service as well as age. If more than five service years are missing, ER/w is not allowed. According to Queisser and Whitehouse (2006, 29), the level of reduction is less than actuarially neutral and it does not create a strong enough incentive to stay in the labour market.

In addition, starting from 2013, the gate of ER/o will be closed and the conditions for ER/w will be further tightened. Accordingly, the current age of eligibility will be raised to 60 for women as well and the minimum requirement on the contributory period will be raised to 37 years. The malus rule will also change: it will no longer be attached to missing service years but only to age. One full year of early retirement will cost 3.6% loss of entry pension; another full year will supplement it with an additional 4.8%.

Figure 2: Newly established pensions of own-right by type, 1991-2007



Source: CANPI (2007, 54).

iii) An alternative route of leaving the labour market is disability pensions. Through most of the 1990s new establishments of this type of retirement were more frequent than the regular old age pension. In the last years, however, early retirement replaced disability as the most common alternative escape route. In Figure 2, I show the relative size of alternative routes of leaving the labour market from 1991.

There are three such routes: the so-called employment policy pensions (early retirement programmes under privileged rules for certain occupations; programmes financed by employers; and the so called pre-pension); old age pensions, including the early retirement paths described above, and disability pensions. The following trends are worth mentioning. The total number of retirements was particularly high in the in the early 1990s. Old age pensions lost ground over the same period. After the pre-pension was abolished and replaced by the pre-retirement unemployment

benefit, which is not part of the pensions statistics, , early leavers chose disability benefits and, in a growing number, the new way of early retirement. After 2001, stricter disability procedures and the easy availability of service-years-related early retirement reduced the number of new disability clients. By 2007, the relative share of old-age benefits among the newly established own-right benefits reached 70%. Most of that, however, is service-year-related early retirement.

iv) BENEFIT FORMULA. Starting from 2008 the authorities redefined net wages in benefit calculation. Thus far, net wages were gross wages less personal income tax. Under the new rule, the gross wage has to be netted by the employee share of social insurance contributions, currently 9.5% but in the past less, as well. This sever cut is partly compensated by the changing valorisation, that is the indexation of past earnings. In the old version, wages of the last three years were not valorised but were taken as nominal values in the formula, and the previous years were valorised to the level of the second year before retirement, not the level of the last year. In the new version, only the last year is not indexed. These corrections return some of the losses; the exact magnitude depends on the inflation rate in the last years of the labour market career.

v) BENEFIT. The so-called 13th month pension, an extra month of bonus was brought in gradually: one week in 2003, two weeks in 2004 and so on until by 2006 a full extra monthly benefit was paid out. It did not last long. In 2008, its amount was maximised at HUF80.000 (around €320), and in 2009, it was withdrawn from people below the age of 62, the retirement age.[1]

Changing rules in the second pillar

As everywhere, 2008 was a particularly difficult year for pension funds in Hungary. All combined, they produced a -21% return (preliminary data) in local currency. This was partly due to regulation that made private funds more exposed to equities just at the dawn of the depression. Offering portfolio choice for fund members was optional in 2008 but it was made mandatory from January 1, 2009. The regulation defined three types of portfolios, *classic*, *balanced* and *growth*. Minimal proportions of stocks were set for balanced and growth portfolios. Funds were obliged to reach these levels by June 30, 2009. In order to reduce the mounting losses, this deadline was postponed in the meantime until 2011.

There is life-cycling in the mandatory portfolio choice in that people at the age of 5 years from retirement age are not allowed to choose the growth portfolio. People, just one year below this age limit could have accumulated larger share of stocks in their portfolios in the year of optional portfolio choice, that is 2008. The reclassification of these clients to the more conservative class would have forced them to realise their losses. This reclassification was postponed by a year.

[1] The yearly average exchange rate of the Euro was HUF 251.25 in 2008. The monthly average exchange rate in May 2009 was HUF 289.2.

2.1.2 Overview of debates and the political discourse

The pension scene was active in the period considered here. Below I will briefly discuss three parametric proposals by Government and an influential pressure group.

Besides the parametric changes listed in the previous subsection, the Government submitted a further package of changes. Below I will refer to that as Gyurcsany-programme and show its key parameters in Table 1. Before it could have come into effect, however, the prime minister resigned. The new government, consisting of non-affiliated as well as socialist ministers and supported by the liberals kept the proposal on the agenda but redrew it to make it stricter (Bajnai-programme, named for the new, non-affiliated prime minister). Since these modifications have not gone through the legislation yet, I present them in this section. By the time the Commission reads the report, the new rules will probably have been in effect.

Table 1: Proposals for parametric changes, 2009

	Reform Alliance	Gyurcsany government	Bajnai government
retirement age	65 after a 3 years transition starting in 2010	65 after an 11 years transition starting in 2016	65 after an 8 years 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

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 academicians, consultants and specialists to write its programme. Since the new government introduced measures the reformers found close enough to their concept, the Alliance has been dissolved.

Indeed, neither government proposals fully met the demanded corrections but they clearly got close by the end. The Gyurcsany-programme aimed at a higher retirement age, 65 years, phased in by 2027. The Bajnai-programme shortened the transition period closing by 2022, still not 2012 claimed by the Alliance, but nearer to it. Instead of price indexation, the Gyurcsany government intended to apply a complex growth-dependent index. As shown in Table 2, the current Swiss-index, that is the 50-50% combination of price and wage growth, would have fully applied only if the annual growth of the GDP 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 keeps the price-wage shares but raise the growth-brackets.

