

**Ministry of National Resources
Ministry of Public Administration and Justice**

National Social Report 2012

Hungary

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1. Introduction

1.1. General economic and social context with special focus on the challenges linked to social protection and social inclusion

One of the most important structural problems of the Hungarian economy which hinders potential growth is the very low level of activity and employment. In 2011 the employment rate of people between 20-64 years of age was 60.7% at annual level which shows improvement according to the data one year ago (60.4%)¹. The unemployment rate had increased during the previous years as the impact of the economic crisis slightly moderated since 2010, and by 2011 it decreased to 10.9% (by 0.3% as compared to the data of one year beforehand).

The main challenges of the social protection and social inclusion field beside low employment are weak social cohesion, increasing poverty and aging of the population. **Increasing employment** has a key role in tackling all of these challenges adequately. Sustainability of the social protection systems, strengthening social cohesion and mitigating poverty depend on a great extent on whether employment can be increased persistently and significantly.

In line with the above the situation analysis of the National Social Inclusion Strategy 2011-2020 also states that the main cause of poverty in Hungary is the low labour market activity of households. Besides the most important social factors influencing poverty are the low educational attainment, Roma origin, the number of children in the families or child poverty as well as the rural place of residence.

After the increase during the '90ies, poverty and income inequalities rather stagnated after 2000 in Hungary. The poverty rate in 2010 was more or less equal to that in the mid-nineties. In 2010 29.9% of the population belonged to one of the three poverty and social exclusion indicators. As a consequence of the crisis, deterioration was observable in the situation of the most disadvantaged groups in 2010 as compared to the 2008 data. An indication of this is that the rate of those living from an income under 60% of the median (at-risk-of-poverty threshold) remained stable as compared to the 2009 data (12.3%) under decreasing amount of the threshold, and furthermore the rate of those living in severe material deprivation increased (from 17.6% in 2008 to 21.6% in 2010). The rate of the third EU social inclusion indicator, people living in households with very low work intensity remained stable (12% in 2008, 11.8% in 2010).

Concerning the other age groups there is no sign of breaking the general trend, that the poverty rate decreases when age grows, and it is the most favourable in case of the elderly. If we look at the figures broken down by age we can see that the deterioration of all three poverty and social exclusion indicators occurred mostly by children, and this caused the deterioration of the general indicator. Poverty rate among children has not changed between 2008 and 2010 (it was 20.3% in 2010), but the rate of children under 18 living in severe

¹ Source: CSO, LFS

material deprivation has increased from 21.5% in 2008 to 28.8% in 2010! The rate of children living in households with very low work intensity has grown from 11.1% in 2008 to 13.8% in 2010 which is still the second highest amount among the Member States.

The multiple disadvantaged situation of the Roma population originates in the fact that the other factors increasing the risk of poverty, ie. low employment and education, large families, rural residence, over-indebtedness, are cumulating among them. Their poverty rate reaches 70%. About half of children living in poverty are also Roma. The territorial concentration of socio-economic disadvantages in Hungary is well-known for a long time; 40% of the settlements characterized by severe social disadvantages can be found in the 33 most disadvantaged micro-regions. In order to stop procedures of territorial segregation a number of programmes have been launched, among them the comprehensive development programme of the 33 most disadvantaged micro-regions in the 2007-2013 EU programming period. After evaluating the experience of the programmes so far preventing territorial exclusion must continue to be a priority.

The relative poverty rate is more favourable than the EU average (in 2010 12.3% as compared to the 16.4% average of the EU-27), which is resulted in a great extent from the performance of the social benefit system, since the poverty rate before social transfers (excluding pensions) would be 28.4%.

One of the challenges towards social protection systems is the **ageing of population**, which is not a long-term consequence but a currently ongoing procedure. This challenge affects as well health care, social care and last but not least pension systems. Increase in life expectancy at birth on the one hand is a triumph of the human factor, however the proper management of consequences requires a new approach and continuous adaptation. Adaptation and a change of attitude in this area is backed by the European Year for Active Ageing and Intergenerational Solidarity in 2012 launched by the European Commission, in the spirit of this European Year Hungary has also prepared its country programmes.

The **old age dependency ratio** (65+ persons in % of younger than 65 population) illustrates the process that occurs in the following decades. This rate was 24.2 % in 2010, is projected to increase to 50.2 by 2050 (in the EU-27 the figures are very similar, increase from 25.9 to 50.2), indicating that the rate of earners-dependants will dramatically change in the forthcoming 40 years. Increasing employment significantly affects adequate individual future pension entitlements and public burden sharing. The - in international comparison - high cost on wages could exclusively be decreased in case the rise in employment is significantly high.

In the field of social services significant challenges are the increasing operational costs and maintaining the same level of normative support of services. This induces the need for control of rationalisation of services, use of resources and the take-up of services, as well as serves as the basis of restructuring professional work, and the requirement of creating a modern, more efficient and effective structure.

Main challenges faced by the Hungarian **health sector** include: unfavourable health status of the population, demographic ageing, growing disease burden, emerging new disease patterns, ever changing population needs, increasing patient expectations and rapid technology development and diffusion, while, in spite of permanent reform efforts in the course of previous decades, the system is still striving with major problems of structural, organisational, management, quality, equity, financing and funding character, engraved by a major further tightening of resources available for the health sector especially under the circumstances of the global economic-financial crisis. By today, it has become evident that the contradiction between growing needs and tightening resources can only be resolved by moving towards

new models of health care responding and flexibly adapting to future needs, and this is the only way of ensuring the financial sustainability of the system.

