

# **Study on the Social Protection Systems in the 13 Applicant Countries**

## **Hungary Country Study**



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# Social Protection in Hungary

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## 1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

### 1.1 Main influencing factors for social protection

In the 1990s, Hungary had to manage a deep debt crisis, go through a long overdue restructuring of its industry, privatize its economy, build up the institutional background for a market economy, and create a social protection system in order to handle the social consequences of economic transition.\* As a result of the necessary measures taken by consecutive governments, GDP fell by almost 20 percent from its 1989 peak, in four years. Employment dropped from 5.2 million in 1990 to 3.6 million in 1996. Recovery started in 1993. Ever since GDP has been growing and it climbed back to its pre-transition level by 2000. Inflation had its first peak in 1991 with 35 percent and then another peak in 1995, at 28 percent. Since then, inflation has been slowly declining and in 2000 it dropped down into single-digit figures. Employment has not improved much, however. It was still just slightly above 3.8 million in 2000. These are the main macroeconomic and specific labor market factors that have challenged the social protection system.

#### 1.1.1 Economic and financial indicators

By 1995, Hungary had in broad terms accomplished the complex and painful task of transforming a centrally managed state-owned economy combined with a dictatorial political regime to a largely private market economy and a multiparty democracy. The 1988 property rights reform, after several modifications, led to large-scale privatization. The 1992 bankruptcy law removed ailing industrial firms from the economy, and the 1995 austerity measures stabilized the macroeconomic situation. As a consequence, efficiency improved rapidly (in 2000 a somewhat higher GDP was produced than in 1989, with a work force of three quarters the size), public finances grew healthier (a current account deficit of EUR 3.3 billion

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in 1994 was restrained to EUR 0.8 billion by 1997, although it grew again to EUR 2.0 billion in 1999), and inflation slowed down (with a decrease of the CPI [see Table 1.1] and the GDP price deflator from 25.6 percent in 1995 to 9.0 percent in 1999).

Since 1997 the economy has been booming, with a 4.5 percent average annual growth of GDP. Tax revenues derived from production have grown even faster than GDP. This trend is interpreted by some experts as an indicator of a slowly diminishing tax-evading section of the economy (Semjén 2001). Subsequent governments have used this additional revenue to mitigate the debt burden and reduce tax rates, in particular social security contributions. Debt service lessened from 17 percent of GDP in 1997 to 10 percent in 2000. The size of the budget relative to the GDP of the country was reduced. Social expenditure also fell in comparison with the GDP, though some other government expenses dropped even faster.

Reflecting the age structure of the society, developments in the labor market and the usual political economy of intergenerational redistribution, it is of no surprise that the largest chapter by far in public social expenditure is pensions. The number of pensioners grew rapidly through the 1990s, and although benefits lost their real value, to an even greater extent than wages, they did not devalue as much as other benefits, such as different family-support programs. Pensioners climbed to a higher position on the income distribution ladder of the society (Medgyesi, Sági and Szivós 1999). As it was in the same move that the pensioners society expanded, as the number of contributors was simultaneously reduced, the pension budget turned negative by the end of the decade. Contributions to social security pensions were the only institutionalized form of preparation for old age before 1994. Since then, voluntary supplementary pension funds have attracted 1.1 million members and collected an amount of EUR 1.2 billion by the end of 2001. Pension funds have a property rights structure of mutual benefit funds - that is they are owned by their members. The larger funds are backed by a financial institution such as savings banks or an insurance companies, or they are they are underwritten by some large employers. In such firms, membership of the voluntary fund is sponsored as a part of a package of fringe benefits. The government offers generous tax-relief for these contributions.

Health care, another social chapter which has a sharply growing age-benefit profile, is also larger than education. Although not reflected in the above table, health care expenditure was hit by the 1995 austerity measures. On the other hand an important part of health care finance - informal payments - do not appear in the statistics. An extensive survey found informal payments in health care to have risen to 0.3 percent of GDP (Bognár, Gál and Kornai 2000). Since this is a tax-evading net value, it would take a wage rise equivalent to 0.8 percent of GDP for the government to clean up this section of the informal economy.

### 1.1.2 Demographic indicators

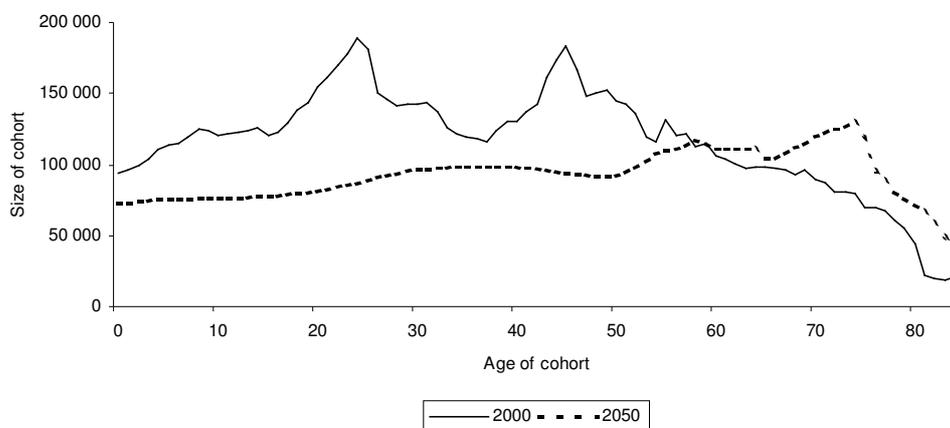
The total population peaked in 1980 at 10.7 million, ever since it has been shrinking. From 1995 to 2000 the decline was 2.3 percent from 10.2 million to 10.0 million. The 2001 census may correct the population data retroactively. As in general, more males are born (994 females fell to 1000 males in the 0-4 age-group in 2000), but higher male mortality turns this step-by-step to a female majority. The rate switches between the age of 40 and 59. Above 70, the number of females is almost double that of males.

