ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Hungary

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Robert I. Gal
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Contact: Emanuela TASSA

E-mail: Emanuela.TASSA@ec.europa.eu

European Commission
B-1049 Brussels

European Social Policy Network (ESPN)

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Robert I. Gal

(Hungarian Demographic Research Institute and TARKI Social Research Institute)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

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Summary / Highlights

Long-term care is a low-priority sphere of public policy in Hungary, receiving hardly any attention and igniting hardly any debates. Having disabled relatives or growing old and becoming dependent is more a family than a social affair. This is reflected in the limited availability of public long-term care services, scarcity of related research and lack of relevant data.

The system is underdeveloped in general, leaving a significant share of needs unmet. There is anecdotal evidence of a large grey zone of elderly care between public services and familial care. People in need, or their families, buy services on an informal market, which is mostly out of sight of the authorities, unregulated and tax evading, and which is not supported by long-term care insurance.

Within the public system, the small package that seeks to ease the burden of familial care providers consists of two measures: unpaid leave (that is, job security and social insurance, but no income) and a cash benefit, which is aimed at people providing care to a disabled or permanently ill relative. In addition, families raising a disabled child are entitled to an increased amount of family allowance (HUF 23,300, about EUR 75, instead of HUF 12,200, about EUR 40) and longer periods of childcare allowance (for the first 10 years of the child's life, instead of 3 years).

The Labour Act allows relatives to go on unpaid leave to care for small children or, for a maximum period of two years, in order to take care of permanently ill relatives. Such needs have to be confirmed by the health care system, and the employee has to provide care by him/herself.

There is no cash benefit for care recipients to ease access to services, but relatives caring for a disabled or permanently ill family member may apply for nursing allowance. Depending on the health conditions of the care recipient, an increased nursing allowance may be paid (*emelt összegű ápolási díj*), at 150% of the standard allowance; or, since 2014, an extra nursing allowance (*kiemelt ápolási díj*). The amount of the latter is HUF 53,100 (about EUR 175) a month, 180% of the standard nursing allowance (HUF 29,500, about EUR 95) and it can be paid to care providers if the health status of the recipient falls below the 30% threshold on a 0 to 100 scale applied by authorities assessing health status.

The nursing allowance is not specifically targeted at long-term care for the elderly, but at disability or permanent illness. It is not intended to fully replace the wage of the carer, but to offer limited compensation. The amount of the regular version is small, about 19% of the average monthly net wage.

The dynamic expansion of home care and social catering, though not directly targeting carers, but rather care recipients, has made it easier for many to balance work and family. The importance of home care has increased rapidly over the last few years, since 2008. Whereas residential capacity has remained practically unchanged (it grew by 7.4% between 2008 and 2014), the number of home-care recipients has nearly tripled, and meal-on-wheels services have grown about 1.6 times over the same period.

Decision makers have yet to grasp the increasing importance of a proper long-term care system in an ageing society, as well as the potential of government intervention for risk sharing and containing social costs.

1 Description of main features of work-life balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime

In sharp contrast to pensions, long-term care is a low-priority sphere of public policy in Hungary, receiving scarcely any attention and igniting little debate. Having disabled relatives or growing old and becoming dependent is more a family than a social affair. This is reflected in the limited availability of public long-term care services, scarcity of related research and lack of relevant data.

Hungary has no separate long-term care system. Long-term care services are administered in the healthcare system and the social care system. The two branches have their own legislation, financing mechanisms and services. They maintain parallel institutional networks in both institutional care and home care. Coordination between them is still weak, despite some minor improvements over the past few years, thanks to the concentration of the healthcare and social affairs portfolios in one authority, the Ministry of Human Capacities (MHC).

The long-term care system still bears 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 than for managing personal networks, such as home-based care; and a kind of organisational blindness that does not notice needs beyond the immediate sphere of operations. The consequence, as in other fields of activity, is a dual structure: a system of institutions and a wide range of household activities by which people adjust to the situation. This structure is still recognisable, although it has changed with the entry of new providers (in particular charities) and, since the start of the economic crisis, with a rapid expansion of home care.