A major challenge is the evolving human resource crises in the health sector. Health experts leave the country in ever growing numbers – a process mainly driven by economic motivations, engraved by the demographic aging of the health personnel. There is an urgent need for measures to retain the workforce; rationalise existing human resource capacities; ensure adequate re-training programmes. Specific measures are necessary for resident doctors (medical doctors in specialist training), whose major outflow represents a grave problem.

1.2. The content of the 2012 National Social Report and the coherence and complementary aspects in relationship to the National Reform Programme

As regards social inclusion the coherence between the National Social Report and the National Reform Programme is ensured by the fact that both documents contain the goals, intervention areas and measures of the National Social Inclusion Strategy 2011-2020 adopted in November 2011. The National Strategy contains the social inclusion target set in 2011, which is the reduction of people living in poverty or social exclusion by 450 thousand people. The main approach of the social inclusion policy in Hungary – which is promoted in both the NSR and the NRP – is promoting interventions based on comprehensive interventions based on inter-sectoral cooperation for the sake of the most disadvantaged groups, mainly the Roma and poor children, as well as the population living in the most disadvantaged territories. The main focus of the interventions are respectively: promoting the employability and employment of long-term unemployed or inactive people at active age, interventions at the earliest age and access to quality education in case of children for breaking the inheritance of disadvantages, as well as tackling the territorial shortages of equal access to services. Besides the abovementioned we also aim at mainstreaming the aspects of social inclusion in the relevant policies and the local planning, as well as monitoring the participation of the Roma population in the various social inclusion policies.

Previously - in 2009 and 2010 and in last year - introduced measures in the pension system on the one hand have largely contributed to state budget consolidation as well as to the mitigation of budget deficit, while on the other hand served for sustainability of the system: the objectives of the reconstruction of the whole system included self-financing of the system from its own resources and not through direct budget supplements.

Compared to the National Reform Programme submitted last year, health aspects will hopefully be represented in a more explicit way, particularly as regards the improvement of the health status and the employability of the labour force, while macroeconomic, growth-friendly fiscal aspects of the health sector are expected to appear in the Convergence Programme.

1.3. Consultation with the relevant stakeholders in the preparation of the National Social Report 2012

A consultation was carried out with the respective sides of the National Economic and Social Council, as well as the Hungarian Medical Chamber, the Hungarian Pharmaceutical Chamber and the Hungarian Chamber of Health Professionals.

2. Overview of the progress made along the overarching common objectives of the Social Open Method of Co-ordination (OMC)

2.1. Main challenges and priorities

Social inclusion

According to the main challenges the National Social Inclusion Strategy (2011-2020) draws the necessary intervention areas and aims in the following fields:

- **Decreasing the rate of people living in poverty or social exclusion, with special emphasis on the Roma population**

One of the biggest social policy challenges in Hungary is to tackle long term unemployment / inactivity, which is at the same time the main aim of poverty. Therefore increasing the employment level of people living in deep poverty and the Roma is an outmost objective. Therefore Hungary plans or implements several measures in order to train this target group, develop their competences and improve their employability. We also aim at involving disadvantaged people into certain economic and entrepreneurship development programmes by developing the labour intensive branches and the social economy. We reform the social benefit system in order to encourage coming back to the labour market. The employment of the disadvantaged job seekers is supported by active labour market policies and temporary within the frame of public employment. The latter provides work income instead of social assistance for long-term unemployed people with low qualifications. Public employment wage ensures their living and the system is accompanied by trainings fitting to the needs of the labour market which enables getting back to the primary labour market.

- **Preventing the inheritance of poverty and social exclusion**

In order to decrease the poverty among children and families with children it is necessary to keep the level of welfare transfers to families, to improve the quality and accessibility of child welfare and child protection services, and to develop early childhood education and care and early capacity development. It is necessary to improve the access of multiple disadvantaged among them Roma pupils to quality education, and supportive programmes are needed to promote their school career and decrease their early drop-out.

- **Improving the equal access to social-economic goods**

The complex problems leading to housing insecurity must be tackled, including the tools of the housing benefit and social housing systems. Programmes are to be launched for the rehabilitation of the housing stock and the environment of segregated urban housing estates or estates with low infrastructure, as well as for promoting the employment and social integration of people living there. The improvement of the health status and access to health care system for the Roma, people in deep poverty and children is also an important goal.

Pensions

Reform measures in the pension system implemented in recent years, aimed at tackling the demographic situation, ensuring the sustainability of the system, and in addition, rules of longer working will contribute to ensure the adequacy of pensions as well. The key priority of the pension reform is to maintain the sustainability of pensions without using extra-budgetary

resources. This expectation should meet the requirements of the pension system that should be self-sustaining and ensure the actual balance of the Pension Insurance Fund at all times. Further other key priorities have remained ensuring the proper pension adequacy and making the pension system adjusted to the proper changes.

Health care

The “Simmelweis Plan for the rescue of health care” is the health policy programme concept of the Government outlining the general framework for restructuring the Hungarian health system. In line with challenges and ongoing processes in Europe, the target health care model is smaller, moving towards new models of care and moving away from the hospital-centric model, better organised, more effective, meeting requirements of quality, equity and sustainability. The essence of the new concept introduced in the Semmelweis Plan is the establishment of the territorial (regional) organisation of health care. 8 such regions have been created, being able to provide health care at all levels of progressivity from the primary to the highest levels. A basic aim is to provide large-scale, simpler care close to the population concerned, while complicated, highly specialised treatments, interventions should be provided in centres with high professionalism. A key element of the proposed model is patient pathway management.