Table 2: 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

Finally, the abolishment of the extra month bonus went through similar changes over the course of 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 conditioned on GDP growth (3.5% a year) and the financial stability of the budget of the general government.

2.1.3 Impact assessment

In this subsection, I will briefly summarise the findings of

- the pension chapter of the OECD country study on Hungary;
- the volume on the consequences of pension reform in Hungary by the Japanese PIE (Project on Intergenerational Equity);
- and the preliminary results of the Pensions and Ageing Roundtable, an expert panel.

All these contributions were published in 2008.

OECD

The OECD study discusses stability of public finances and sustainability of growth in general. This determines the focus of the pension chapter. The evidence regarding financial sustainability is based on the projections of the Economic Policy Committee (EU 2006) and the pension wealth calculations of the OECD. The results make the organisation conclude to the recommendations of further gradual increases in the statutory retirement age, starting as early as 2009; of modification of the benefit formula so that the effects of early or late retirement are actuarially neutral; and of a switch to price indexation. As shown above, these points appeared in the programme of the Reform Alliance and later, in watered-down versions, in legislation.

Besides financial sustainability, the study also discusses social sustainability. It calls the attention to low coverage rate of the active population, which is a consequence of the extended informal economy; the strong link in the current benefit formula between contributions and benefits, which may result in the growth of old-age poverty in the future. The chapter also analyses the work incentives created by the current rules and the pathways out of the labour market.

In addition, the chapter repeats the findings of an earlier OECD/World Bank study that found the operation costs of mandatory private funds of the second pillar too high and the portfolio too conservative in international perspective. Also, the chapter recommends improvements in the regulation of the payout phase, to become effective from 2013, and the corporate governance of the funds. More specifically, the property rights structure of the Hungarian pension fund is that of a mutual savings association. However, since most funds were established by large financial institutions, such as commercial banks and insurance companies, the link between members and management is less direct. Therefore, the OECD recommends the demutualisation of funds and the shifting of legal capacities and responsibilities to pension-fund managing firms.

PIE

The Project of Intergenerational Equity (PIE) was launched in 2001 by the Institute of Economic Research, Hitotsubashi University (Tokyo, Japan) and carried forward by the Center for Intergenerational Studies, newly established in 2007 within the Institute. The project covered a wide range of issues from the field of intergenerational equity. One of the subprojects focused on the effect of pension reforms in Eastern Europe and Central Asia on financial sustainability and redistribution across generations. The project produced numerous books in Japanese and English; one of them, a collection of papers on the consequences of the Hungarian pension reform, was published last year in English in Budapest (Gal, Iwasaki and Szeman 2008). The chapters, with one exception, appeared first as PIE working papers in Tokyo.

Some of the main findings include the demonstration that retirement is due to ageing of skills and not to physical ageing; that the pension system delivers negative returns to all cohorts born after 1930; that future generations would have got worse than currently active generations, should the 1998 pension reform have not taken place; that the so called transition crisis, that is the fall of employment between 1990 and 1997, had a devastating effect on the labour market career, and consequently future pensions, of the cohorts born between 1945-1959; that the maturation of the pension system largely contributed to the decrease of fertility, which was only partly compensated by the opposite flow of intergenerational transfers, family benefits.

Pensions and Ageing Roundtable (NYIKA)

The Pensions and Ageing Roundtable (NYIKA by its Hungarian acronym) is an expert panel convened by the prime minister in January 2007. It published its first report as well as its base-case model in 2008 and is expected to present its alternatives for a comprehensive long-term reform by the end of this year. During its time of operation, the NYIKA oversaw the development of 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 dataset of the National Pension Insurance Fund and the Financial Supervisory Authority.

The four main reform alternatives the panel is currently working on are a point system with marginal minimum pension guarantees; a point system combined with an extended minimum pension; a notional defined contribution system; and a fully funded system. Three of the alternatives are proposals by academics; the fourth proposal, the NDC-reform, has been submitted to Parliament by a smaller opposition party.

Similarly to its counterpart, the Education Roundtable, the NYIKA is expected to release a Green Book later this year.

2.1.4 Critical assessment of reforms

The 2007-2009 parametric reforms, the very recent steps in particular, will largely contribute to the restoration of long-term sustainability of the system. Based on the experience of similar measures in the past, higher retirement age and the tightening of early retirement will most likely extend the working life of cohorts affected and raise the overall employment level.

In general, the mix of the current corrections is more input-based (longer contributory period) than output-based (less pensions), although both components are present. This improves the achievements of the system in several of the Open Method of Cooperation (OMC) objectives, by enhancing sustainability at a low cost in terms of adequacy.

Some of the measures, such as the new benefit formula, the higher retirement age and stricter eligibility for early retirement will affect future pensioners. Other corrections, namely the withdrawal of the extra month benefit and the new index formula, will burden current pensioners as well. In this way the consequences of improving the balance of future generations are shared by active and retired cohorts.