Long-term care (LTC) needs differ by age. Reflecting the institutional environment, most of this report deals with LTC in old age. We discuss the services and benefits available for families with disabled children and working-age adults in separate paragraphs at the end of the respective sections.

1.1.1 Institutional structure and procedures

The services provided under healthcare are nursing care in the 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.

Generally speaking, the financial system of public long-term care subsidises the supply. Services are funded directly, and those in need of care do not get cash benefits to buy services. Private insurance schemes are not involved. Operational costs are financed by the Health Insurance Fund (HIF; *Egészségbiztosítási Alap*) for healthcare and by the government or local government for social care. In addition, care providers may charge user fees. The exact amount varies from service to service. Formulas for its calculation are set out in regulations, 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. The maximum fee is 80% of monthly income for residential care, and 50% for rehabilitative care. In addition, since 2015 providers of residential care have also been able to charge an admission fee for new users. Its maximum amount is HUF 8 million (about EUR 26,000). At least half of the places in a residential care centre must be free of any admission fee.

Need for care is established by a complex assessment process, which was recently revised. This assessment process is initiated by a general practitioner and carried out by an expert committee appointed by the local notary (in the case of home care) or by the expert committee of the National Office for Rehabilitation and Social Affairs (NORSA; *Nemzeti Rehabilitációs és Szociális Hivatal*) in the case of institutional care. The criteria are national standards, and they are binding; but they apply to only a segment of social

care, and not at all in healthcare. Eligibility for healthcare is insurance based in principle, but it is nearly universal. In practice, almost every citizen holds a social insurance card, which is the condition for access to healthcare.

Since December 2015, applicants have been evaluated on the basis of 14 different activities, such as independence in daily activities (eating, bathing, dressing, toilet use, continence); following therapy; moving and changing position; mental functions (orientation in space and time, communication, proper behaviour); eyesight and hearing; need for supervision. Abilities are measured on scale of 0–4 and a formula translates the resulting values to care time. This formula has been made tougher, leaving many potential applicants with fewer or no services. Only new applicants are affected; established eligibilities have not been withdrawn.

1.1.2 Needs

Limitations in activities of daily living (ADL) or instrumental activities of daily living (IADL) can be estimated from the annual income survey of the Central Statistical Office, which is part of the EU-SILC comparative survey, and the Hungarian element of the European Health Interview Survey (EHIS). The first wave of EHIS was conducted in 2009 in Hungary, reflecting health conditions prevalent in 2008. The second wave was conducted in 2014. At the time of writing, only preliminary data from the latter have been published.

In total, 38% of respondents aged 65 and over reported limitations in personal care activities in the first wave (Table 1). This is about 620,000 people. Household activities created problems for 48% in 2008 (780,000 persons). By the second wave of EHIS, the 38% share of ADL limitations had decreased to 29% (Central Statistical Office, 2015a), about 500,000 people. As expected, the frequencies are higher in older age groups: 55% are limited in personal care and 77% in household activities in the 85+ age group (first wave data). Severe limitation in personal care affected about 220,000 people (14% of the 65+ age group); in household activities, the corresponding figure was about 510,000 (31%). Because of different definitions, sources and estimation methods, the projections of the 2009 and 2015 Ageing Reports (European Commission, 2015) were based on 594,000 and 788,000 dependants, respectively.

Table 1: Limitations in daily activities in old age

	65+	75+	85+
Limitations in personal care activities (hlth_ehis_st10)			
Severe	14	22	31
Some or severe	38	50	55
Limitations in household activities (hlth_ehis_st11)			
Severe	31	47	65
Some or severe	48	65	77

Source: Calculations are based on the European Health Interview Survey (EHIS) wave 1 (Eurostat). Codes in brackets are Eurostat codes for the respective questions.

1.1.3 Public capacities

Unit costs of both residential and home care are low in European terms. In 2013, the method of calculation for the financial support of residential care changed. Rather than the per resident quota used up to 2012, the government now regulates the average wage of carers in residential homes. By applying further rules on residents per carer, and special multipliers for the difficulty of care, the normative support per resident can be calculated. Accordingly, the quota for regular care is HUF 651,510 per annum,

unchanged since 2013 (currently about EUR 2,100). The corresponding figure is HUF 145,000, some EUR 470, or about 4% of per capita GDP, for home care; this was cut back from HUF 166,080 (about EUR 575) in 2012 because of the rapid increase in overall LTC expenses.