Another task of high importance is the further development of the public health institutional system and the involvement of all societal sub-systems and players as partners in the implementation of the Public Health Programme, in addition to central government institutions.

Major inequalities exist in our country as regards the health status and its determinants, as well as social-economic factors. The dissemination and support of community settings (workplace, school, settlement) based public health programmes is a continuous task.

2.2. Policy changes to be pursued in 2012 with possible impact on the three strands of the Social OMC

- During 2011-2012 considerable changes are taking place in the **system of personal income tax** with the end goal of the switch to the flat rate personal income tax. During the transitional period the Government provides compensatory options in order to keep the net wage level of low income groups (see in details in chapter 3.4.).
- The new Act on **public education** operative from 1 September 2012 orders among others the decrease of the compulsory school age to 16 years of age. However it doesn't mean that the pupil gets out of the school system at 16. Prevention of early school leaving is promoted by the strengthening of early childcare, modern pedagogical methods, and targeted programmes are also available for disadvantaged pupils or pupils with special education needs endangered by school drop-out. The aim of the comprehensive reform of the **tertiary education** taking effect from 2012 is to increase substantially the rate of those with natural science, IT or technician qualifications as well as to improve the quality of higher education.
- **Public employment:** in order to lead the long-term unemployed, inactive people back to the labour market the Government changes the system of public employment. For motivating people employed in public employment to enter the open labour market, the public employment wage is set to be higher than the social assistance, but lower than the official minimum wage. Trainings for the development of competences and improvement

of employability are launched for participants with low educational attainment. In 2012 200 thousand people are expected to get into public employment.

- The maintenance of social services providing residential care has been the task of county local governments by law so far. However, taking into account the accumulating debt of counties, from 1 January 2012 the government took over the tasks related to the maintenance of these institutions and elaborated the necessary structural framework for county-level institution maintenance. Thus the governmental maintenance provides the conditions necessary for smooth operation. This change affects altogether 86 institutions and 12.333 service recipients.

3. Reducing poverty and social exclusion

3.1. Latest state of play of the national social inclusion target

The Hungarian social inclusion target undertaken in the National Reform Programme in 2011 is to decrease the number of people living in poverty or social exclusion by 5 percentage points by 2020: this means a decrease of cca. **450 thousand people**, from 2.83 million in 2008 to 2.38 million. This numerical goal is to be reached by the equally 20-20% decrease of three indicators: the at-risk-of-poverty rate of households with children, the rate of people living in severe material deprivation and the rate of people living in households with very low work intensity. This is also the main target of the National Social Inclusion Strategy adopted in 30 November 2011.

After the basic data in 2008 the number of people living in poverty or social exclusion came about **2.96 million** people in 2009 and **2.99 million** in 2010, which requires a 610 thousand decrease from people concerned by 2020.

The following table shows the change in the amounts of the three sub-indicators:

	Indicator	Basic data (2008)	2009	2010
1.	at-risk-of-poverty rate of households with children	16%	17%	16,6%
2.	rate of people living in households with very low work intensity (0-60 years of age)	12%	11,3%	11,8%
3.	rate of people living in severe material deprivation	17,8%	20,3%	21,6%

The at-risk-of-poverty rate of households with children slightly deteriorated, the rate of people living in very low work intensity households remained stable, while the most significant deterioration can be observed in the rate of people living in severe material deprivation. If we analyse these indicators according to age groups we can see that the deterioration of the indicators occurred **mainly among children** and it caused the general decrease of the indicators. For example the rate of children under 18 living in severe material deprivation increased from 21.5% in 2008 to 28.8% in 2010! In case of people living in households with very low work intensity it can be observed that the rate improved among the adults but worsened among children (from 11.1% in 2008 to 13.8% in 2010).

The realization of the social inclusion target can be expected in parallel with the economic growth and the increase of the employment rate. Therefore, according to the mid-term growth

and employment projections, among the three social inclusion indicators mainly the rate of household with low work intensity indicator may improve by 2013 because of the widening of the circle of long term unemployed people get into public employment. We expect noticeable improvement in the two other indicators and therefore in the general indicators only **from 2015 onwards**.

3.2. Main measures taken or to be taken in relation to reducing poverty and social exclusion

Along the lines of the National Social Inclusion Strategy, in the interest of reducing poverty and social exclusion measures are necessary to be made on the following intervention fields:

- Child well-being
- Education
- Employment
- Housing
- Involvement, awareness raising, combat against discrimination

The Governmental action plan attached to the Strategy for the years 2012-2014 envisages the following measures indicating the responsible implementing bodies, deadlines and resources:

- I. On the field of **child well being and child protection** implementation of complex territorial children's' chance programs have to be continued in the most disadvantaged micro-regions of which central elements are the Sure Start Children Houses. Quality early childhood care services have to be extended to territories short of such services and capacities, as well as discount meals during the summer holiday for disadvantaged children and high school students. On settlements in the course of becoming ghettos, programs have to be launched in order to enhance family support and child welfare services. School social work system has to be developed and installed. Training of surrogate parents of Roma origin has to be reinforced as well as institution of juvenile probation service has to be inserted in the system of child protection.
- II. Introduction of compulsory kindergarten attendance from age 3 is of great importance among the interventions of the **education system** to which significant capacity enlargement is to be attached. The Government goes on implementing its integrative and capacity developing programme (IPR - Integrative Pedagogical Programme) in preschool, elementary and high school education. Extra-curricular "Tanoda" ("Learnery") type and Second Chance type educational programmes are to be extended primarily in the most disadvantaged regions. Scholarship programs for the disadvantaged and Roma youth continue. Roma boarding school programs are supposed to be extended in tertiary education as well as programmes aiming to reinforce the participation of disadvantaged students in sport and leisure activities have to be launched. Significant role must be ensured for programs, formal and informal learning methods offered by cultural institutes supporting the implementation of the goals of public education and providing preventive and rehabilitating functions in the interest of social inclusion.
- III. On the field of **employment** the main target group of social inclusion policy are primarily inactive long-term unemployed groups. In the interest of the open labour market integration of these groups, targeted allowances and reliefs are to be deduced from the employment costs of the employers in case they hire individuals belonging to disadvantaged social groups (inter alia the long term unemployed, the disabled, youth and from 2013 those with low qualifications). Placement of individuals with low qualification is to be favoured in certain enterprise development programs.

Employment of disadvantaged job seekers on the basis of public employment service is to be assisted by targeted, active labour market tools provided by job centres. Enhancement of social land programs and development of organizations operating on the field of social economy are necessary in order to ensure seamless transition into open labour market integration. Wide range of public employment programs combined with professional training are to be launched in 2012 which will provide better employability and possibility of gaining salary for the disadvantaged ones. The target group of the EU financed integration and training programs aiming to better employability, consists of the disadvantaged ones, the Roma and those living in segregated areas. Training of Roma women for social and child protection qualifications are to be provided as well.

- IV. In **healthcare**, in the aspect of social inclusion, the most emphasised parts are the development of early childhood screening, education of disadvantaged parents on children's health, improvement of preventive capacities of primary care as well as the development of health improvement in educational institutions. Programs for the better involvement into public health screening of those living in segregated areas are to be launched. Access to healthcare is supposed to be facilitated by reinforcing the health visitor service and filling general practitioner and paediatrician vacancies in the given territories. In the most disadvantaged micro-regions calls for application have been issued aiming the dissemination of individual behaviour patterns of health promotion, community values, communal programs for health improvement and also for consolidating an institutional and organizational base of sustainable health improvement services in micro-regional level.
- V. In order to resolve **housing** and over-indebtedness issues social housing and housing benefit system is to be restructured. In 30th of April 2011 the social-based gas and district heating support was removed from the supply system. In order to mitigate the consequent growth of additional household burdens the housing benefit system has been augmented: the eligibility criteria based on the 150% of the minimum old age pension of the income per capita in the household was increased to 250%, as well as the rule that stipulated that acknowledged monthly cost of housing maintenance must have exceeded the 20% of the total household income, became abolished. As a consequence of the amendment the number of recipients of housing benefit considerably increased. In the field of housing ongoing urban social rehabilitation programmes and settlement rehabilitation programs to be launched soon financed by EU resources need to be mentioned.
- VI. Trainings are to be launched for the employees of the Roma self-governments in order to **involve** the disadvantaged ones and the Roma. In order to promote awareness raising, and combat against stereotypes Roma cultural institutes and the skills developing programmes of cultural institutions are to be supported as well as realistic media representation of the Roma is to be encouraged. In order to enforce the interests of social inclusion in local planning, from the end 2012 all municipalities applying for development resources must elaborate an equal opportunity program. For the purpose of resolving local conflicts community-developing, conflict-mediating, crime preventive programs are to be launched. Employment of Roma youth at law enforcement authorities and defence forces is also encouraged.

The implementation of the measures of the action plan will be reported to the government by the end of May of every year, and the National Social Inclusion Strategy has to be reviewed

biannually, 2014 at the earliest. A monitoring system of the Strategy to be established by 31th of May 2012.

In 2011 the total number of 253 thousand persons received the so-called benefit of active age people which can be regarded as the minimum income benefit. (The data do not contain the number of those whose benefit was suspended due to their participation in public work program). As it was emphasised at the measures to be introduced on the field of employment, the situation of long term unemployed people, labour market integration and the strengthening of the self-care capabilities of the inactive ones are main priorities. To this end changes aiming to motivate for work occurred in the social benefit system. From 2012 eligibility criterion for the so-called employment substituting benefit will be that the applicant must have been pursuing gainful activities at least for 30 days in the previous year or participating in labour market program or training in order to better his or her situation by his or her own effort. Opportunity for participating in public employment program will be accessible for wide range of the beneficiaries. In 2012 200 thousand persons are expected to be involved into public employment programs. In 2011 more than 70% of those involved in public employment program were employed for short 4 hours of activities for a 1-4 months short-term run. At the same time in 2012 according to preliminarily expectations only a minimum number of persons are to be involved into this type of public employment, however daily 6-8 hours of socially meaningful activities for a longer run will be emphasised. The new public employment programs will accentuate the reintegration into primary labour market. The changes occurred relating the amount of benefits aim that the income gained through public employment shall exceed the amount of social benefit receivable. In the interest of guaranteeing the access to public goods as well as of curbing the phenomenon of loan-sharking the proportion of benefit in kind will increase.