None of the changes, however, seem to target the very root of the recent problems of the system, which is, unlike in many countries, not ageing, but the political exposedness. The country has effectively restored long-term stability a decade ago but the results of this painful operation were wasted. Unless distinctive measures are taken in order to bring in a longer time horizon to the decision making process, pressure will mount again, and politics will be tempted again, to soften the restrictions.

Instead of making the rules simpler and based on algorithms, the current changes complicate them even further. Some new rules, such as the indexation and the pension premium are particularly open to new political interventions. Others, such as the higher age of eligibility of regular as well as early retirement are likely to be more stable. In general, rules that affect current pensioners are more exposed to interventions, whereas those that shape future pensions are easier to insulate from short-term considerations.

This predicts future parametric manipulations, balancing between the widening space of manoeuvring once the crisis is over and the deeper problem of the pensions system that policy making should focus on in the first place: the growing pressure of rapid ageing of the labour market in the near future. Although, due to the latest developments, the age of leaving the labour market and entering the pension system will be higher in the large cohorts born in the mid-1950s than in their predecessors, the system dependency will still likely be negatively affected by the mid-2010s.

2.2 Health

2.2.1 Overview of the system's characteristics

Organisation

The Hungarian health care system went through major changes after the transition. Institutional reforms in the 1990s transformed the system from integrated state-socialist health ser-

vices to a split purchaser-provider contract model controlled by a self-government body. 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. 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 role in determining the benefit package or delegated regulatory role in health financing issues. The various financing methods, such as the price per patient for GPs, value of DRGs for hospitals, etc. are regulated by the Government, and the NHIFA has essential decision right only on the reimbursement decisions to pharmaceutical expenses.

A comprehensive reform plan of the Government aimed at decentralising the NHIF into NUTS2 level regional funds, which, in the final version of the plan that went to the 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 plan had to be withdrawn (see the section on political discourse for details), and the Government returned to less ambitious reform measures. The new Minister of Health, Tamás Székely announced a new health policy programme called “Security and Partnership: Tasks in Health Care until 2010”. The main goals of the programme focused on public health policy objectives, such as the continuation of national public health programmes with improved intersectoral cooperation in cardiovascular and cancerous diseases; developing the outpatient care capacities to enhance the performance of the system in terms of equity. As for the reorganisation of health insurance, the programme proposed a partial decentralisation of the national fund in order to improve the efficiency and quality of the services, but regional funding was not initiated. The government decree on the new structure was passed in December 2008; the reorganisation started at the beginning of 2009.

It remained largely unnoticed that, as part of the new approach, the Government put an end to the managed care experiment, which started in 1999 and was extended to 2 million people, one-fifth of the population, by 2004.

Financing

The source of data on financing is the OECD Health Data 2008 for the year of 2006. 2007 figures are preliminary. Recurrent costs of health services took 97% of total health expenditures (THE) in 2006. The rest, capital costs made up to 3%. The public-private mix was 70.9 vs. 29.1%. The main financier is the NHIF (60.1% of THE). Services are delivered predominantly by local government-owned public providers, who contract with the NHIFA, the administrative body of the NHIF. Local governments also finance some health costs of curative care and capital formation from their own sources amounting to 5.6% of THE. 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 (5.2% of THE).

Contributions to social insurance, and health care in particular, are subject to frequent adjustments. Subsequent governments feel forced by the international tax competition to make efforts in cutting total labour costs. As a consequence, the total rate of health contributions de-

creased from 23.5% to 11% between 1994 and 2009. This has been slightly compensated by a fixed-amount contribution, which lost much of its real value over the years.

The Government pays contributions on behalf of the so called non-payer social groups like students, pensioners, but the detailed method of the calculations made by the Ministry of Finance, has never been published. The amount of such contributions increased slightly in 2008 compared to 2007, but in nominal terms it is almost the same as it was in 2006. The total amount of government transfers to the NHIF decreased in 2008 since the refunding for the child-care-fee, a cash benefit financed by the NHIF was reduced in 2008 and fully withdrawn in 2009. 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.

Table 3: Health contributions, 1994-2009

	Proportional contribution (% of gross wage)								total	Fixed contribution (HUF)
	Employer				employee					
	general	for in-kind	for cash	total	general	for in-kind	for cash	total		
1994	19.5			19.5	4			4	23.5	
1995	19.5			19.5	4			4	23.5	
1996	18			18	4			4	22	
1997	15			15	4			4	19	1800
1998	15			15	3			3	18	2100
1999	11			11	3			3	14	3600
2000	11			11	3			3	14	3900
2001	11			11	3			3	14	4200
2002	11			11	3			3	14	4500
2003	11			11	3			3	14	3450
2004	11			11	4			4	15	3450
2005	11			11	4			4	15	3450
2006/1	11			11	4			4	15	1950
2006/9		7	4	11		4	2	6	17	1950
2007		5	3	8		4	3	7	15	1950
2008		4.5	0.5	5		4	2	6	11	1950
2009		4.5	0.5	5		4	2	6	11	1950

Notes:
Fixed contribution: per capita per month.
2006/1, 2006/9: changes through the year of 2006.
General, for in-kind, for cash: contribution separated in 2006 by purpose.

Voluntary health insurance exists in Hungary, but it is a negligible source of health care financing, an estimated 1.3% of THE in 2006 (CSO). There have been no essential changes since then. As for the provider side, the “functional privatisation” model, according to which a private provider delivers services using the publicly owned facility and infrastructure, gained recently importance, and is open to providers at all levels of care.