The normative support does not cover all the costs of service providers: 43% of the operational costs of residential care centres were covered by fees charged to clients or their families in 2014. The amount of these fees – HUF 69.3 billion (EUR 224.5 million) – was equivalent to about 0.4% of the total individual consumption expenditure of households. The share of such fees in the budget of care providers has been constantly growing: it accounted for 20% in 1993 and 30% in 2007.

In 2014, 11.9% of the 65+ population received either home nursing care (2.7%) or home care (6.4%) or residential care (2.8%) (Table 2). Against this share, the Hungarian sample of EHIS found 38% of the 65+ population facing some degree of limitation in activities of daily lives and 48% had limitations in household activities (as shown above in Table 1). Even simpler and cheaper services, such as meal provision or alarm system-based assistance reached only 7.0% and 1.3%, respectively, of the reference population. The rest either have to pay full price for such services or get help from family (or else have the needs unmet).

Table 2: Basic capacities of the LTC system for the elderly

	Total	per 100 inhabitants	per 100 65+ inhabitants
Healthcare			
Chronic beds	26,747	0.3	
of which lasting care	2,735		0.2
Home nursing care patients	63,820	0.6	
of which 65+	46,499		2.7
Social care			
In kind (for the 65+)			
Home care recipients	110,047		6.4
Meals-on-wheels recipients	120,795		7.0
Alarm system-based home assistance	22,126		1.3
Attendees of day care for elderly	29,109		1.7
Residents in elderly homes	47,722		2.8
In cash			
Recipients of nursing allowance	62,972	0.6	
Total spending on nursing allowance (% of GDP)	0.1		
Nursing allowance per recipient (% of per capita GDP)	1.0		

Sources: Central Statistical Office (2015b; 2015c).

1.1.4 Long-term care for disabled children and working-age adults

Long-term care needs and services are strongly age related. The EHIS data show that 70% of people with severe limitations in personal care are 65 years or older and only 30% are aged between 15 and 64 years (the data do not contain children with disabilities). This is reflected in the use of care facilities: 67% of all residential care, 77% of all home care (including domestic care, meals-on-wheels services and alarm system-based home assistance), as well as 60% of day care, is used by the elderly (Table 3). In light of the ageing process, which starts at a younger age in Hungary than in Northern or North-Western Europe, the dominance of older age groups is even more explicit. The utilisation rates mentioned are 74%, 88% and 65%, respectively, if old age starts at age 60 rather than 65. Utilisation rates are particularly low among children.

Table 3: Use of long-term care services by age group

	0–17	18–59	60+	total
Residential care, total for all types (78,127) =100				
Home for the elderly	0	7	61	*53,540*
Home for psychiatric patients	0	8	4	*8,775*
Home for disabled persons	1	17	2	*15,812*
Total	1	32	67	*78,127*
Domestic care, total for all types (327,860) =100				
Home care	0	7	34	*132,985*
Meals-on-wheels	0	15	37	*171,998*
Alarm system-based home assistance	0	0	7	*22,877*
Total	0	23	77	*327,860*
Day care, total for all types (49,608) =100				
Day care for the elderly	0	20	59	*39,194*
Day care for disabled	1	13	1	*7,450*
Day care for psychiatric patients	0	5	1	*2,964*
Total	1	39	60	*49,608*

Source: Central Statistical Office (2015b).

1.1.5 Households in long-term care

Most long-term care activities are left to households or an informal market. Empirical evidence shows that familial relations play a particularly important role in LTC for the elderly in Hungary. The 2012 wave of the European Quality of Life Survey (EQLS12) found that over 88% of respondents aged 65 or over said they would turn to a family member to get support if they needed help around the house when they fell ill (Table 4). This rate was the third highest among Member States, and was higher than in the group of former (largely socialist) New Member States (NMS) (81%) or the EU as a whole (76%). In contrast, Hungarians do not report turning to institutions at all (the corresponding rate is 9% in the EU and 15% in the three Nordic Member States). Yet, the lack of institutions (or distrust of people therein) does not render the elderly particularly isolated: the rate of those who said they had nobody to turn to was fairly low: 1.5%, the seventh-lowest among Member States.