3.3 Measures which are in place in response to the target and the main target groups

Based on the National Social Inclusion Strategy from the aspect of social inclusion the main considerable target groups consist of the **Roma, children living in poverty and the population of disadvantaged regions**. (There is significant overlapping between these above mentioned groups.) According to the section 3.2, one of the target groups of measures introduced on the field of health, child wellbeing and education is the group of Roma children. Great part of the measures put the target on the basis of social situation; however certain programs (for example scholarship programs or certain labour market programs) specifically favour or impose quotes on the participation of the Roma.

3.4. Measures which are in place or which are to be implemented in order to tackle in-work poverty

In-work poverty in Hungary hit 5.3 percent in 2010 which in comparison with EU data does not seem to be extremely high. Therefore the main poverty risk factor in Hungary is unemployment and inactivity. At the same time, one of the country-specific recommendations of 2011 points out that in the interest of the motivation for participation in the labour market, mitigation of the impacts of the tax system on low income labourers must be guaranteed. During the transition to flat rate personal income tax system the Government introduced various measures in order to maintain the net income of the low income employees. As first, from 1st of January 2012 the minimum wage and the guaranteed wage minimum (for skilled workers) was increased. In the public sector wage compensation initiated in 2011 is to be continued in order to counterbalance the eventual reduction of low

net monthly income. In the private sector the Government motivates the employers to lift wages through tax allowances on one hand. On the other, companies which cannot afford lifting wages by 5% easily, can apply for financial assistance in order to maintain employees' net wages and not to be forced to implement cut-backs.

4. Adequate and sustainable pensions

4.1 Main measures taken in 2011 and in 2012 to ensure adequate and sustainable pensions and modernise pension systems

The National Social Report focuses on those changes introduced in the pension system that deal with the benefit side of the system while the NRP primarily deals with the role of the pension reform in the fiscal consolidation process, the transformation of the pension system from the aspect of financing and analysis, and its impact on the evolution of employment.

The effective retirement age has grown by a 1-1,5 year between 2008 and 2011 and the expenditures spent on pensions (in % of GDP) are as follows during the same period:

	2008	2009	2010	2011
Pension Expenditures in % of GDP	10,8 %	10,9 %	10,6 %	10,8 %

Before showing the most recent changes in a more detailed way, it is necessary to shortly refer to pension measures introduced in 2009 addressed to tackle financial crisis which brought substantial changes in the pension area:

The pension package in 2009

Measures introduced in 2011-2012 are based on a previous set of significant measures implemented in the pension system, aiming at stabilizing the situation occurred due to the global financial and economic crisis. The essential elements are:

- **From 2012 the retirement age will increase by six months** for every age cohort starting with those who were born in 1952. In 2009 retirement age was 62 for both men and women. This retirement age will increase by 3 years and the process will be completed by 2022. This means that the age cohort born in 1957 will have the unified retirement age of 65. In line with increasing the retirement age, further tightening rules have been applied for early retirement options as well;
- **The abolition of the 13th-month pension;**
- **The former pension indexation rules have been changed.** According to former rules the annual pension increase was calculated in terms of the Swiss indexation (50:50 percent increase of CPI and net average earnings). From 2010 the pension indexation has been attached to increase of the GDP growth as well. This means that in case of 3% of GDP growth, pensions are indexed exclusively to consumer price index, while the GDP growth is 5% or over Swiss indexation (50-50%) is applied to pensions. Between 3 and 5% of GDP growth, pensions are increased by consumer price index than the net average earnings (e.g. 3 to 4% of GDP growth, 80% of CPI and 20% of net earnings, 4 to 5% of GDP growth rate in 60 and 40% of inflation and net average wages are taken into account in determining the level of pension increases).

2010 – 2011 - transforming the mandatory private pension pillar

According to a decision made by the Government in October 2010 and the subsequent regulations, payments of the membership fee into the private pension funds were suspended for 14 months and the entry to the private pension funds was not be obliged to new labour market entrants any longer. During this period (1 November 2010 - 31 December 2011) the private pension fund members had to pay their total pension contributions into the Social Insurance Pension Fund. The fund members could choose between two options: either returning to the social insurance pension pillar until 31 January 2011 or remaining in the private pension funds. 97% of members chose the social insurance pillar.

This measure was needed in order to reduce central state budget deficit, to mitigate the high deficit of the Social Insurance Pension Fund as well as to ensure the pension system matching the expectations that the Pension Insurance Fund should maintain proper balance between actual contributions and expenditures. These measures partly reflected on the negative experiences accumulated in the operation of private pension funds (including the expensive operation, and the low real returns in 10-year average). Due to choice of fund members the pension system was transformed to a two-pillar system: one element is the publicly financed social insurance pension system (state pension) and the other one is the supplementary voluntary savings pillar.

2011-2012 – Measures introduced in the social insurance pension scheme

1. **Introducing the “women 40 years” rule** – From 1 January 2011 women are entitled to old-age pension irrespective of their age, if they have gained at least 40 years of eligibility period, in which not only the whole duration of contribution payment but also child-rearing time will be taken into account. As a general rule, at least 40 years of eligibility must be gained which should include at least 32 years of contribution payment period (from gainful activity) and no more than 8 years of child-rearing related service time can be taken into account in this respect. In case of five or more children the 32 years of contributions can be reduced by a year per child, but at least 25 years contributions payment period must be provided by all means.

2. From 1 January 2012 the financing of the system changed: each insured person has to pay his/her individual pension contribution into the compulsory social insurance pension scheme. This is obligatory for those insured as well who had chosen the private pension fund's membership and the payments into the private insurance funds became supplementary from this date. However, the extent of voluntary membership fee is defined by each private pension fund in its statute.