Expenditures

Of THE, 35.1% were spent on medical goods, 25.4% on inpatient care, 20.9% on outpatient care including day cases and curative and rehabilitative home care, 2.7% on long-term nursing care, 3.9% to auxiliary services (including clinical laboratory, diagnostic imaging, patient transportation, emergency ambulance services and blood supply), 6.8% on prevention and public health services, 3.1% on capital grants, 1.1% on administration, and 0.8 on not specified expenses.

Public expenses on pharmaceuticals remained under strict control by the NHIF, so the spending on medicines in the last year was almost the same as in 2007. Nevertheless, spending on medicines is still high, about 30% of the THE. Patients have to pay a considerable share out of pocket. Private spending on pharmaceuticals and other medical goods amounts to 14.6% of the THE.

Quality of services and access to 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 January 2009, there were 9,039 patients on waiting lists. About half of them have been there for more than 8 weeks. The longest queues are waiting for orthopedic hip and knee replacement surgeries, where the median waiting time increased significantly in 2008, and there is a long median waiting time for spinal stabilisation surgery. Nevertheless, the HISA reported that more than half of the patients could get the necessary care within one week, and only 1% of the patient had to wait for more than one month for the services in the framework of the advance registration lists of the out-patient facilities. Here, patients had to wait the longest for MRI diagnostic services and for some special dental services.

The self-reported unmet need for medical care indicator was 2.4 in 2006 (EU average: 3.1). At the same time, the number of doctor consultations was the second highest in the EU. 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.

2.2.2 Overview of debates and the political discourse

A comprehensive health care reform was one of the main priorities of the government elected in 2006. Key components of the reform plans included decentralisation and partial privatisation of the mandatory health insurance along the line of the health finance reforms of the Netherlands and Slovakia; weakening the incentives for excessive use of health services; rationalisation of the utilisation of capacities; and improvements in the transparency of the system. These plans had to be achieved under the restrictive circumstances of the convergence programme.

However, by the end of 2008, the structural elements of these policy objectives disintegrated. Between December 2007 and June 2008 the same National Assembly approved twice and then revoked practically the same bill. The legislation process brought about the intervention of the President of the Republic, László Sólyom, who sent the first version back to Parliament for reconsideration, and finally, after some 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.

In his criticism, the President cited the lack of a proper impact assessment; the visible resistance of the public and professional organisations; the expected increase of administrative costs, and what he called the lack of evidence of potential gains from competition. The referendum, that forced the Government to withdraw the bill, targeted the abolishing of user charges. The turn up of voters was unusually high for a Hungarian referendum (50.5%), and the rejection got an overwhelming majority (over 80%).

As a consequence, the mandatory health insurance remained public. In the meantime, however, functional privatisation of medical facilities, in particular inpatient centres, has started at the municipal level. Other reform measures, such as more strictly controlled patient routes, restructuring of the inpatient system and capping the public expenses on pharmaceutics and other medical non-durables, have shaped the characteristics of the system more deeply.

2.2.3 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 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 Parliament set up a permanent subcommittee of the Permanent Committee on Health Affairs at the end of 2006, which should deal with the evaluation of social and economic impacts of the health regulation. The subcommittee held six sessions in 2007 and only one in 2008.

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 the National Assembly for reconsideration. The Ministry of Health (MoH) and the NHIF do not publish performance reports on the health care system, but the WHO initiated recently a project in this topic in cooperation with different bodies of the Government.

2.2.4 Critical assessment of reforms

The cost control components of the reform would have hurt many interests to start with but the pressure of the convergence programme, which the Government had to manoeuvre under, amplified the resistance. Nevertheless, many of these measures were effective in decreasing utilisation. The visit fee decreased GP visits by 20%, special care visits by 6-10% for a low price (the total revenue collected from the user charges was about €52 million, which was around 0.71% of THE in 2007).

The threat of taxing the supply of pharmaceutics in case of overspending effectively controlled prices. The revised system of selecting the benchmark product successfully induced price competition among generic distributors. In 2008, the general price decrease was 13% in the case of 746 products. In addition, since the end of 2007, the liberalisation of establishing pharmacies, the growth potential in the number of new pharmacies seems to be unbroken. Public expenditures were also reduced by cutting subsidies of medicines, which increased contributions by consumers. The reorganisation of the inpatient system (a re-classification of

active beds to chronic beds, the cut of the number of hospital beds in general and some other measures) also helped keeping what the Government considered unjustified utilisation under control.

There are price tags on these successes, though. The decrease of financial resources resulted in shortages in doctors and nurses, which cause a growing concern among managers and health politicians, although the actual magnitude is not known. The Public Office for Health Care Licensing reported on 730 special certifications issued to doctors in 2008. The request of such a certificate can be connected with job-seeking in abroad but this number is likely inflated by multiple requests. The media sometimes mention higher numbers and report on county hospitals struggling to get qualified specialists to some of their departments.

Also, it is unknown yet how the reforms affected access to health care and health conditions of the population.