Table 4: From whom would you get support if you needed help around the house when ill; responses in the 65+ age group

	HU	HU rank	NMS-11	EU-28
A family member	88	3rd highest	81	76
A service provider, institution or organisation	0	lowest	3	9
Nobody	1.5	7th lowest	2.6	2.0

Notes: HU rank: Hungary's position in the rank order of Member States. NMS-11: BG, CZ, EE, HR, HU, LV, LT, PL, RO, SI, SK.

Source: Eurofound (2015, YI11_Q35a).

1.2 Description of carers' leaves

The Labour Act allows relatives to go on unpaid leave in order to take care of a child under the age of 3 (Labour Act 62, §128). The maximum age of the child rises to 10 if the care provider receives childcare allowance or its 2016 successor, child-raising support (respectively, *gyermekgondozási segély* and *gyermekgondozást segítő ellátás* – both are GYES for short; Labour Act 62, §130). GYES can be extended from 3 to 10 years only if the child is disabled or permanently ill.

In addition, unpaid leave should be allowed for a maximum period of two years for employees who provide personal care for a permanently ill relative (Labour Act 62, §131). Needs have to be confirmed by the healthcare system and the employee has to provide care by him/herself.

1.3 Description of carers' cash benefits

The long-term care system does not offer benefits for recipients to ease access to services. There is one type of cash benefit that supports familial care: the nursing allowance.[1] This can be claimed by relatives caring for a disabled or permanently ill family member.

Applications, based on the expert opinion of a GP, are evaluated by the local authority. The nursing allowance is aimed primarily at those caring for severely disabled or permanently ill family members. Depending on the health of the care recipient, an increased nursing allowance may be paid (*emelt összegű ápolási díj*), at 150% of the standard allowance; or, since 2014, an extra nursing allowance (*kiemelt ápolási díj*). The amount of the latter is HUF 53,100 (about EUR 175) a month, 180% of the standard nursing allowance (HUF 29,500, or about EUR 95) and it can be paid to care providers if the health status of the recipient falls below the 30% threshold on a 0 to 100 scale applied by authorities assessing health status.

The nursing allowance is not intended to fully replace the wage of the carer, but rather to offer limited compensation. The amount of the regular version is small, about 19% of the average monthly net wage. It is not indexed, and its level is set annually by Parliament in the budget law. The comparison with the net wage (rather than the gross) is justified because the nursing allowance is exempt from income tax. It is, however, subject to pension contributions (10%), unless the care provider is a pensioner. The nursing allowance builds up eligibility for old-age pension (although in order for someone to participate in the "women-40 programme",[2] the care recipient must be a child). The

[1] In official texts and statistics it is alternatively called nursing allowance or nursing fee. Here I use the former variant.

[2] The women-40 programme is the colloquial name of an early retirement path allowing women to retire after 40 contributory years (including periods on maternal leave).

allowance is also exempt from health contributions, but recipients are entitled to public healthcare.

It can be combined with work, for four hours a day. No such limit applies if the care provider works from home.

The nursing allowance is not time limited. It is terminated if the conditions of eligibility cease to exist (if the health of the recipient improves, or if he/she dies; or if the authorities find the care provider to be failing in his/her duty).

People raising a disabled child are entitled to an increased family allowance (*családi pótlék*) up to the amount of HUF 23,300 (about EUR 75), instead of HUF 12,200 (about EUR 40).

1.4 Description of carers' benefits in kind

Home care and meals-on-wheels are not in-kind benefits for carers as such. Yet, in addition to improving the quality of life of care recipients, they also help in balancing the labour market and household obligations of family members.

As for proper carer's benefit, there is no reference to any such programme in Hungary's social protection portfolio.

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

Since the issue is marginal in public policy, our knowledge on the functioning of work-life balance measures is frequently anecdotal, or based on evidence fragmented at best.

There is a large grey zone of elderly care between public services and direct familial care. People in need, or their families, buy services on an informal market,[3] which is mostly out of sight of the public social protection system for the time being. In this segment, public policies usually focus on market regulation, including the provision of quality standards; enforceability of contracts; promotion of long-term care insurance; collection and share of relevant information; and mitigation of inequalities. There is no assessment available of any of these features.

