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Analytical support on social protection reforms and their socio-economic impact

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Pensions, health and long-term care

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Table of Contents

1 Executive Summary

After three years of parametric adjustments to the financial crisis and two years of far-reaching reforms 2013 was a year of consolidation in social protection in Hungary. Only minor corrections were made on the structure that took shape in 2011-2012 and the new institutions started operation.

The two keywords of the 2011-2012 reforms are centralisation and the increasing role of the state.

In the *pension* system, the funded second pillar was renationalised and to a large part defunded. Three quarters of the portfolio was used for debt conversion (63%) or it is still held by the government (12%) in the Pension Reform and Debt Reduction Fund or the National Asset Management Inc. The rest was either liquidated in order to finance the deficit of the first pillar (16%) or distributed among former members (8%) or lost in revaluation (2%).

The government sent another strong message to the pension field by dealing simultaneously with the alternative routes of early retirement. Previous efforts failed because once the administration closed one exit route another opened wider. The new regulations locked many of these ways and narrowed those that remained open making retirement below the standard pensionable age more difficult. Since most recipients whose benefits have been in payment kept their eligibility the effects will be felt gradually. Nevertheless, the administration's efforts to raise the effective retirement age are not consistent. A new path of early retirement was opened allowing women to retire after 40 contributory years (including periods on maternal leave).

The Hungarian pension system, and in general the public budget, is exposed to a strong political business cycle. Since 2014 is a year of general and local elections this is a tendency to watch closely in the months to come whether and to what extent previous cycles repeat themselves.

In the *health care* system the government opted for a systematic move on the way to a national health service by further centralising the allocation of capacities; establishing a new hierarchical system of actively managed patient routes; organising more effective competition of generics in public purchases of pharmaceutics; and making steps towards replacing contributions by taxes. The focus of the reform is the new system of managed patient routes. On the local level outpatient centres take on this responsibility. At a higher level Regional Health Management Centres (RHMCs) were established. RHMCs are supervised by the Institute of Pharmaceutical and Medical Quality Control and Organisational Development, a newly established background institute of the State Secretariat for Health Care of the Ministry of Human Resources. The new institute also organises services beyond the competence of RHMCs.

Over the last five years public *long-term care*, a small and inadequate system, which still leaves much of the need unmet, saw an expansion of home-based care. Yet, despite of this development the bulk of long-term care activities are left to households or an informal market. Empirical evidence shows that familial relations play a particularly important role in old-age care in Hungary.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

After the funded national pension system, established in 1929, collapsed in the Second World War, a pay-as-you-go scheme replaced it by 1950. It was extended, although under less favourable conditions, to workers of the collectivised sector of agriculture in 1958. Conditions were made uniform in 1975 making the scheme a universal national programme managed by one single administration offering near-full coverage and providing the sole financial source for the majority of older people. A comprehensive reform in 1997 significantly downsized the system by raising the retirement age and cutting back the indexation of pensions in payment. However, due to tax competition that resulted in a cut of contribution rate and the frequent misuse of the system for short-term political gains, these results were soon lost and a significant parametric adjustment became unavoidable. The 1997 reform package also aimed at building up a mandatory funded pillar in order to diversify the risks of old age income. The initial accumulation period corresponded with a window of demographic opportunity. However, in the end this chance has been missed in that the transition phase was financed all but full from government debt.

These developments led to a series of significant corrections in 2009-2011 including parametric adjustments, such as further increases in retirement age and an additional cut in indexation; the nearly complete defunding of the second pillar and the reversal of pre-funding; and a series of forceful measures against early retirement.

2.1.2 System characteristics

The institutional structure of the Hungarian pension system is simple in international comparison. It is safe to say that after the almost complete defunding / re-nationalisation of the second pillar it is a single-pillar system complemented by a small supplementary voluntary funded scheme.

The system finances 2.0 million old-age pensions. One third of the recipients of this benefit, 665 thousand people, receive a supplementary payment, most often survivors' benefit. An additional 196 thousand people is paid a survivors' benefit as his/her main or exclusive allotment. Since 2012 disability pensions are paid from the Health Insurance Fund (HIF) and most early retirement benefits (many of them in a phasing-out period) are paid from the National Fund for Family and Social Policy, (*Nemzeti Család és Szociálpolitikai Alap*). The only notable exception is the special early retirement programme for women having collected a 40 contributory years, which remained the responsibility of the Pension Insurance Fund (PIF).

In 2011 the pension contribution rate was 34% of gross wages (24% for employers and 10% for employees). Altogether this made up to 27% of the total wage cost, which included further taxes and contributions both on the employer and the employee side. In 2012 the employers' contribution was replaced by a tax, the social contribution tax (*szociális hozzájárulási adó*) but the rate devoted to pensions remained the same. In 2013 this new tax was redistributed among the various public funds resulting in a rate of 27% for pensions. Since the employee side remained unchanged the total rate of pension contributions/taxes grew to 37% or 29% of total wage cost.

The minimal service period for a full old-age pension is 20 years. Since CANPI, the pension insurance administration, does not yet have an electronic register on contributions paid by or on behalf of the insured the benefit formula is based on length of service and net wages in and after 1988. Pensions are tax exempt for they are calculated from net wages (although what constitutes *net* wage was redefined in 2008).

Retirement age is 62 years for both genders, which will gradually grow to 65 by increasing the age limit by half a year for each consecutive cohort. Accordingly, the transition period will end in 2022.

Pensions in payment are indexed by prices in a forward looking manner. In January pensions are raised by the inflation rate set in the annual government budget plan. If the actual rate calculated from a special pensioners' consumer basket is higher, pensions are retroactively adjusted in November.

2.1.3 Details on recent reforms

Below I will briefly summarise the 2009-2011 reform measures under three headings: parametric reforms, de-funding/renationalisation of the funded pillars and closing the routes of early retirement. I will close the section with the most recent changes.

The 2009 parametric corrections and their further modifications in 2011

The increasing current deficit and the accumulating implicit debt of Pension Insurance Fund forced the government to revise the basic parameters of the first pillar in 2009. However, some of the new measures were revised in a second wave of adjustments even before they could have taken into effect. In order to save space here I review only the final versions.

First, the half-wage-half-price index was replaced by a price index. This ended a two-decade long struggle of consecutive governments to reduce the full wage-index to a price-index. Second, the retirement age was raised. In principle, retirement age has been 62 years for both genders since 2009. However, various exit routes of early retirement (to be detailed below) made over 90 percent of new old-age pensioners retire below this age. The reform package of 2009-2011 raised the standard retirement age from 62 years to 65 years by 2022 and closed or significantly narrowed early exit routes. The third main measure of the 2009 package was the final abolition of a controversial boon to pensioners, the 13th month of extra benefit, which was gradually introduced between 2003 and 2006, reduced in 2008 and finally withdrawn in 2009. This episode revealed the severe lack of insulation of the public pension scheme from political short-termism in Hungary.

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

The establishment of the funded pillar in 1997 was one of many similar reforms across Eastern Europe. The government's decision in 2010 to slow down the funding process by diverting contributions aimed at the private funds to the pay-as-you-go pillar also fitted well into similar measures by governments in the wider region. However, the second step of reversing the entire accumulation process altogether was for a time unique and even now it is still the most radical. In 2010 the government created conditions that made 97% of members of the mixed system return to full pay-as-you-go. These conditions meant the restoration of accruals in the first pillar which went lost previously at the time of opting out to the mixed scheme; they also would have resulted in major losses for those who remained. The private funds had 3.1 million members on June 30, 2011 but only 0.1 million three months later on September 30, 2011. This number has further decreased to 0.07 million since then. Although the harsh conditions were softened significantly in the meantime no new members can join

the mixed system any longer. The funded pillar can be considered a closed chapter in the history of Hungarian public pensions.

In order to absorb the savings returning to the public fund, equivalent to 10.6% of GDP, the Pension Reform and Debt Reduction Fund (PRDRF; *Nyugdíjreform és Adósságcsökkentő Alap* in the original) was established. Three quarters of the portfolio was used for debt conversion (63%) or it is still held by the government (12%) in the PRDRF or the National Asset Management Inc. The rest, about one quarter was either liquidated in order to finance the deficit of the PIF (16%) or distributed among former members (8%) or lost in revaluation (2%).