The programme for identifying contributors and filtering out non-payers perceptibly decreased evasion. The MoH reported that the NHIF clarified the entitlement rights of 760,000 people in 2007 and 2008. The number of the contract-based, as against employment-based, social insurances more than doubled over the same period clearly signalling the retreat of evasion.

The technical efficiency of the health care system improved considerably in recent years. Whereas, the number of beds in hospitals has been reduced by 27% since 1994, and the occupancy rate remained almost the same, the number of patients discharged from acute hospital wards was at the same level in 2007 as in 1994 and the number of medical interventions in out-patient care increased by 59%. The average length of stay in acute hospital beds decreased by 41%, in chronic hospital beds by 25% over the same period. At the same time public expenditure on health decreased from 7.1% to 5.2% in terms of GDP between 1994 and 2007. Some experts expect a further decrease to 5.0% in 2008 and an increase in 2009. The latter is mostly due to the severe decrease in the denominator, the GDP, as well some large investment projects co-funded by the EU. All told, Hungary spends significantly less on health care from public sources than the European average.

The reorganisation of hospital beds in 2007 and the strict volume limit set for providers combined with user charges caused a significant drop in the performance of providers. According to preliminary data, the main output indicators of the sector have not changed significantly in 2008, whereas public health expenditures remained nominally constant resulting in a lower share of GDP, and an improving technical efficiency in 2008.

An important caveat is needed here. Part of the impressive improvement in technical efficiency may stem from manipulated reporting and from the improved administration of the reports. Indeed, there is much anecdotic evidence of, if not systematic research on, “DRG creep”. There are no effective mechanisms in preventing unjustified hospitalisations, and providers have a strong incentive to increase their output until they reach the volume limit set by the regulator.

2.3 Long-term care

2.3.1 Overview of the system's characteristics

Eligibility

Universal LTC coverage, based on the principle of social equity, is an expressed policy goal for Hungary. Until 2008 only age counted for eligibility. Anybody reaching the age of 62 years, the retirement age, was entitled. No means tests or personal insurance history were required; not even the extent of lost physical or mental capabilities was taken into account.

Since January 1, 2008 eligibility has been restricted to those who need care for more than 4 hours a day. People who need care 2-4 hours a day are entitled to home care service. For needs below 2 hours a day no care is financed from public sources. Need is established by a complex assessment process. Applicants are evaluated by 16 dimensions, including various aspects of their ability to live independently as well as their social circumstances. These dimensions are measured on a 1-to-5 scale and an algorithm translates the resulting values to time.

According to expert estimates, these restrictions diminished utilisation by about 10% among new applicant, which clearly affect an OMC objective in long-term care, accessibility.

Benefits and services provided

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. All other expenses finance services.

The two main types of LTC services in health care are nursing care in nursing departments of hospitals and home nursing care. The three main types of LTC services in social care are home care (with meal on wheel service), day care and residential care. The number of authorised places in institutional care is just below 50 thousand; nearly completely filled. Experts say the waiting list, about 17 thousand people, is largely inflated by double or triple registration; they estimate the effective waiting list to about 5-7 thousand.

Administration

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 home care. There is no cooperation between the two systems. According to a recent report by the State Audit Office (2008) the optimal division of labour would be to care for people who need special health services in the health care system, whereas those who do not, but whose physical and mental stability depends on special care, would stay in institutional care facilities. The report finds this frequently not to be the case.

Formal care services are provided for mainly by local governments. The presence of for-profit and non-profit providers is secondary. LTC for older people living at home is mostly informal.

Funding

Overall the financial system of public LTC subsidises supply. Services are funded directly and those in need of care do not get cash grants so as to buy services. Private insurance schemes are not involved.

Operational costs are financed by the NHIF for health care and the government budget for social care. Local governments receive normative support from the Government by the number of beneficiaries they care for. It is set for each type of service by the Government each year. It is meant to fund services, not tasks. There are services for which there is no normative support. Local authorities frequently supplement normative support from their own revenues depending mostly on resources available. In addition, they may charge user fees. The exact amount varies from service to service. Algorithms of its calculation are given by regulation, taking the user's income into account. The maximum fee is 80% of monthly income for residential care and 20-30% for home care. There is a difference in the amount of user fees in the governmental and in the non-governmental sector.

The ratio of the three sources, central government, local government and beneficiary, can be different, depending on the type of the benefits and the financial situation of the given local authority.

2.3.2 Overview of debates / political discourse

LTC reforms have started in 2008 by imposing restrictions in availability. The government programme on *Shifting paradigm in social services* (Paradigmaváltás a szociális szolgáltatások területén) implies further measures in the next years. More specifically, it suggests preparations for setting up a case management system at local level; introduction of a voucher system; relocation of capacity coordination and resource allocation to the regional level as well as other preparatory steps.

More importantly, capacity building programmes that started in 2006 have concluded or will conclude in the near future offering better quality data and more evidence-based policies. These new tools include the evaluation system of homogenous needs (detailed above), a central register of social services and a standardised methodology in cost calculation.

It has to be added that these new programmes hardly reach the sensation level of national politics. Political debates on social protection are dominated by pensions and health care.