2.1.1 Carer's leave

As mentioned above, the only care-related leave is unpaid. There are no statistics, either from government, non-governmental organisation or the academic sector, on the frequency and average length of such leave or its cost in terms of lost income.

An alternative to carer's leave can be flexible labour market practices. In Table 5, we present some evidence from EQLS12. Thus, the Hungarian labour market is among the least tolerant in this respect, and does not show the typical European pattern of growing flexibility as income rises. The proportion of workers who can vary their start and finishing times at work is the lowest of the EU Member States, and the difference is most visible in the higher-income groups. Also, Hungarian workers are among those with the least opportunity of being able to take a day off at short notice. Here again, the largest difference between the Hungarian and the European values appears in the highest

[3] Informality has a double meaning. It can refer to economic activity based on familial relations or other personal networks that do not use money. However, it can also mean regular markets for services functioning under the radar of authorities, which evade taxes and are regulated by habits, norms and force. Throughout the paper I use the word in the former meaning; however, in this paragraph I apply the latter.

income category. The only measure of flexibility on which Hungarians fare relatively well, especially at lower income levels, is the chance to accumulate hours for time off.

Table 5: Labour market flexibility by income level: % of employees who ...

	total	low	2nd	3rd	high
can vary start and finishing time					
HU	18	15	19	10	23
HU rank	lowest	3rd lowest	2nd lowest	lowest	lowest
EU-28	40	38	36	38	52
can accumulate hours for time off					
HU	39	54	43	30	43
HU rank	11th lowest	4th highest	13th highest	9th lowest	12th lowest
EU-28	43	40	43	46	49
can take a day off at short notice when needed					
HU	45	39	48	46	43
HU rank	4th lowest	4th lowest	7th lowest	4th lowest	2nd lowest
EU-28	64	58	62	63	67

Notes: HU rank: Hungary's position in the rank order of Member States.

Source: Eurofound (2015, Yl11_Q13b).

Caring obligations can create obstacles to taking up a job, particularly among women. As Table 6 shows, 20% of inactive Hungarian women between the ages of 15 and 64 gave the obligations of looking after children or incapacitated adults as the main reason for not seeking a job. This is higher than in the EU as a whole, and much higher than among men.

In general, women are more active in familial care than are men. Labour Force Surveys show that in Hungary about 60% of people taking care of children or persons in need are women – the same as the EU average.

Table 6: Caring obligations as the main reason for not seeking employment

	Men	Women	Total
HU	2	20	13
EU-28	1	15	10

Source: Eurostat database (lfsa_igar).

2.1.2 Carer's cash benefits

In 2014, about 63,000 people received nursing allowance (Table 2), all forms combined. This number includes all cases of caring for disabled or permanently ill relatives, not only elder care. The Central Electronic Registry of Service Recipients (KENYSZI by its Hungarian acronym) of NORSA contains information on the age distribution of care recipients.

The amount of the nursing allowance is small, and it can be effective only in low-income or inactive households.

2.1.3 Carer's benefits in kind

The importance of home care has increased rapidly over the past few years. Whereas residential capacity has remained practically unchanged (it grew by 7.4% between 2008 and 2014), by 2014 the number of home-care recipients had grown more than 2.7 times and the number of recipients of meals-on-wheels had increased by about 1.6 times, compared to the 2008 levels (Table 7).

Table 7: Dynamics in home care, 2008–14 (2008=100)

	2008	2009	2010	2011	2012	2013	2014
Recipients of home care	100	132	156	183	260	274	276
Nurses in home care	100	138	156	176	240	203	219
Recipients of meals-on-wheels services	100	116	136	144	153	158	160

Source: Central Statistical Office (2015b).

These measures improve the well-being of care recipients, but it is unclear to what extent they relieve familial care providers, or just provide services to people previously uncared for.