2011: Closing the routes to early retirement

In 2011, nearly 30% of beneficiaries, younger than the official retirement age took up 25% of benefits. The routes to leave the labour market were various. The new regulations that came to effect on January 1, 2012 locked many of these ways and narrowed those that remained open making retirement below the standard retirement age more difficult. Since most recipients whose benefits have been in payment kept their eligibility the effects will be felt gradually.

Starting from 1 January 2012 disability ceased to be part of the pension system. It was rearranged from the PIF to the HIF, and the disability pension was transformed to disability provision (*rokkantsági ellátás*) and rehabilitation provision (*rehabilitációs ellátás*), the latter being different from the former rehabilitation benefit, which was also withdrawn. The disability provision functions in effect in the same way as the disability pension. People belonging to disability classes 1 and 2 receive this new provision.[1] The same applies to people classified to the 3rd category provided they were born in 1954 or before. The rest obtained rehabilitation provision till 1 May 2012. At this point eligibility for the provision ceased to exist unless the beneficiary had requested a complex review of his/her health conditions. Depending on the result of this re-check the rehabilitation provision was transformed to disability provision (if the client cannot be rehabilitated) or reduced (if he/she can be rehabilitated) or withdrawn (if health conditions allow the client to work).

The other large group of early retirees included regular old-age beneficiaries consisting of several subgroups. One of them were beneficiaries of a service-length-based early retirement (*előrehozott nyugdíj*), which offered benefits with no or just minor reductions. This route of early exit was closed down altogether. No new such benefits can be established any longer since January 1, 2012. The benefit of current recipients (that is old-age pensioners younger than the retirement age) was transformed to the new below-retirement-age provision (*korhatár előtti ellátás*), which functions the same way as the previous allotment and be converted back to the regular old-age pension upon reaching the retirement age. Since no new eligibilities can be established for this provision it will be phased out in the next years.

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

It has to be noted that the administration's efforts to raise the effective retirement age are not consistent. Before the municipal elections held in October 2010 the government opened up a

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

new retirement channel for women independent of age but based exclusively on working years. In order to meet an electoral promise, women are allowed to retire after 40 contributory years (including periods on maternal leave).

Most recent changes

After these turbulent years, which restructured the pension system to its root, 2013 is a year of only minor changes.

Potentially the most important correction is the abolishment of the contribution ceiling. The ceiling, the value of which was set annually by government, applied to the contribution paid by the employee but not on the contribution levied on the employer. It was set around three times the average annual gross wage. Without ceiling contribution revenues grow in the short and medium term but benefits are expected to grow even faster on the long run. The Convergence Programme of the government estimated the instant effect as 0.2% of GDP.

The other significant change was what should have happened but did not. The 1997 reform package set down the re-writing of the benefit formula in 2013 and the abolishment of the tax exemption of pensions. The current non-linear formula based on net wages should have been replaced by a linear scale calculated from gross wages. The new, higher entry pensions would have been subject to the personal income tax. The law has not regulated the way pensions in payment should have been taxed. The working assumption was that these benefits would have been grossed up so that the net amounts would have been the same as before or pensions established before 2013 would have remained tax exempt altogether. In the end the government decided to scrap this part of legislation.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

In terms of absolute poverty Hungarian elderly are poor in European comparison. Men and women are respectively, 21st and 24th (in the 65 years old and older age group) and 20th and 23rd (among the oldest old that is the 75+ age group) in the frequency of facing severe material deprivation (see as SMD in Table 1). These frequencies are lower than the average of the 12 new member states but higher than the overall average of the EU28 and increased from 2011 to 2012.

The Hungarian pattern of absolute poverty has two distinct features. First, poverty becomes less severe by age; second, the gap between men and women seems to be more explicit than in the NMS12 group or among the EU28.

However, the Hungarian elderly are poor in the European context because Hungary is poor in general. In relative terms older people are doing quite well. Indeed, the relative income position of Hungarian elderly is the most favourable in the European Union. The at-risk-of-poverty measure (AROP in the table) is the lowest both in the 65+ and the 75+ female populations and the 3rd and 2nd lowest, respectively in these two age categories among men. Here again relative poverty risks increased from 2011 to 2012.

The relative median income ratio (RMIR in the table, persons aged 65 years and older compared to persons aged less than 65 years) is the 3rd highest among the member states for both genders (in the case of men in a draw with France). Its value is above one for men meaning that the elderly in fact have a higher median income than those younger than 65 years.

Table 1: Poverty of the Hungarian elderly in European context

			2011				HU 2012
			HU	NM12	EU28	HU rank	
AROP	65+	m	3.5	9.1	13.2	3rd	4.7
		f	5.0	16.5	18.1	1st	6.8
	75+	m	3.1	8.5	14.7	2nd	3.4
		f	4.9	18.0	20.2	1st	6.4
SMD	65+	m	10.5	17.2	5.7	21st	12.7
		f	18.4	22.6	8.4	24th	20.1
	75+	m	7.8	17.3	5.4	20th	10.0
		f	17.1	23.8	8.8	23rd	20.3
RMIR	65+	m	1.07	0.98	0.93	3rd-4th	1.01
		f	0.97	0.87	0.87	3rd	0.95

Source: Eurostat (ilc_li02, ilc_mddd11, ilc_pnp2).
Notes: HU: Hungary, NMS12: new member states; m, f: male, female; HU rank: position of Hungary among the EU28 countries.
AROP: at-risk-of-poverty (threshold: 60% of median equalised income after social transfer); SMD: severe material deprivation; RMIR: relative median income rate (persons aged 65 years and over compared to persons aged less than 65 years).

2.2.2 Sustainability

The Ageing Report (EC 2012a) expected a moderate long-term increase in the pension budget in terms of GDP from 11.9% in 2010 to 14.7% in 2060 (see Table 2). This 2.8 percentage point rise is a result of a strong demographic push, which by itself would nearly double the pension budget relative to GDP, and various labour market and pension system variables, which mitigate the impact of ageing. Most importantly the coverage ratio[2] will partly counterbalance the ageing effect due to the increase in the retirement age. Also, the price index replacing the previous half-price-half-wage makes the benefit ratio add to fiscal sustainability. The two components have different effects on adequacy nevertheless. The improvement in coverage ratio is adequacy-neutral or even raises benefits due to longer contributory periods. In contrast, the changing index rule will further detach pensions and wages in long pensioner careers. The population particularly at risk in this respect are older women living alone.

The Ageing Report reflects a situation prior to the phasing-out of most forms of early retirement. The Fiscal Sustainability Report (EC 2012b) published later in 2012 presents results that take these effects into account. Accordingly, the expected long-term increase of the public pension budget is a mere 0.5 percentage point instead of 2.8 percentage points decomposed above.

In addition to the results on general sustainability in Table 3 I summarise the findings of the OECD (Whitehouse 2012) on the specific sustainability effects of the reversal of the pre-funding episode. The simulation compares switchers, who opted out for the mixed system, and non-switchers, who did not. The latter group also represents people who returned to pure pay-as-you-go after a spell of membership in a private fund. The simulation exercise assumed full restoration of accruals lost at the time of switching, which indeed was the case in Hungary.

[2] The decomposition equation applied by the Ageing Working Group is the following:
Pension expenditures / GDP = dependency ratio (= population 65+ / population 20-64) x coverage ratio (=pensioners / population 65+) x employment effect (= population 20-64 / working people 20-64) x benefit ratio (= average pension / (GDP / hours worked 20-74)) x labour intensity (= working people 20-64 / hours worked 20-64) x residual (hours worked 20-64 / hours worked 20-74).

Table 2: Sustainability of the Hungarian pension system

	2010	2060
Public pension benefits	11.9	14.7
Change 2060-2010		2.8
Decomposition of change		
Dependency ratio		*11.1*
Coverage ratio		*-4.3*
Employment effect		*-1.3*
Benefit ratio		*-1.8*
Labour intensity		*0.0*
Residual		*-0.9*
Public pension contributions	8.6	9.9
Public pension assets	0.0	0.0

Source: EC (2012a).

If full-careers workers are compared switchers would have had a replacement rate in the public sector about three quarters of what non-switchers got (44.4/60.1). This is in line with the share of contributions diverted to the private funds, which in reality changed over time due mostly to changes in the denominator that is total pension contributions. However, benefits from the pre-funded pillar would have well compensated for the losses in public pensions. The two sources combined would have given about a quarter (75.8/60.1) higher pensions to switchers than the sole public pension of non-switchers. This is the loss of the reversal for future beneficiaries especially among young workers.