2.3.3 Impact assessment

Both administration and academic research require more data for proper analysis than currently available. The last national survey on health conditions, which could serve as a basis for the estimation of needs, was conducted in 2003. It will be repeated later this year or early next year. Informal care can be best estimated from the time budget survey (http://www.tarsadalomkutatas.hu/termek.php?termek=TDATA-F48c , which saw its fieldwork in 2001. The latest efforts by the administration to build up more specific datasets will contribute to the improvement of analysis. For the moment, however, the available studies, mostly by the administration and hardly in the academia, focus on institutions and use macro data.

2.3.4 Critical assessment of reforms

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. I expect the effects turning up in the next years in the form of more accurate mapping of needs, cost planning and cost projections.

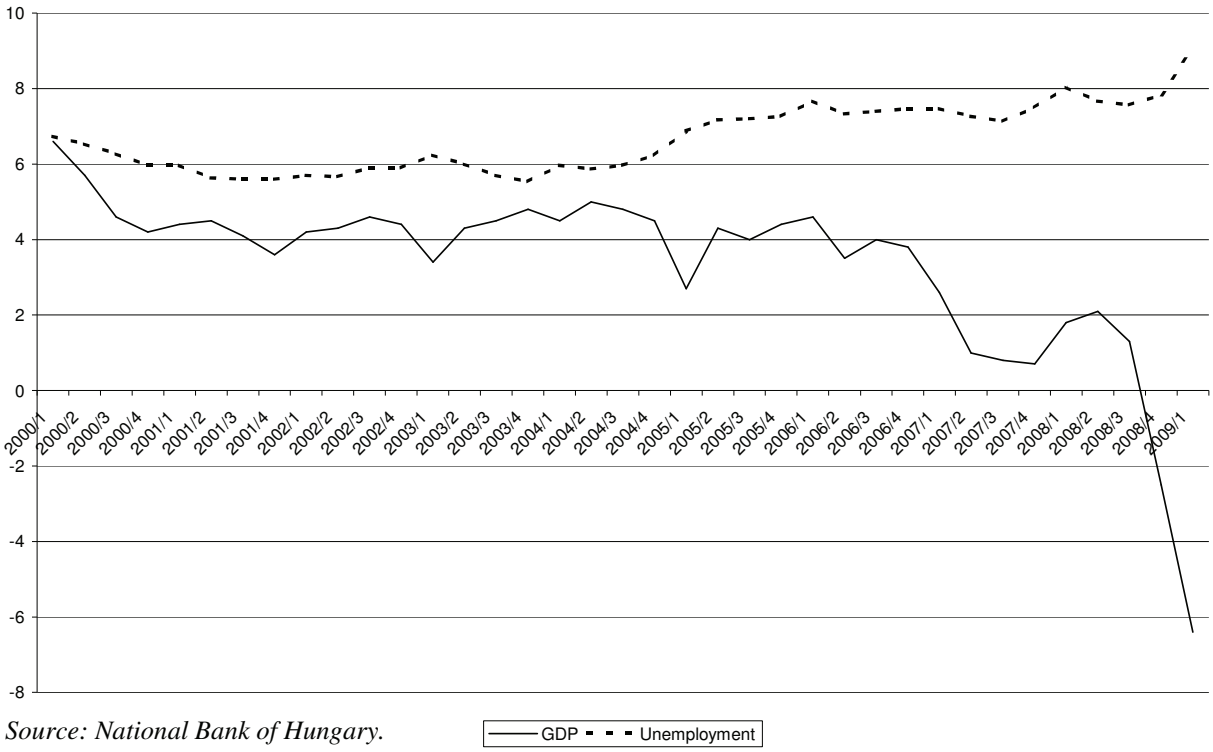
Nevertheless, these small-step improvements still leave some key questions unanswered. In particular, the Hungarian LTC system has a dual structure. The health care system and the social care system hardly communicate with each other. Division of labour between the two branches is unplanned and frequently inefficient. The recent measures do not target this issue. Indeed, addressing it would require more attention from the Government.

3 Impact of the Financial and Economic Crisis on Social Protection

Introduction: Peculiarities of the crisis in Hungary

There are two peculiarities of the crisis in Hungary that distinguish it from the typical international pattern.

Figure 3: Growth and unemployment, 2000-2009, quarterly data



Source: National Bank of Hungary.

First, in contrast to most other countries of similar size and exposedness to foreign markets, the Hungarian crisis is homegrown and not merely a result of difficulties in special sectors, such as real estate development, or low demand in export markets. Long before stock ex-

changes started to decline after the summer of 2007 and the consequences spilled over to the real economy in the Autumn of 2008, Hungarian Government expenses became unsustainable and required correction. Long overdue austerity measures were introduced in 2006 and marked a path of growth and employment that makes adjustments to the current real economy crisis particularly difficult. In Figure 3, I demonstrate, 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 were left without buyers and the country had to apply for an EU-IMF stand by loan, to the even stricter requirements of the named financial institute.

Second, the crisis started in the Government and not in finances nor in production. That is particularly important for a social protection aspect. The domestic debate is not considering 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 has to cut back expenses, in particular in social protection.

Social protection: the solution or the problem

The general consent of macroeconomic analysts say that the main reason of the particular exposedness to the international crisis is overspending on social protection and, in particular, the high share of cash payments that create counterincentives to work. Yet, the 2006 macroeconomic correction that rapidly reduced the budget deficit was based more on tax increases than cuts in public spending.