2.2 Assessment of overall package of measures and interactions between measures

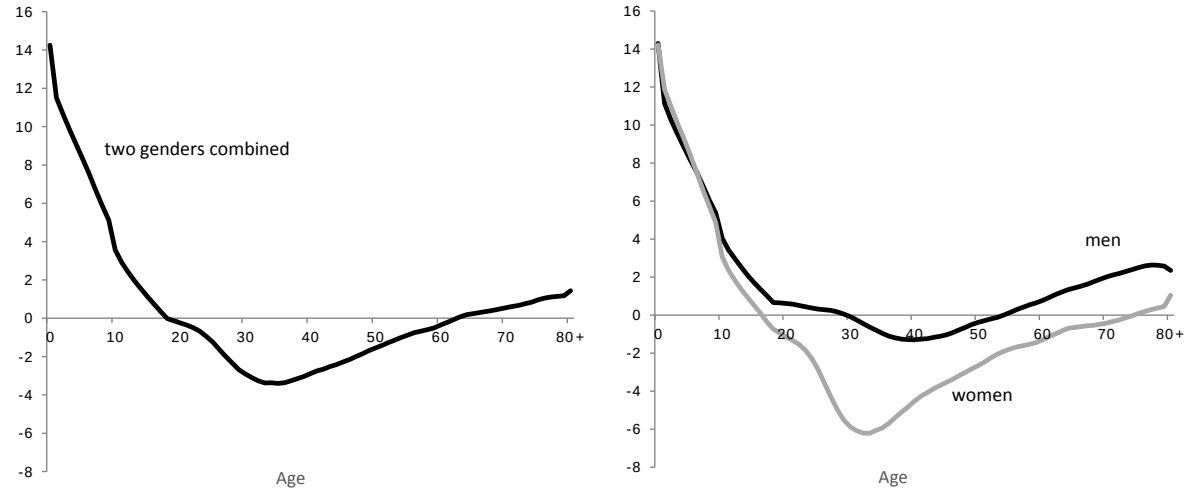
The elderly care portfolio of the Hungarian social protection system is generally underdeveloped, leaving a large share of needs unmet. Within this system, the small package that aims to ease the burden on familial care providers consists of two measures: unpaid leave (that is, job security and social insurance, but no income) and a cash benefit, which is not aimed directly at elderly care, offers a small amount and has limited reach.

In the Hungarian case, the main issue of work-life balance measures is not efficiency and optimal coordination, but adequacy. The current measures are insufficient. Yet, it is important to realise that the dynamic expansion of home care and meals-on-wheels services, though they do not directly target carers, but rather care recipients, has made it easier for many to balance work and family.

The inadequacy of measures affects women disproportionately. In Figure 1, we present net time transfers by age and gender. Time transfers are calculated from time-use surveys. Time-use surveys give an opportunity to identify the activities of unpaid household labour and to assign the services and goods produced by such labour to its consumer in the family. This information allows the drawing of per capita age profiles for both consumption and production of unpaid household labour. In the left-hand panel of Figure 1, the two curves are netted out by deducing production from consumption. The resulting net value is called the net (time) transfer because the non-zero values of the goods and services are provided by someone else or for someone else of a different age.

Apart from children, people become net receivers of time transfers at the age of 63 on average. The figure gives the value of such transfers in terms of monthly wages. On average, the value of annual net time transfers passes one monthly wage at the age of 75 and reaches 1.4 monthly wages among the oldest old (the 80+ age group). The aggregate value of net time transfers received by older people is HUF 361 billion, or 2.6% of individual household consumption.

Figure 1: Net time transfers by age and gender in terms of monthly wages, 2010



Source: Gál et al. (forthcoming).

Age-specific averages hide significant gender differences. The right-hand panel makes it clear that the lion's share of time transfers is provided by women both to relatives of another age and to men. Women are net providers between the ages of 17 and 74. By contrast, only 24 male cohorts – those between the ages of 30 and 53 – give net time transfers. Starting with children, females always receive fewer, or give more, net transfers than men; the difference is sizeable even among the oldest old.

2.3 Policy recommendations

In general, long-term care is a backwater issue in Hungary, barely registering public attention. Within this marginal field, the burden of caring obligations on affected families attracts even less attention. Neither the national income lost in the provision of care by family members themselves nor the impact of such efforts on their well-being is assessed. Decision makers have yet to grasp the increasing importance of the problem, as well as the potential of government intervention for risk sharing and containing social costs.

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