Table 3: The effect of the reversal of the second pillar on adequacy and sustainability

	Switcher		Non-switcher	
Replacement rate (%)				
Total	75.8		60.1	
Of which public	44.4		60.1	
Of which private	31.4		-	
Effects in terms of annual earnings at the time of retirement				
	Men	Women	Men	Women
Value of diverted contributions	3.6	3.6	-	-
Lifetime public pension	6.0	7.4	8.1	10.0
Benefit payment saved	2.1	2.6	-	-
Aggregate cost of switching for public budget	1.5	1.0	-	-

Source: Whitehouse (2012, Tables 3.5 and 3.6).

In contrast, the public budget gains from the reversal. After a full career of 45 years the total value of contributions diverted for funding would have been 3.6 times the annual earnings both for women and men. This would have resulted in lifetime benefits equivalent of 6.0 and 7.4 years of earnings of switchers, respectively for men and women. Non-switchers, whose contributions were not parted between the two pillars, would be eligible for higher public pensions equal to 8.1 years and 10.0 years of earnings, respectively. The proportions (8.1/6.0 as well as 10.0/7.4) are the same as the proportions of replacement rates above. However, the savings in benefit payment would be only 2.1 years (8.1-6.0) and 2.6 years (10.0-7.4), respectively, well below the contributions, equivalent of 3.6 years of earning, lost by the public system. So the balance of the reversal for the pay-as-you-go pillar is a gain of 1.5 years and 1.0 years of earnings, respectively for men and women. The short-term gain of the reversal exceeds the long-term costs. According to Whitehouse (*ibid*) this is due to the over-

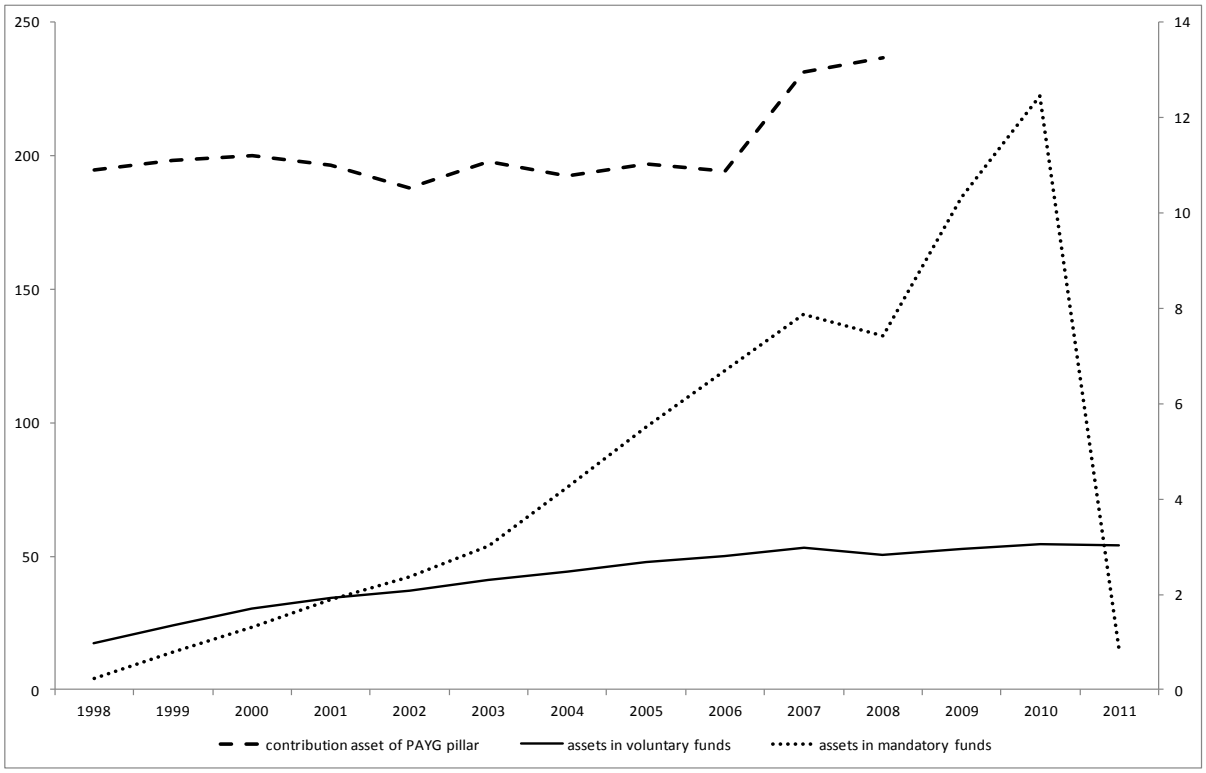
compensation of fund members at the original design of switching for the losses in their public benefits.

This short section on sustainability was based on simulations made by international organisations. From among Hungarian government agencies or research centres only the Ministry for National Economy is doing such exercises on a regular basis in cooperation with the Ageing Working Group of the EPC and their results hardly reach public debates locally. The National Bank, which published several projections in the mid-2000s closed their project and limited their focus on quantifying the implicit pension debt. CANPI, the pension insurance administration is currently working on a dynamic microsimulation model in the framework of a PROGRESS programme but this will produce results only in 2015.

2.2.3 Private pensions

After decades of the exclusivity of state property and the lack of capital markets funded schemes were re-established in the 1990s. Voluntary funds started operation in 1994 and the mandatory funds of the second pillar followed suit in 1998. The latter were still in the accumulation phase when they got all but closed. Voluntary funds have started paying benefits but they almost exclusively give out lump-sum payments, not annuities. So the best way to compare the relative importance of the pension pillars is their assets.

Figure 1: Contribution asset of the PAYG pillar and the capital value of the mandatory and voluntary funded pillars (% of GDP)



Source: CANPI and CBH statistics (2nd and 3rd pillars), Gál and Simonovits (2012) (1st pillar).

This requires further specifications. Pension funds keep their reserves in physical capital the value of which is evaluated on a daily basis. The concept of the assets of an unfunded pay-as-you-go scheme is less trivial. However, the establishment of non-financial defined contribution (NDC) pension schemes in numerous countries and especially the introduction of automatic balance mechanisms made it imperative to set up a system of double book-keeping, which registers all revenue flows and their effect on asset value. This method identifies the

assets of the first pillar as the present value of net future contribution flows (Settergren and Mikula 2006). In Figure 1 I present an estimation of the asset value of the pay-as-you-go pillar and compare it with the assets of the mandatory as well as the voluntary funds.

The figure reveals that the first pillar was much larger than the second and the third pillar. I use two vertical scales so as to keep the three curves in one figure. Contribution assets were oscillating around 200% of annual GDP till 2006 and grew to around 230% after the raise of the contribution rate in 2007. In contrast, the second pillar held assets worth of 12.5% of GDP at its highest. This was expected to grow to between 15-20% of GDP by the end of the accumulation phase and stabilise at that level. That is, the mandatory funded pillar was always meant to be auxiliary to pay-as-you-go unless the contribution rate diverted to the private funds was to be raised further. The wealth of the voluntary pillar is about 3% of GDP, marginal compared to the pay-as-you-go scheme.

2.2.4 Summary

In short, the main weaknesses of the pension system are the lack of insulation from short-term political interests and in general the short time horizon of decision makers and the public and the lack of financial reserves. The main strength is the apparent willingness of the population to work longer for adequate pensions or, to put it in other words, the limited resistance to increasing effective retirement ages.