In this respect, the various chapters of social protection scored differently. Whereas expenditures on public health care decreased in real terms, pensions increased as share of GDP. Despite the chronic overspending of the general government and the required correction in 2006, pension expenditures kept growing in the last years. The social security fund spent 8.3% of GDP on pensions (old-age, disability, survivors) in 2000; this rate grew to 9.9% by 2006 and 10.9% by 2008. On top of this, the central government pays out an additional 0.6-0.8 percentage points a year. This increase went in parallel with a stagnation or slow reduction in the number of beneficiaries from 3.1 million in 2000 to 3.0 million in 2006 and 2008.

The high number of beneficiaries (30% of the population) is not a particular ageing phenomenon but to a large extent a legacy of the transition crisis of the early 1990s, when subsequent governments opened the gate of the pension system to absorb a significant part of the employment shock.

For the moment, the current crisis does not seem to repeat this development. Although the economy still has not reached the bottom of the downturn, for now there are no sings of the massive structural reconstruction, which made skills obsolete in a large scale at the time of transition. Chances are better to recover the employment of people who lose their jobs now and avoid their escape to the pension system. Also, for the moment it seems that the pension system will not absorb much of the current employment crisis. To the contrary, early retirement paths have been narrowed. Table 4 displays the employment gains and losses by age group and gender between the last quarter of 2007 and of 2008. There is a gender pattern in the numbers (women are less affected than men; indeed, female employment grew over this period). The age pattern is much less clear. The true affect of the crisis, however, will only appear in the 2009 data, not yet available.

Table 4: Changes in the employment rate between 2007 4th quarter and 2008 4th quarter, by gender and age

	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
Men	-0.5	-1.7	-3.7	0.8	-0.9	-2.0	0.0	1.4	-1.0	-2.0	-0.8
Women	-0.5	1.2	-1.4	-0.3	0.4	1.3	0.4	0.7	1.0	0.8	0.2

Source: Central Statistical Office.

In contrast, public health care is losing ground. Between 1994 and 2007 the public expenditure on health decreased from 7.1% to 5.2% in terms of GDP. In order to manage the crisis the Hungarian Government is intent to take further restrictive steps in health care. On 13 March 2009, the Government submitted a bill to the parliament including the following measures:

- Further decrease in the employer contribution rate. The employer health insurance contribution rate is to decrease from 5% to 2% of gross wages (0.5% for benefits in cash, 1.5% for benefits in kind) from July 1, 2009 on. The employer contribution rate for the part of the wage above the double of the minimum wage remains 5%.
- The maximum period of entitlement to sick pay after termination of employment is to decrease from 45 to 30 days.
- The criteria of eligibility for Child Care Fee (GYED) are to be toughened (longer period of employment will be required).

Health insurance subsidies to in-kind benefits are to be decreased significantly as well. In the case of pharmaceuticals the percentage of the price subsidised is decreasing in certain cases. The subsidy category of 85% is to be changed to 80%, which means a HUF18 billion cut in the subsidies. HUF billion cut of expenditures on outpatient care is planned. In total 30 billion HUF cut of expenditures is expected that means an estimated 0.11 percentage point decrease in public expenditure as a percentage of GDP in 2009.

The economic downturn will likely affect the revenue side of the social protection system. For the moment, only sporadic information is available of how much this will take place. According to the second monthly report of the NHIF only 91.6% of the – time proportionately – expected revenues were realised due to the crisis, in particular 89.6% of the contribution revenues were collected. This means a 9.8 billion HUF loss of revenue in the first two months.

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.

[H1][H4][R1][R2][R3][R5] OECD: "Reforms for Stability and Sustainable Growth: An OECD perspective on Hungary", 2008.

The book provides analyses of a wide range of issues. Separate chapters deal with health care and pensions. As for the former, the study anticipates the planned but later withdrawn decentralisation and partial privatisation. It demonstrates the mixed international experiences of privatisation and focuses on potential risks and advantages. Other sections discuss fine-tuning and extending the supply-side reforms and improving the quality and economic regulation. In the pension chapter, the organisation conclude to the recommendations of further parametric reforms many of which soon appeared in the public debate and later, in watered-down versions, in legislation. Besides financial sustainability, the study also discusses the low coverage rate of the active population, and the potential for future increase in old-age poverty.

[R1][R2][R4][R5] Gál, Róbert Iván, Iwasaki, Ichiro and Széman, Zsuzsa (eds.): "Assessing intergenerational equity: An interdisciplinary study of ageing and pension reform in Hungary". Budapest: Akdémiai, 2008.

This book is a collection of academic papers organised into three parts. The chapters, with one exception, appeared first as PIE working papers in Tokyo. Part I contains a chapter on demography and two chapters on the sociology of ageing. The latter find that ageing is a social rather than a biological phenomenon to a large extent and retirement from the active world is due to ageing of skills and not the ageing of the body or the mind. Part II includes three separate chapters, each covering a pillar of the pension system. Part III is a small collection of papers on issues related to intergenerational equity. The first one undertakes to estimate net present values of lifetime contributions by cohort and the consequences of the 1998 comprehensive reform on redistribution across entire life-paths. The second paper draws employment and wage careers by cohort and their aftermath in the retirement careers. It demonstrates the devastating effect of the transition crisis on particular cohorts, the "losers of the transition". The last chapter contains a time series analysis on the effects of the pension system and family benefits on fertility.