3. From 2012 onwards the method of indexation of pensions is changed according to Act on State Budget: the annual pension increase is set by planned consumer price index in the future.

4. **Pension measures implemented in the social insurance pension system in 2011:** From 1 January 2012, it is a significant change in the social insurance pension system that, as a general rule, those persons are considered pensioners who have reached the retirement age or who have completed their eligibility period according to the "women 40 years" rule and receive pension according to this rule. Other early retirement pension options from this date are no longer considered as pensions, however these benefits are defined as other social benefits, financed by social resources and from the Social Insurance Pension Fund. Disability

pensions are also excluded from the pension system, so from 1 January 2012, these benefits are other types of benefits.

4/a. **Early retirement benefits:** according to former regulations there were several options to claim pensions before reaching the statutory retirement age. The extensive use of the wide-ranged preferences has contributed to maintaining a significant gap between the effective and the statutory retirement ages, and despite the more stringent regulations that have been initiated for several times, the widespread use of early retirement became typical.

- **The conversion of early retirement pensions to social benefits prior to retirement age** -This measure is implemented to the recognition of acquired pension rights and guarantees further payment of these benefits, furthermore on terms based on promises of the social insurance pension legislation. The transformed benefits² will not be qualified as pensions in the future, but their amounts will be increased the same as the pensions, and in addition taking up employment is subjected to the same rules as formerly in case of early retirement options.
- In the future, early retirement options will be ceased and social insurance pension system will consist of old-age pensions and survivors' pension benefits. Different laws will regulate the eligibility and disbursement criteria of benefits prior to retirement age and following the restructuring of the disability system, benefits for persons with changed working capacity.

4/b. New provisions for people with changed working capacity

- A new type of system has been set up by the transformation of the former disability pension system and other benefit schemes regarding disabled persons on the basis of the similar principles. The emphasis is put on the remaining capabilities and rehabilitation, instead of the former passive tools. These changes intend to maintain active life as an employee by examining complex status of the applicant and by providing the tools needed for better health status.
- People with changed working capabilities can be qualified for **rehabilitation or disability benefit**, based on a complex assessment. These persons receive financial support and services promoting employment, while disability benefit recipients receive cash benefits. The period of rehabilitation and the period of work along with disability benefit are considered as service period for pension eligibility. As a transitional provision, recipients, reaching their retirement age within five years, and those who have the worst health status will get the same amount of disability benefit they had received before. Younger cohorts' status and benefits can be changed depending on the results of the new complex assessment.

5. Further measures: During this year, other rules and elements of the system will be reviewed (such as valorization, accrual rates etc.) and, if necessary, they will be corrected/modified. Further work is to be foreseen as regards the setting up of individual pension accounts, according to the former statutory obligations established by law.

To sum up: The above mentioned measures, reframing retirement rules represent essential steps moving towards the sustainability of the system, and they provide further impulses for

² The former early retirement benefits are covered in the transformation of the system: advanced pension and advanced pension with reduced sum, early retirement pension, miner's pension, early retirement pension paid by the employer, pension for artists, pension for mayors, pension for Members of the Parliament (MPs).

continuing our work, although further measures and fine-tuning activities will be needed later in order to maintain long-term sustainability of the system.

4.2. Cross-references to the relevant parts of the National Reform Programme

When the NRP deals with pension measures and the pension system, the main issue is how these measures would contribute to the stability of the system, to the maintenance of self-financing and to the central budget consolidation. The pension system has a prominent role in impacting employment, as it determines a framework and expectations which support the stay in the labour market instead of leaving it early.

In the 2011 country-specific recommendations, no special recommendations for pensions were included, but measures taken during the year correspond to the same direction as the previous country-specific recommendations: expectations to withdraw the widespread practice of early retirement and claiming disability pensions.

5. Accessible, high-quality and sustainable healthcare and long-term care

5.1 Measures, actions taken implemented during 2011 and 2012 aiming at improving access, quality and adequacy of healthcare and long-term care

5.2 Actions taken aiming at ensuring financial sustainability of the health and long-term care systems (including cost-containment, co-payments, de-reimbursement of drugs, increase of hospital fees, and transfer of activities to the private sector).

Health care:

In line with the target model and priorities as specified in the Semmelweis Plan, the following main measures have been taken during 2011 and 2012:

- Extensive **consultations** with stakeholders, with all those concerned, several tours around the country;
- Laying the foundations for evidence based decision making, comprising an extensive **database** appropriate for modelling and mapping of various alternatives;
- **Debt consolidation**, ensuring an extra funding of more than 10 billion HUF for health service providers during the past two years to be able to decrease their debts accumulated during several years;
- To increase resources available for the sector, the introduction of the **accident tax** as of 1 January 2012, based on the recognition that using a vehicle is associated with higher risk of accidents and potentially higher health expenditures. That is why it is reasonable that those using vehicles contribute more to health expenditure coverage. The tax is paid by the user of the vehicle together with the liability insurance fee. The rate of the accident tax is 30% of the vehicle liability insurance fee. The tax is collected by the insurance company from the tax payer.
- **Establishment of the institutional background:** as of 1 May 2011, the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) was established with the following main tasks:

- *institutional maintenance and supervision responsibilities*: in line with the increasing role of the state and the consequent rearrangement of responsibilities between local authorities and the state, the implementation of the taking over of health service providers transferred from local to state ownership, as well as fulfilling maintenance and supervisory duties over state owned health institutions (*implementation in progress*);
 - *institutional structural rearrangement*: the overall assessment of the health care institutional system (patient turn-over statistics, activities performed, contracted capacities, utilization), definition of levels of progressivity based on recommendations by the National Health Advisory Board, and in line with the defined progressivity levels and with the help of the accessibility maps, rendering capacities and territorial care responsibilities to individual care providers (*implementation in progress*);
 - *patient pathway management*: establishment of the National Health Management Centre and regional health management centres in order to shape the forms of functional co-operation (professional relations, support services, joint procurement) among health care institutions and to fulfil regional patient pathway management tasks (*implementation in progress*);
 - *health sector informatics*: fulfilment of tasks related to developmental, analysis, evaluation, research, professional and expert support activities concerning health, health care and health sector financing issues (*implementation in progress*);
 - *quality*: establishment of the institutional background for the definition of the health sector's quality and patient safety strategy and its main directions, as well as for the elaboration of quality targets and the toolbar supporting their implementation.
- The ***strengthening of Primary Health Care***, providing definitive care to the highest possible extent, taking measures to improve health promotion activities, as well as addressing the human resource crisis among general practitioners (GP):
 - To *incentives high quality, effective activities among GPs and paediatric general practitioners*, as of 1 April 2011 a country-wide, uniform indicator system has been introduced aiming at improving the quality of care. This complex system allows for the assessment of GP's work on the basis of their overall activities. The means of incentivising is providing extra financing depending on the measured performance of individual GP services, so practices can have extra incomes through bonuses.
 - Renewal of the *practice right of GPs*: the connection between practices and territorial care responsibilities has been strengthened to create a more unambiguous situation.
 - A *Practice Fund* was created to enhance filling long-term vacancies in practices and to boost the practice market. This measure aims at providing help to young GPs in having access to a practice right under favourable conditions. The Government made 300 million HUF available for young GPs to apply for financial support to purchase a practice and the necessary medical equipment, while they have to commit themselves that they will remain in the given practice for a period of time proportional to the magnitude of the grant. It also helps elderly GPs to have better chances for decent retirement through facilitating the selling of their practice.
 - As part of the ***development of pre-hospital emergency care***, in 2011 the National Ambulance Service was awarded major grants, partly from EU funds, for the purchase of

ambulance cars, the reconstruction or construction of ambulance stations as well as for purchasing life-saving equipments.

- The aim of ***developing rehabilitation services***, financed from EU and national resources, is to mitigate geographical-territorial and professional-contextual inequality as well as to improve the level of available services through the improvement of infrastructure and equipment in medical rehabilitation services, the spread of ambulatory forms of such services, the improvement of human resources and the enhancement of professional co-operation. Priority areas for development are: cardiology, lung and respiratory, paediatric, neurological and loco-motor rehabilitation.
- ***Measures aimed at improving the balance of the pharmaceuticals budget:***
 - o ***Measures introduced as of 1 July 2011:***

Increase in claw back from the present 12% to 20%

Pharmaceutical producers were obliged by law to pay back 12% of the amount of reimbursement based on medicinal products' producer price into the Health Insurance Fund on a monthly basis. This rate was raised to 20%.

An increase in the fee paid after medical sales representatives

In order to reduce marketing activities, the yearly fee paid after medical sales representative was raised from 5 million HUF/ person to 10 million HUF/person.

Re-concluding subsidy-volume contracts

Subsidy-volume contracts are binding contracts based on civil law between the Health Insurer and the distributors in order to share the financing risks. The re-conclusion of expired contracts is necessary with a threshold limit lower by 10%. It means an increase in payment by pharmaceutical companies having subsidy-volume contracts.

Generic program, the scheme of preferred reference price band, generic incentives

Following the patent expiry of original products the reference product of a fixed group formed after the market entry of generic products did not have enough advantages which could make its marketing authorization holder interested in reaching, by means of price decrease, *reference product* status for its medicinal product. Therefore it was necessary to develop a multi-component scheme which makes all parties of the market interested in attaining the reference product status. Further to the reference product, this system gives preferences to other products, as well falling within the margin of 5% (in case of active substance fixed groups) or 10% (in case of therapeutic fixed groups) above the reference price level (preferred reference price band).

The spread of first generics

Earlier, following the patent expiry, a 6-month period after its placing on the market was required from a generic product to become a reference product. It was necessary to reduce this period to 3 months to make drug prescription more economical. The adequate guarantee of supply can be ensured by a sufficient number of marketed products.

Review of certain fields of therapy

In addition to the comprehensive development of financing protocols, it is necessary to review specific therapeutic fields with the aim of reconsidering reimbursement rates. The aim is to develop financing protocols in all fields.

Review of combined products

According to the regulation in force since 1 January 2011 the reimbursement of medicines containing a combination of active substances has been fixed in keeping with the reimbursement rate applicable to the relevant monocomponent medicinal products.

- *Measures entering into force in 2012:*

Marketing activities of pharmacies

Regulations concerning the marketing activities of pharmacies were made more rigorous in order to strengthen their health service provider roles.

Solidarity fee

As of 1 January 2012, the solidarity fee paid by public pharmacies with a higher total gross margin on the marketing of reimbursed pharmaceutical products has been modified in a way that the payment obligation is based on the publicly financed sales of entrepreneurs with the same tax identification number and not of individual pharmacies and the payment obligation increases in cases when the quarterly reimbursed total gross margin exceeds 15 million HUF.