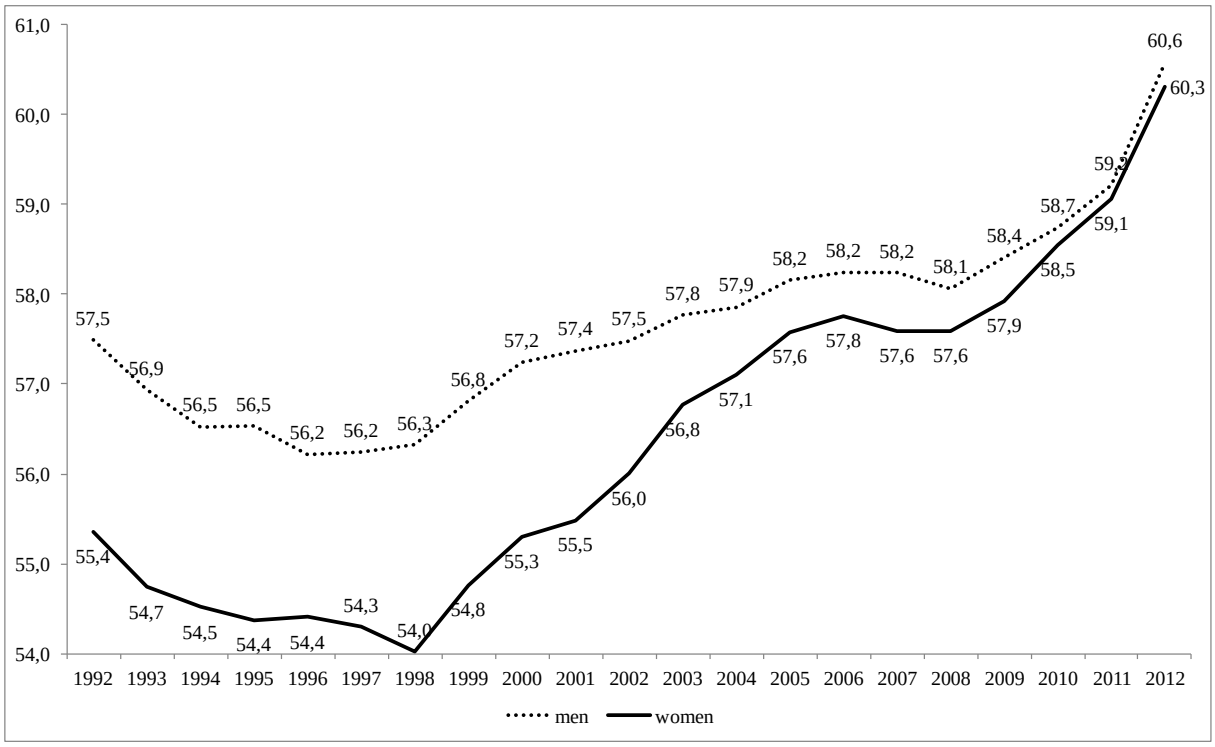
The first problem, exposedness to the electoral cycle, is part of a more general political business cycle, which can be perceived in various fields of public life as well. Examples include cycles in public investments either by the central government (Szabo 2005) or local governments (Kalman 2012) as well as pensions (Gal and Tarcali 2008). It could be mitigated by installing constitutional limits on deficits and public debt (Tremmel 2006); the establishment of fiscal councils with weaker or stronger mandates to stop overspending (Hagemann 2010); or the spread of automatic mechanisms in government (Weaver 1998). Automatic balance mechanisms (ABMs) are particularly popular in the pension field, because pensions are easier to describe in a set of equations. An ABM stabilises the system by triggering a response in some parameters if other parameters moved to unfavourable direction. For instance, if long-term stability of the system defined by a set of equations came under threat by decreasing fertility, lower employment or increasing life expectancy, the contribution rate or the retirement age would automatically increase or benefit levels would decrease. In the Hungarian case a proposal including an automatic balance mechanism was part of one of the reform scenarios modelled by the Pensions and Old-age Roundtable. The final report of the Roundtable also included an alternative suggestion of establishing a Hungarian version of the Social Security Advisory Board. However, both suggestions were shelved.

The second question, the lack of reserves seems particularly urgent after the second pillar was defunded. In fact the problem is older and to a large extent independent of the 2010-2011 events. In order to paint a background we have to go back to the start of the 1997 reform, which established the second pillar. The build-up of this pillar was to create a limited double-burden problem: while pensions in payment had to be financed all along, a part of contributions was saved in order for pre-funding future pensions. The resulting deficit of PIF had to be financed by government. This transition cost was to be covered from reduced public spending on other chapters of the budget rather than debt.

The unambiguous balance of this process is not available. No special pensions-related flows were earmarked, so the exact extent of debt-financing cannot be determined. Yet, it is safe to say that the transition was not based on current but future revenues (see e.g. an OECD report

by Égert, 2012). The trends of public spending on other chapters and the rapid increase of government debt over this period all imply a debt-financed transition. So the reserves accumulating in the second pillar were more an illusion of savings than net wealth. In parallel with the build-up of the funds government debt of similar size was gathering. The problems of the funded pillar started long before it was erased.

Figure 2: Effective exit age from the labour market, 1992-2012



Author's calculation based on OECD labour statistics.

This will be particularly damaging in a generation time. The Hungarian age-tree has two large humps, two relatively big generations, those who were born in the mid-1950s and their children born twenty years later in the mid-1970s. The entry of the latter, in the late 1990s, to the labour market resulted in two large taxpayer generations and no similarly large cohorts in dependent age. This opened a window of demographic opportunity to handle the double-burden problem over the transition period of the 1997 reform. This window is about to close now as the older baby boomers are retiring. Nevertheless, their retirement is mostly hedged in human capital, the large generation they raised, not in physical capital. The reserves of the private funds, should they have embodied net wealth, would have safeguarded against financial tensions at the time the younger baby boomers will retire. Their old-age income will be less easy to assure since their fertility is lower than their parents. There is no third hump in the age-tree, no new large generation to enter the contributory period of the lifecycle in the 2030s. So the cohorts currently in their late 30s will need savings or have to accept longer working careers or face poverty in old age.

The strength of the Hungarian pension system is the willingness of working longer. Since the opportunity to accumulate net wealth and reap the second demographic dividend was missed, Hungary turned to the promotion of longer working lives as an alternative means for balancing adequacy and fiscal sustainability. In Figure 2, I present the time series of the effective retirement age by gender estimated as a weighted average age of leaving the labour force. It is still rather low in European comparison but it is increasing in particular in the last years. In the course of the four years between 2008 and 2012 the average exit age grew by 2.5

years for men and 2.7 years for women. Due to the phasing out of most early retirement options discussed above this figure is expected to grow further still in the next few years.

2.3 Reform debates

The political discourse on pensions is typically inconsistent and it has a cross-sectional view. Trusting the short time horizon and memory of voters political forces represent frequently changing positions depending on whether they are in government or in opposition or even whether they are near to elections or can still wait some years. This is not simply to say that the quality of public debates is shallow. Rather it has declined over the last 10-15 years to a level that it has all but frozen. Since the Pension and Old-Age Roundtable, an ad hoc expert team that was convened by the Prime Minister in 2007 and released a report in 2009, has outlined four reform alternatives, no new proposals were presented.

Public debate on the reversal of the pre-funding experiment or the closing of the channels of early retirement was practically absent. This is quite the opposite of how the 1997 reform package was prepared and debated. Anecdotes say that the administration learnt about the defunding and re-nationalisation of the second pillar from the press. Once the proposal was released it produced an outburst of populist language exceptional even by Hungarian standards both from the government and its opposition. The government blamed the funds of losing pension reserves by playing murky games in the stock exchange (but nevertheless thought it attractive for fund members to offer the take-up of real returns in case of returning to the first pillar). The opposition called the defunding/re-nationalisation manoeuvre "theft" and "predatory" (as if the ruling coalition and their supporters pocketed the reserves). The language of the debate certainly did not help anchoring the image of the pension system as part of lifecycle finances, and that of pension benefit as depending on lifetime savings and human capital investments.

The early retirement issue invited similar quality of remarks. When the trade unions wanted to discuss the new regulation, the Prime Minister referred them to "his secretary of state holding the clown-portfolio". On the other side of the political spectrum the leading speaker on pensions of the main opposition party compared the revision of health conditions establishing eligibilities to disability pension to the Mengele-test in Auschwitz (he later apologised). Again the debate made it all the more difficult to explain to the public that current pensions depend on past achievements and today's proportions of contributory and retired periods cannot be sustained.