[R1][R2][R4][R5] Nyugdíj és Idősödés Kerekasztal:

- <<Első jelentés a Nyugdíj és Idősödés Kerekasztal 2007.évi munkájáról
- Eredmények a "változatlan nyugdíjrendszer" paradigmájának társadalmi és gazdasági hatásvizsgálatáról>>,

"Pensions and Ageing Roundtable (NYIKA) reports:

- First report of the Pensions and Ageing Roundtable
- Modelling the "unreformed pension system"

The Pensions and Ageing Roundtable (NYIKA by its Hungarian acronym) is an expert panel convened by the prime minister in January 2007. It released its first report in March 2008, which established the potential alternatives of major paradigmatic pension reforms. In October 2008, results of the base-case model were published.

[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

[H1][H4][R1][R2][R3][R5] OECD: "Reforms for Stability and Sustainable Growth: An OECD perspective on Hungary", 2008.

The book provides analyses of a wide range of issues. Separate chapters deal with health care and pensions. As for the former, the study anticipates the planned but later withdrawn decentralisation and partial privatisation. It demonstrates the mixed international experiences of privatisation and focuses on potential risks and advantages. Other sections discuss fine-tuning and extending the supply-side reforms and improving the quality and economic regulation. In the pension chapter, the organisation conclude to the recommendations of further parametric reforms many of which soon appeared in the public debate and later, in watered-down versions, in legislation. Besides financial sustainability, the study also discusses the low coverage rate of the active population, and the potential for future increase in old-age poverty.

[H5] Erdész, Diána, Kassai, Lili, Brandtmüller, Ágnes, Dr. Gulácsi, László, Dr. Boncz, Imre: "Priority setting in health care decisions: Evaluation of the outcome of a EUROBAROMETER survey", IME, 2008/1

The aim of the Eurobarometer survey performed in six European countries in 1998 was to map public attitudes to health care priority setting and rationing. The paper discusses international results and compares it with evidence collected in a Hungarian pilot survey carried out in 2006 with 178 participants. Although the survey was not representative for Hungary, the authors believe that the results reflect the public approach towards health care politics and are suitable for setting up hypotheses and preparing further studies. The article gives an overview on the preferences of the population in other countries. Methods: Descriptive data analysis of survey output

[H4] Gaál, Péter: "Analyses of Act I/ 2008 on Health Insurance Funds from the point of view of health care providers", IME, 2008/2.

The paper gives a thorough analysis of the key steps of the health care bill on health insurance funds, which was passed by the Parliament on February 11, 2008 but was later withdrawn. The milestones of the law included the establishment of for-profit health insurance funds, the entering of private investors into the system, the contracting process with health care providers, their control and, on the basis of these, the competition between providers, which, by expectations of the Government, would have increased the income of providers and health care workers. The author expressed his

doubts in the article whether private investors would have entered the market, but even if they did, significant improvement was uncertain from the point of view of health care providers, since the bulk of the required investment would have been used for the establishment of the multi-insurance model, and significant savings could have primarily been realised by further downsizing the provider sector (hospital closures). According to the author, all these would have meant that the otherwise limited scope for provider competition would have been limited further, while there would have been no opportunity for a substantial increase in wages without massive lay-offs. Methods: Qualitative policy analysis

[H4] Sinkó, Eszter: "Health policy analysis of the recent history of the restructuring process in the health insurance system, 2006-2008", IME, 2008/4.;6.

This article analyses the main events and political motivations underlying the changes in the governance structure of the Hungarian health care system. The author finds that the governance of the health insurance system between 2006 and 2008 was not based on evidence and was not carefully thought after. Methods: Qualitative policy analysis

[H4] Tóth, Árpád: "Analysis of the regionalisation of the health system", IME, 2008/3.

In the Hungarian health care system, various measures were taken in order to settle the regional management of regional health care provision. This publication gives a good overview on the history of regional boards, evaluates their activities and the socio-political environment, in which these boards had to operate. The author concludes that regionality is a slogan; the influence of the Regional Board of Health on the regional health policy is negligible.]

[L] Long-term care

[L] State Audit Office: <<Jelentés az önkormányzati kórházak és bentlakásos szociális intézmények ápolásra, gondozásra fordított pénzeszközei felhasználásának ellenőrzéséről>>, "Report on the supervision of the use of funds on nursing and caring by hospitals and institutional care facilities of local authorities", 2008.

The State Audit Office (SAO) conducted the so far most comprehensive supervision on the functioning of long-term care facilities. Response and cooperation of the surveyed sector with the authority was obligatory; thus the results can really be considered inclusive. The main focus of the report is the coordination, or more the lack of it, between the health care sector and the social sector. The SAO concludes that the estimation of needs is not sufficiently evidence-based; that the sector is underfinanced; and that the two parallel sectors should be better coordinated.

[L] Ministry of Social Affairs and Labour: <<Javaslat a szociális szolgáltatások átalakításának fő irányaira>>, "Recommendations for the main directions of restructuring social services", 2007.

The short report summarises the main achievements and further plans for restructuring social services. The programme is not particularly far-reaching, rather, it focuses on small administrative steps that can establish more structural reforms.

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 assessment

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/employment_social/progress/index_en.html