Subsidising operation of pharmacies with lower sales levels

In order to ensure continuity in the provision of pharmaceuticals in the countryside, conditions of applying for operational subsidies have been modified in a way that, up to the total sum of 100 million HUF per year made available by the state plus the income from solidarity fee paid by bigger pharmacies, those pharmacies are entitled to apply for subsidy which are the only public suppliers of medicines in the given settlement, their total gross margin was not higher than 7,2 million HUF during the first half of the previous year and they are open at least for 40 hours per week. Pharmacies with higher than 6 million HUF total gross margin during the first half of the previous year receive a 20% lower subsidy than those with a total gross margin below 6 million HUF. The advantage of this differentiation is that pharmacies with lower turnover are entitled to higher state subsidy. It is a new rule that pharmacies meeting the above criteria might receive a monthly 20-thousand HUF subsidy also after their branch pharmacy.

Prescription of pharmaceuticals for the socially deprived population

In line with regulatory changes related to the introduction of the preferred reference price band, from 1 January 2012 in those pharmaceutical product groups where there is no preferred reference price band established only the reference product or a product with more favourable daily therapeutic price can be prescribed under the specific system for the socially deprived.

Active ingredient based prescription

To further enhance generic competition in a certain specified group of pharmaceuticals, it seems to be reasonable to introduce active ingredient based prescription. It is planned to be introduced in case of cholesterol reducing drugs, as a pilot, as of 1 April 2012, parallel to fixing processes related to the new preferred reference price band system.

- From among measures aimed at ***improving the health status of the population***, it is worthwhile to mention the following::
 - o Strengthening of the *institutional system of public health* has been started, and as part of this process, through merging a number of institutions, the establishment of a public health institute is in progress, being able to operate more effectively and act as a driving force of public health actions.
 - o As of 1 September 2011, the *public health product tax* was introduced, with the aim of providing incentives for the population for a healthier lifestyle, for actors of the food industry for producing products with more favourable ingredients through levying taxes on products whose consumption bears in itself risks (essential sugar and salt content or caffeine contained by certain products with high sugar content). Income collected through the tax is used to support the improvement of the health status of the population.
 - o The amendment of the act on the *protection of non-smokers* entered into force on 1 January 2012 providing for a ban or essential restrictions on smoking in indoor and certain outdoor public places.
 - o Financed by the EU and the Government, implementation of a number of projects aimed at *improving the health status* is in progress, primarily targeted at addressing social determinants contributing to the development of chronic diseases (fight against smoking and harmful use of alcohol or obesity, promotion of healthy diet and physical activity). In addition to that, a tender was published for a co-ordinated development project for the establishment of health promotion offices as part of developing prevention capacities of the healthcare system, with the task of conducting co-ordinated, risk assessment based health development activities with the involvement of Primary Health Care services.

- To enhance the ***retention of health professionals in the country*** as well as to ensure their adequate, needs based training:
 - o the development of their *career model* based on homogenous career groups is in progress, together with the *renewal of the professional training system*;
 - o to retain *residents* to work in the country, a scholarship programme was introduced ensuring for participating residents to receive a monthly grant of 100.000 HUF in addition to their wage in case they commit themselves to remain in full-time employment in Hungary for a period of time equal to their participation in the scholarship programme and they do not accept any direct payments from the patient.

Long term care:

In order to further develop the set of professional tools in the social institutions, where institutional long term care is provided, two programmes have launched.

First, within the framework of the Social Innovation Operational Programme 3.4.2. financed by ERDF, long term care service provider institutions can apply for support aiming at modernising the building and its facilities. In this modernization programme 5.77 billion forints were allocated. On the one hand applicants can improve their services by renovating the building, the rooms and community spaces of the institutions. On the other hand they can

apply for modernisation in order to reduce overcrowding, to widen living space or displace part of the accommodation places in small buildings, or houses in settlements, where users can live in a community without isolation.

The main fields of the development are:

- Modernization of institutions giving permanent long term care for creating more environmentally friendly and energy-efficient buildings and rooms.
- Renovating outdated buildings in order that the caring circumstances meet the legal requirements.
- Widen the possibilities of long-term care provided at home. open the services of institutions for the inhabitants living nearby, and for basic services.
- Maximum 20 per cent increase in the number of places of institutions during the renovation, modernization programme.
- Procurement of equipments for better care and employment of beneficiaries.

Another type of development was an application launched by the Ministry of National Resources for service providers providing institutional long-term care to get anti-decubitus mattresses and beds. In 2011 300 mattresses and beds were delivered. In 2012 following a central public procurement process 987 mattresses and 1500-1600 beds can be obtained improving the quality of long term care from the 300 million forints governmental support. The final result expected in spring in 2012.

The SIOP 3.4.1.A-11 application was also launched, which intends to support deinstitutionalisation of residential institutions for people living with disabilities, psychiatric illness or addictions. The main purpose of the measure is to replace places of large institutions to smaller units integrated into the living environment and providing a wide range of services, strengthening and developing user's ability for self-care in accordance with to the Strategy for deinstitutionalisation approved by the government resolution 1257/2011. (VII. 21.). For implementation 7 billion forints are available for service providers operating in convergence regions.

From 1st of March 2012 all social, child welfare basic service or child protection service providers financed by governmental normative support should record the main data of users at a daily basis in a nation-wide on-line programme. The system covers all long term social services. The aims of the new administration process are to monitor and document better the expenditure of budgetary supports, and to avoid double financing and making budgetary spending more efficient.