Nevertheless, the European context is changing the way the Hungarian social protection system is presented to the public. It became common to talk about national developments in international comparison. The main reference points are the Visegrad countries, Slovakia in particular. The Hungarian Presidency of the European Union in 2011 has boosted this process. The presidential position forced the administration to rethink their preferences and try to formulate them in a European context. In the end the Central Administration of the National Pension Insurance Fund organised two presidential conferences, which were later followed by international conferences and workshops in 2012 and 2013.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

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

The new government elected in 2010 opted for a systematic move on the way to a national health service by further centralising the allocation of capacities; establishing a new hierarchical system of actively managed patient routes; organising more effective competition of generics in public purchases of pharmaceutics; and making steps towards replacing contributions by taxes.

3.1.2 System characteristics

Administration
The 2011 reform, the Semmelweis Plan, includes the reorganisation of health care administration. The new organisational structure keeps the administrative functions and system management centralised in the hands of the State Secretariat for Health Care of the Ministry of Human Resources (MHR) and its background institutions, the Institute of Pharmaceutical and Medical Quality Control and Organisational Development (IPMQCOD, *Gyógyszerészeti és Egészségügyi Minőség- és Szervezetfejlesztési Intézet*), the National Centre for Patient Rights and Documentation (NCPRD, *Országos Betegjogi és Dokumentációs Központ*) and the Office of Health Authorisation and Administrative Procedures (OHAAP, *Egészségügyi Engedélyzési és Közigazgatási Hivatal*). Epidemiological and other public health issues belong to the National Public Health and Medical Officer Service (NPHMOS, *Állami Népegészségügyi és Tisztiorvosi Szolgálat*) and its affiliates.

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

All actors are connected to the National Health Insurance Fund Administration (NHIFA, *Országos Egészségbiztosítási Pénztár*), which administers the finances of the system. The emergence of the new institutional actors in patient route management has reduced the importance of NHIFA, which used to be a central institution in health care management. A further organisational change to diminish the former role of NHIFA is the redistribution of responsibilities between them and a new network of NUTS3-level administrative centres, the government offices (frequently referred to as "government windows").

Property rights
From January 2012, the government took over the property rights, including debts, of hospitals formerly owned by local governments as well as outpatient centres belonging to these hospitals, which make about three quarters of outpatient capacities. The government

also intervened in the pharmacy market. In December 2010 a new regulation was accepted by Parliament with the aim of maintaining or restoring the market position of pharmacies owned by pharmacists. Accordingly, in order to hold up their licenses pharmacies have to have a majority (over 50%) of property rights in the hands of a pharmacist from 2017 (over 25% by 2014). Also the size of chains has been limited and wholesale traders as well as producers of pharmaceutics have been excluded from potential owners.

Financing and benefits

As mentioned above in the Pensions section the social contribution tax, which legally is a tax not a contribution, replaced employers' social insurance contributions in 2012 (see Table 4). In 2012 it was shared between the two funds. In 2013, HIF received no social contribution tax any longer; the entire amount was channelled to the PIF budget. Instead, the share of government transfers in the health budget exceeded 50% for the first time (see Table 5).

Table 4: The share of contributions between the Pension Insurance Fund and the Health Insurance Fund (% of gross wage)

	contributions by employer			social contribution tax		contributions by employee		
	pensions	health care		pensions	health care	pensions	health care	
		for in kind services	for cash benefits				for in kind services	for cash benefits
2010	24.0	1.5	0.5	0.0	0.0	9.5	4.0	2.0
2011	24.0	1.5	0.5	0.0	0.0	10.0	4.0	2.0
2012	0.0	0.0	0.0	24.0	2.0	10.0	4.0	3.0
2013	0.0	0.0	0.0	27.0	0.0	10.0	4.0	3.0

Source: Annual legislation.

Due to the redistribution of responsibilities between the two social security funds and the central government already mentioned in the Pensions section, more specifically the concentration of disability pensions below retirement age in HIF, the time series of the various revenue and expenditure items should be used with care.

Table 5: Revenues and expenditures of HIF (% of GDP)

	2011	2012	2013
REVENUES			
contributions and taxes	2.51	3.05	2.39
government transfers	2.32	2.12	3.20
other revenues	0.25	1.05	0.34
total	5.08	6.22	5.94
EXPENDITURES			
cash benefits	0.73	1.97	1.83
in kind	4.52	4.36	4.05
curative-preventive care	2.92	3.00	2.92
pharmaceutics	1.36	1.12	0.92
medical aids	0.18	0.18	0.14
other expenses	0.05	0.05	0.06
total	5.38	6.39	5.97

Source: NHIFA.
Notes: 2012: preliminary data, 2013: planned budget and GDP.

The 2012 health budget seems significantly larger than that of 2011 (see Table 5). The increase is mostly due to the rearrangement, to the amount of 1.27% of GDP, of disability and rehabilitation benefits from the government and from the PIF to HIF. In addition, two new smaller taxes, the vehicle accident tax (*baleseti adó*) paid by automobile owners and the public health tax (*népegészségügyi termékadó*) levied on consumers of unhealthy food (such as chips, soda and similar products) were introduced in order to extend the tax base of the health care system. They added an amount equivalent to 0.16% of GDP.

The composition of the expenditure side of the budget also changed as the redirected disability and rehabilitation benefits appeared among the cash benefits in 2012. In contrast, public spending on pharmaceutics decreased sharply due to the government stepping up more vigorously in price setting and to organising an effective competition of generics.

The trends in public spending on health are also influenced by the poor output of the economy as a whole in 2012, which decreased the denominator of the numbers presented in Table 4.

3.1.3 Details on recent reforms

The government introduced a comprehensive reform package, the Semmelweis Plan, in 2011. The focus of the reform is the establishment of a new system of actively managed patient routes. On the local level outpatient centres take on this responsibility. At higher level the newly established Regional Health Management Centres (RHMCs, *Térségi Egészségszervezési Központ*) will be in charge of the management of patient routes within their territorial responsibility. Altogether 8 RHMCs were formed each covering 1.2 million people on average. RHMCs register, optimise and monitor patient routes in their respective region; plan capacities; prepare implementation plans, management systems and cooperation models of regional actors; prepare contracts, set up project organisations and other forms of cooperation of regional actors; organise joint use of diagnostic capacities, laboratories, etc.; organise regional business management; monitor and supervise the activity of regional actors; and organise trainings for the personnel.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The HIF covers practically the entire population. Self-reported unmet needs due to financial reasons are about as frequent in Hungary as in the EU28 in general (see Table 6). The distribution of this measure across income quintiles also follows the average European trend. In Table 6 I present Hungarian data for three consecutive years, 2010, 2011 and 2012. Although the SILC sample is relatively small, so the confidence intervals are rather large, especially in subsets, the trend of slowly increasing access problems is visible.

Table 6: Self-reported unmet need for medical examination or treatment due to financial reasons, by income quintile

	1st	2nd	3rd	4th	5th	Total
EU28, 2011	4.8	2.8	2.0	1.3	0.6	2.3
HU, 2010	2.9	1.4	0.6	0.7	0.4	1.2
HU, 2011	5.7	2.0	2.0	0.9	0.4	2.2
HU, 2012	5.9	2.6	1.5	1.1	0.8	2.4

Source: Eurostat, hlth_silc_08.

Unlike coverage, health conditions are worse in Hungary compared to the EU28 (see Table 7). In every income quintile and at every level of education the proportion of Hungarians reporting good or very good health is lower than the European average. Results of self-

assessment are consistent with the picture offered by output indicators (see next subsection). Also, health inequalities are wider than inequalities in the access to health care services and health inequalities are wider still in Hungary than in Europe. The share of people reporting on bad and very bad health is twice as high in the poorest as in the richest quintile in the EU28. In Hungary this gap is three-fold. Only about half of the poorest respondents of the Hungarian survey give a good or very good assessment of their health against 70% of the richest.

The income ladder hides an age effect. People usually have lower income and better health when young compared to when they are middle aged. In this respect the measurement of inequalities by the level of education is preferable because once people leave school their education level is more stable than their income.

Indeed, self-assessed health status is more unequal by level of education. 41% of people with lower secondary or primary education (or less) reported on good or very good health against 71% among those having higher education (55% and 81%, respectively, in Europe). On the other side of the health status, among those having bad or very bad health the proportions are 29% against 7%, respectively (the corresponding figures are 16% against 4% in the EU28).

This observation of deeper health inequalities by education than by income is further confirmed by the fact that Eurostat presents data only in three educational categories against the five quintiles of income distribution. In most distributions a five-category classification would result in larger differences between the two extreme classes than a three-category classification.

Table 7: Self-reported health status by income quintile and level of education

		very good and good	fair	bad and very bad
by income quintile				
EU28	1st	60	26	14
	2nd	61	26	13
	3rd	67	24	10
	4th	73	20	7
	5th	78	17	5
HU	1st	53	26	22
	2nd	49	28	22
	3rd	54	29	17
	4th	62	26	12
	5th	70	23	7
by level of education (ISCED97)				
EU28	0-2	55	29	16
	3-4	72	21	7
	5-6	81	15	4
HU	0-2	41	30	29
	3-4	61	26	12
	5-6	71	22	7

Source: Eurostat hlth_silc_02, hlth_silc_10.
Notes: Hungary: 2012, EU28: 2011. Levels of education: 0-2: pre-primary, primary and lower secondary education; 3-4: upper secondary and post-secondary non-tertiary education; 5-6: first and second stage of tertiary education.

Finally, a critical issue to discuss is the widespread informality mentioned above. The informal out-of-pocket payment is frequently perceived as purchase of privilege and queue jumping, which it is, but the effects are more far-reaching. Since this system creates a raw and unregulated market for services based on direct patient-provider contacts there is a tendency of over-treatment. Anecdotic evidence as well as sporadic statistics indicate that the

Hungarian health care system is skewed to more expensive interventions, such as doctor visits instead of phone contact; hospitalisation instead of outpatient treatment; and inpatient surgery instead of same-day surgery. Also, since gratitude money buys services but not health management the result is a poorly regulated and frequently accidental system of patient routes, which discourages prevention and early contacts and often results in broken patient routes. In addition, for obvious reasons no insurance can be bought against the risk of the emerging informal payments. The result is a new source of inequality. Again anecdotic evidence and a handful of systematic studies show that influential, better-connected and better-to-do people can buy better services.

3.2.2 Quality and performance indicators

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

A frequently used general performance indicator of the health care sector is life expectancy (LEXP). Hungarian mortality at birth is 71 years for men and 78 years for women (see Table 8); on average 5 years lower than the EU average. However, in the course of half a decade between 2006 and 2011 it improved nearly a full year for women and almost two full years for men. This also reveals a diminishing gender gap, which, too, is relatively large in Hungary in European comparison. Although some of the improvements occurred in the active or newly retired cohorts LEXP at the age of 65 years also increased by half a year over the same period. Tendencies are similar, though less clear, in the case of another general performance indicator, healthy life expectancies (HALE) with the important difference that the gender gap is smaller. This predicts longer periods of morbidity and disability for women.

Table 8: Potential years of life lost, life expectancy and healthy life expectancy

	2006	2007	2008	2009	2010	2011
Potential years of life lost						
males	9 968	9 742	9 193	8 852	8 390	7 922
females	4 190	4 295	4 036	3 948	3 744	3 703
Life expectancy at birth						
males	69.0	69.2	69.8	70.1	70.5	70.9
females	77.4	77.3	77.8	77.9	78.1	78.2
Healthy life expectancy at birth						
males	54.7	55.3	54.7	56.0	56.4	na
females	57.5	58.0	58.3	58.7	58.6	na
Life expectancy at age 65						
males	13.4	13.4	13.6	13.7	13.8	13.9
females	17.2	17.3	17.5	17.6	17.6	17.7
Healthy life expectancy at age 65						
males	5.0	5.3	5.7	5.9	5.4	na
females	5.6	5.9	6.5	6.1	5.9	na

Source: OECD health statistics (PYLL), Central Statistical Office, sustainable development indicators (LEXP, HALE).
Note: Potential years of life lost of all causes, 100,000 persons aged 0-69 years.

Finally, the potential years of life lost (PYLL), a measure of premature mortality, which focuses on mortality below the reference age, 70 years in the case of the OECD, describes an even faster improvement. Yet, these advances do not make Hungary perform better in cross-

country comparisons. Among OECD members Hungary produces the 2nd or 3rd worst numbers.

As for quality assurance we need to look back a few years to understand the current situation. Responding to the OMC objectives of ensuring access to, and quality of health care services, a supervisory agency, the Health Insurance Supervisory Authority (HISA, *Egészségbiztosítási Felügyelet*) was established in 2007 with the task of monitoring the waiting lists of providers and publishing monthly reports on access to health services. HISA was established in order to supervise the participants of a multiple-actor health insurance market. Since plans for creating such a market did not materialise activities of the organisation were refocused on protection of patient rights, quality control and waiting lists. It also tried to become a centre for research and analysis and published some path breaking studies. It had a relatively strong mandate (e.g. it was allowed to levy fines) but it could not establish itself as an influential authority before it was closed in 2010. After this reorganisation patient rights became the responsibility of the NPHMOS, whereas the task of monitoring waiting lists was taken over by the NHIFA. The latter created a webpage (https://varolista.oep.hu/varolista_pub/), which informs about waiting lists by type of intervention, region and health care centre.

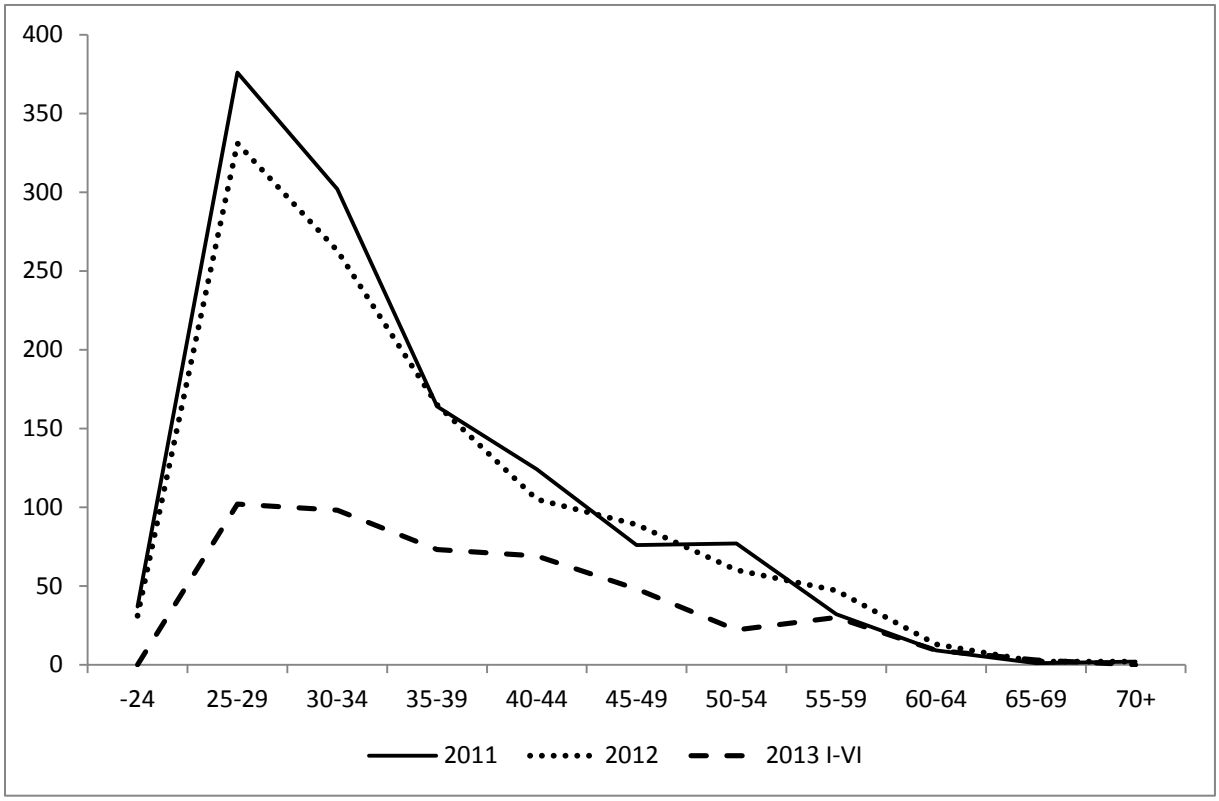
3.2.3 Sustainability

The 2012 Ageing Report departs from health expenses of 4.9% of GDP in 2010 and expects them to grow by between 0.4 and 2.3 percentage points by 2060 depending on the set of assumptions applied in the various projection exercises. The reference projection puts health expenses at 6.1% of GDP in 2060, which is as much lower than the EU27 average (this projection does not yet cover Croatia) than it is today.

Migration of health personnel accelerated in the last years. This development is relatively new but due to the wage differential between richer EU member states and Hungary, it is becoming increasingly serious. The authorities do not have exact figures of actual emigration but the OHAAP registers requests for official licenses needed for employment in abroad, which is a close proxy. Accordingly, 1,108 doctors requested such license in 2012 compared to 1,200 a year before. In the first half of 2013 the corresponding figure was 454, but it is unsafe to use this number for assessing the expected total for the whole year. Many of the migrants are young graduates who submit their request to the authorities after completing university in the second half of the year. At any rate, these figures exceed the number of doctors trained in the country.

Not only are the numbers alarming but also the age composition of emigrants. In Figure 3, I demonstrate that the brain drain as usual affects the young disproportionately. This creates a cumulative effect: for a period the consequences of emigration are not directly felt but eventually when older cohorts retire the shortage of expertise becomes all of a sudden acute.

Figure 3: Age-composition of doctors requesting licenses for working abroad, 2011-2013



Source: OHAAP (2013).
Note: Since the distribution of submissions of requests is not uniform over the year, the half-yearly data of 2013 are to be treated with care when used for assessing yearly developments.

3.2.4 Summary

In 2011-2012 the government opted for a systematic move on the way to a national health service by further centralising the allocation of capacities; establishing a new hierarchical system of actively managed patient routes; organising more effective competition of generics in public purchases of pharmaceutics; and making steps towards replacing contributions by taxes. The focus of the reform is the new system of managed patient routes. 2012 and 2013 was spent on making the system function under the new conditions.

3.3 Reform debates

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

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

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Long-term care (LTC) is generally treated as a marginal section of the social protection system in Hungary. It barely attracts attention and does not invite political forces to reform. Yet, over the last five years a rapid though hardly recognised shift to publicly financed home based care took place.

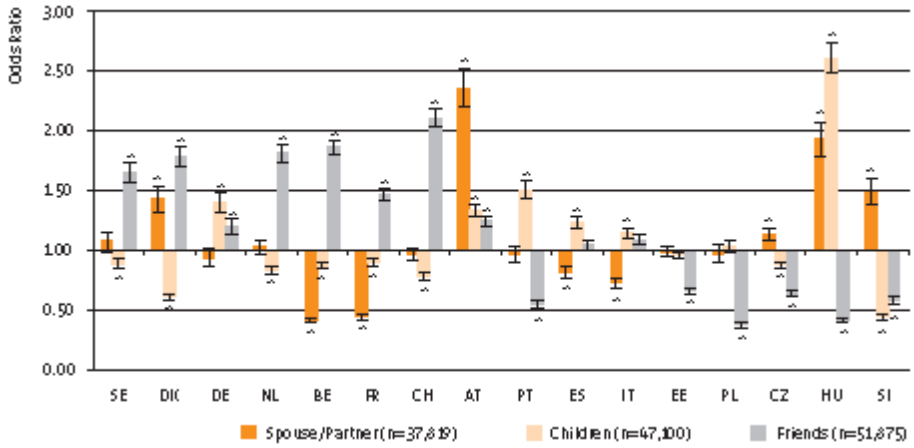
4.1.2 System characteristics

Hungary has no separate LTC system. LTC services are administered in the health care system and the social care system. The two branches have their own legislation, financing mechanism and services. They maintain parallel institutional networks both in institutional care and home care. Coordination between them is still weak despite some minor improvements over the last three years due to the contraction of the health care and social affairs portfolios in one authority, the Ministry of Human Resources (MHR).

Until recently the LTC system still bore the marks of the organisational logic of central planning, which 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. However, as mentioned above over the last five years this institutionalised structure has been shifting to home care. Below I will return to this issue.

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.

Figure 4: Country differences in the selection of spouse/partner, children and friends within named personal social networks



Notes: ^ denotes statistical significance of .05 or less; models adjusted for age, gender, education and marital status, living siblings, granmdchildren, activities of daily living (ADL), instrumental activities of daily living (IADL) and mobility limitations.
Source: Stoeckel and Litwin (2013, 284).

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

All other LTC expenses finance in-kind services.

The bulk of LTC activities are left to households or an informal market. Empirical evidence shows that familial relations play a particularly important role in long-term care for the elderly in Hungary. The first results analysis of the 4th wave of SHARE (Survey of Health, Ageing and Retirement in Europe), which for the first time included Hungary, found that Hungarian elderly are by far the most likely to mention their children among their confidants they can rely on and second most likely, behind their Austrian fellows, to name their spouses (Stoeckel and Litwin 2013; see their results here as Figure 4).

Generally speaking, the financial system of public LTC subsidises supply. Services are funded directly and those in need of care do not get cash grants to buy services. Private insurance schemes are not involved. Operational costs are financed by the HIF for health care and the government budget for social care. In addition, care providers may charge user fees. The exact amount varies from service to service. Algorithms of its calculation are given by regulation, taking the user's personal income into account. Real estate assets are also part of the income calculation but other types of assets are not. Nor is the availability of informal family carers taken into account. The maximum fee is 80 percent of monthly income for residential care and 50 percent for rehabilitative care.

Unit costs of both residential and home care are low in European comparison. In 2012 the financial support was HUF 635,650, about €2,200 for residential care a year, an equivalent of 22% of per capita annual GDP (see Table 10). In 2013 the method of calculation has changed. As against the per resident quota in effect till 2012, the government regulates the average wage of carers in residential homes from this year on. By applying further rules on residents per carer and special multipliers for the difficulty of care (1.0 for regular elderly homes, 1.18 for dementia care and 1.19 for special elderly care) the normative support by resident can be calculated. Accordingly, the quota for regular care has slightly increased to HUF 651,510, but has not changed in euro (still about €2,200 per annum). The corresponding figure was HUF 166,080, some €575 or about 6% of per capita GDP, for home care in 2012, which was cut back to HUF 145,000 (about €490) in 2013.

4.1.3 Details on recent reforms in the past 2-3 years

Without much fanfare the importance of home care increased rapidly over the last five years. Whereas residential capacities remained practically unchanged the number of home care recipients as well as nurses grew by about 80% between 2008 and 2011 and meal-on-wheels services by about 40% (see Table 9).

Table 9: Dynamics in home care, 2008-2011

	2008	2009	2010	2011
Total				
Recipients of home care	48 120	63 392	75 054	87 941
Nurses in home care	6 815	9 433	10 611	11 975
Recipients of meal-on-wheels services	107 803	124 693	146 443	155 091

Source: CSO 2012a.

The expressed preference of the government, also introduced to the new Constitution, to intergenerational responsibilities within the family spell further moves towards de-institutionalisation.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Key figures of coverage and other background information are presented in Table 10. The source of the data is the Yearbook of Welfare Statistics of the Central Statistical Office, which, by its nature follows the events with a delay of somewhat more than a year. A recent development in the sector, the creation of a social register based on half-yearly reports of welfare institutions, gives the opportunity of more updated decision making. For the time being this data base is not available for research.

Table 10: Summary statistics of the LTC-system, 2011

	Total	per 1000 inhabitants	per 1000 65+ inhabitants
Health care			
Chronic beds	27 094	2,7	
of which lasting care	*2 626*		*1,6*
chronic psychiatry	*5 643*		*3,4*
Home nursing care patients	53 509	5,4	
of which 65+	*37 740*		*22,5*
Social care			
In kind			
Home care recipients	87 941		52,3
Home care nurses, total	11 975		7,1
Meal-on-wheels recipients	155 091		92,3
Alarm system-based home assistance	25 503		15,2
Attendees of day-care for elderly	37 066		22,1
Number of elderly homes	1 004		
Residents in elderly homes	52 140		31,0
Unit cost of residential care (% of per capita GDP)	23		
Unit cost of home care (% of per capita GDP)	6		
In cash			
Recipients of nursing allowance	57 970	5,8	
Total spending on nursing allowance (% of GDP)	0,07		
Nursing allowance per recipient (% of per capita GDP)	13		

Source: CSO 2012a,b; annual government budgets.

The last column of Table 10 reflects unmet needs. About 10% of people 65 years old or older receive either home nursing care or home care or residential care. Against this share the Hungarian sample of the European Health Interview Survey (EHIS) found 29% ADL dependency in the over-60 years old male population and 42% among women (see Table 11).

IADL dependencies are even higher, 51% and 59%, respectively for the two genders in the population 60 years old or older.

Table 11: Level of ADL and IADL dependence by age and gender, 2009 (%)

	Men				Women			
age group	60-69	70-79	80+	*60+*	60-69	70-79	80+	*60+*
ADL dependency rate	20.6	34.5	47.4	*28.6*	26.5	47.0	69.8	*42.2*
IADL dependency rate	40.9	56.4	81.3	*51.2*	38.4	65.6	94.2	*58.9*

Source: Czibere and Gál (2013, Tables 2 and 3).
Note: including moderate, serious and severe dependence.

The EHIS offers a closer look at unmet needs in home based social care than the indirect evidence of confronting Tables 10 and 11. In Table 12 the basis of comparison is not the total population but the population with various levels of dependencies. Of those who need some type of assistance, 3.4% and 5.7%, respectively men and women receive it from public services. The rest either have to buy it or get help from family or his/her needs remain unmet. Importantly, the table hides a gender gap. Even though dependent older women receive public home based care more frequently in every age group and type of service than men, their needs are likely more frequently left unmet. Women are more likely to live alone without the access to spousal care. Among the 60 years old and older about three quarters of men but only about one third of women are married. So despite their higher coverage of public services they are more likely to be left relying on themselves or their families.

Table 12: Access to home-based care among people with dependencies by type of care, age and gender, 2009 (%)

	Men				Women			
	60-69	70-79	80+	*60+*	60-69	70-79	80+	*60+*
Home care	1.8	3.8	6.1	*3.4*	3.2	6.1	7.7	*5.7*
Meal-on-wheels	6.1	8.0	10.3	*7.6*	6.7	8.3	9.7	*8.2*
Alarm system-based home assistance	0.5	1.6	2.4	*1.3*	1.3	3.2	3.5	*2.7*

Source: Czibere and Gál (2013, Table 6).

Another inequality in the access to services is based on settlement hierarchy. The larger a settlement, the less dense the network of social services (see Table 13). The national average of 5% and 9% access in the 65 years old and older population to home care and meal-on-wheels services (see Table 10), respectively hides 17% in small villages and 1% in Budapest (home care) and 19% against 4% in the same settlement types in the case of social catering. The relationship is not completely monotonous. Mid-size and bigger towns (above 50,000 inhabitants) have somewhat denser service network than smaller towns.

Table 13: Care recipients per ten thousand of over-65 population by settlement size

Settlement population	Home care	Meal-on wheels service
– 499	1680	1887
500– 999	1092	1879
1 000– 1 999	979	1528
2 000– 4 999	711	1213
5 000– 9 999	489	900
10 000–19 999	430	792
20 000–49 999	327	616
50 000–99 999	328	797
100 000–	436	753
Budapest	143	439
Total	523	923

Source: CSO (2012a).

4.2.2 Quality and performance indicators

Within the framework of the ANCIEN project (http://www.ancien-longtermcare.eu/) Dandi et al (2012) found that the Hungarian quality assessment system is based on input and process definitions and indicators in the formal care. This puts the country in a group with Austria, Finland and Spain in contrast to systems, which are based on output indicators or have no quality assessment at all. The informal care system however is largely unregulated and left un-assessed.

4.2.3 Sustainability

The 2012 Ageing Report expects an increase in public LTC spending from 0.8% of GDP in 2010 to 1.4% in 2060. Under various scenarios the projected figure varies between 1.3% and 2.0%, which confirms the view that the main problem of the LTC system in Hungary is quality of life in old age, and adequacy, rather than sustainability.

It has to be added that the ECFIN-AWG projection applies a different definition of LTC spending than the OECD. The point of departure, 0.8% of GDP in 2010, is only 0.3% in 2008 in the OECD analysis of LTC systems (OECD 2011).

4.2.4 Summary

The LTC system of Hungary is rather inadequate and leaves either too much burden on families or old people uncared for. Public LTC spending is small and, due to the lack of coordination between health care and social care it is spent inefficiently.

4.3 Reform debates

In December 2010 the State Secretariat for Social, Family and Youth Affairs of the Ministry of Human Resources invited an expert team to prepare a concept paper. The Concept Paper on Social Policy 2011-2020 (*Nemzeti Szociálpolitikai Koncepció 2011-2020*) was released in January 2012 (Czibere et al 2011). The Concept Paper would rearrange the division of labour between central and local government. Currently, local governments have a double act as an authority and as a service provider. The law order them to evaluate the need for LTC services and also to meet them by maintaining facilities and programmes. The programme would redistribute the primary responsibility to government offices and make service providers, among them local governments, to compete for their purchases. Government offices would also give a background for closer cooperation between the two branches of long-term care by establishing the system of case management. The Concept Paper has not reached the level of public attention and was shelved.

It is difficult to judge the impact of EU social policies on other but anecdotic evidence and subjective assessment. The impression of the author of this report, confirmed by discussions with practitioners, is that there is no better explanation for the shift to home-based care than the regular presence of the administration at cross-country exchanges of best practices.

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Annex – Key publications

[Pensions]

BOTOS, K and BOTOS J, A nyugdíjreform alapkérdései, 2012, Pénzügyi Szemle Online.

"Key questions of the pension reform"

A 5-piece series of a pension reform proposal in an online journal. The authors suggest a child-related point system. The proposal initiated a public debate, which resulted in a conference (see below at Kovacs (ed)). The two authors, now in the academic sector or in retirement, were well-known policy-makers of the 1990s: Katalin Botos was cabinet member of the first democratically elected government (1990-1992) and she was the first head of the supervisory agency of the banking sector (1992-1994) whereas Jozsef Botos was director general of the social insurance administration before the split of PIF and HIF.

The five pieces can be downloaded from http://www.penzugyiszemle.hu/vitaforum/a-nyugdijreform-alapkerdesei-5-egy-uj-magyar-nyugdijrendszer-alapjai. The link was still active at the time this report was written.

KOVACS, E (ed.), Nyugdíj és gyermekvállalás, 2012, Budapest, Gondolat.

"Pensions and fertility".

Papers of a one-day conference at Corvinus University on child-related pensions and comments from invited experts. The conference was motivated by a reform proposal by Botos and Botos (see above).

The volume is part of the new Társadalombiztosítási Könyvtár (Social Insurance Library) series of Gondolat Kiadó, a publisher.

[Health care]

CENTRAL STATISTICAL OFFICE, Európai Lakossági Egészségfelmérés – Magyarország, 2009 (*"European Health Interview Survey – Hungary, 2009"*)

1. Összefoglaló eredmények (*"Main results"*)
2. A lakosság egészségi állapota (*"Health conditions of the population"*)
3. Az egészség társadalmi, gazdasági összefüggései (*"Socio-economic factors of health"*)
4. Az egészségi állapot és az egészségügyi ellátó rendszer (*"Health conditions and the health care system"*)

The Central Statistical Office started to publish the results and the first analyses of the Hungarian leg of the European Health Interview Survey in 2012. So far four volumes have been published containing the summary results, description and analysis of health conditions; and the functioning of the health care sector. The last volume is particularly relevant for this report. It includes, among others, a chapter on inequalities of access; another one on regional differences; and one on the long-term care system. Above I used some of these results.

THE HEALTH SYSTEMS AND POLICY MONITOR (HSPM)

The HSPM, an online platform collaborating with the European Observatory of Health Systems and Policies and supported by the Bertelsmann Stiftung, offers detailed descriptions

of the health care systems of 17 countries including Hungary. National systems can be compared by a "compare countries" engine. The page also offers health policy articles.

The Hungary page, which started its operation in 2013, is an important source of information both in actualities and general descriptions of financing, organization and governance, provision of services, physical and human resources and major reforms. It can be accessed at http://www.hspm.org/countries/hungary25062012/countrypage.aspx.

[Long term care]

CZIBERE, K et al, 2011, Nemzeti Szociálpolitikai Koncepció, 2011-2020, Budapest. Retrieved on 19 October 2013 from:
http://www.szoszak.hu/adat/dokumentumtar/hu32_NSZK_2011_10.pdf.
"*Concept Paper on National Social Policy, 2011-2020*"

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

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