Decreasing fertility made the youth dependency ratio decrease from 27 percent to 25 percent between 1995 and 2000, where youth is defined as below 15 years, and the number of children is projected against the number of people in the active age population, that is, between 15 and 64. In terms of labor market activity, however, the ceiling of youth is better set at 20 years. Moreover, in the light of the official retirement age, 57 for women and 61 for men in 2000, the upper limit of the active population is more realistically 60. Figure 1 shows the current and the projected 2050 age distribution. Presently there are two large groups of cohorts, one that was born in the early 1950s and their children born in the mid-1970s. The former age group has just reached its prime earning years whereas the latter left school and entered the labor market in the 1990s. The more labor market oriented definition of youth dependency captures this second move whereas the standard demographic definition reflects only the effect of diminishing fertility. This is why the labor market oriented youth dependency ratio dropped more sharply from 48 percent in 1995 to 41 percent in 2000.

Old-age dependency, however, did not change much over the period in question. It remained at 19-20 percent (where the active population was 15-65), or 32-33 percent (where the active population was 20-60). It will be shown in Chapter 3 that despite the stagnation of old-age dependency, the so called system dependency, that is the proportion of real pensioners to real contributors, as opposed to the proportion of potential pensioners to potential contributors, took its own course. Financial difficulties of the pension system were created more by the labor market than the demographic factors in the 1990s.

The contraction of the total population is mainly due to low fertility. The total fertility rate, which was just slightly below 4.0 in the 1920s, and even in the first half of the 1950s it was always above 2.5, fell to under 2.1 (the sustainability condition of a steady population), for the first time in 1959, and has remained there since, with a brief episode of four years of higher fertility rates in the mid-1970s. From 1995 to 2000 the total fertility rate fell from 1.57 to 1.33 reaching its trough, 1.29 in 1999. The number of births has been under 100,000 a year since 1997. The population is unable to reproduce itself: the net reproduction rate was 0.75 in 1995 and decreased even further to 0.64 by 2000.

Figure 1: Cohort sizes in 2000 and 2050



Source: Demographic Institute of the Central Statistical Office

The effects of low fertility on the total population are amplified by poor mortality figures. Life expectancy at birth was 70.9 years on average in the period of 1995-2000, only exceeding Turkey's among the OECD countries. Recently it has been improving slowly from 65.3 to 67.1 for males and from 74.5 to 75.6 for females between 1995 and 2000. Nevertheless, it is expected to remain significantly lower than the OECD-average even in the long term. Life expectancies at the age of 60 are also among the worst in the OECD, although they are slightly improving, from 14.8 to 15.3 for males and from 19.5 to 20.0 for females in the second half of the 1990s. As mentioned before, neither the official nor the practical retirement age coincides with the age of 60, so life expectancy at the age of retirement is different.

The number of immigrants oscillated at around 15,000 a year in the 1990s. There is a special case in Hungary with respect to immigration. A large proportion of immigrants come from ethnic Hungarian minorities of neighboring countries due to the Yugoslav wars and, over the last few years, due to rising real wages and the continuous revaluation of the forint, the Hungarian currency, which makes employment here attractive. About one-third of foreign citizens with residency permits or immigration permits come from Romania alone. This special feature may explain the relatively high proportion, 45-50 percent in each year, of women. Another peculiarity of immigration is the growing proportion of elderly immigrants. Whereas in 1990, the rate of immigration of 60 years old or older was 2 percent, in 1999 it reached 11 percent of immigrants. This is probably due to portability of pension rights: Hungary accepts social security accrual rights obtained in some neighboring countries, where these rights would offer lower pensions. The other source of older immigrants is, by contrast, repatriates from Europe and the United States. Altogether, about 85 percent of immigrants come from European countries (out of which 11 percent from EU member states).

### 1.1.3 Social indicators

The most important challenge to the social protection system came from the labor market. Restructuring industry removed around a net 30 percent of jobs, and despite the take-off period of the business cycle the labor market has not recovered. Activity in the cohorts of 15 to 64 fell from almost 90 percent to a mere 60 percent. Between 1995 and 2000 when the GDP grew 22 percent the number of jobs increased by only 5 percent.

An important feature of the Hungarian labor market is the divergence of unemployment and inactivity. In OECD countries unemployment and inactivity usually operate more or less in parallel. If one increases, so does the other; if one decreases, the other follows. In Hungary, a lower-than-average and falling unemployment rate is combined with one of the highest inactivity rates. Whereas the rate of unemployment was 10.2 percent in 1995, it dropped to 6.4 percent by 2000. At the same time, participation has hardly changed (see Table 1.4). This does not apply to the 55-59 cohorts. Their activity grew as early retirement programs were closed and retirement age for women was raised.

It is a key question for the social protection system to know where these people have gone. Age- and gender-specific activity rates offer a preliminary answer. In 2000, participation rate was 90 percent for males between 25 and 39 and it was still 80 percent between 40 and 54. Between 55 and 59, however, it dropped to just 52 percent. Unemployment is below average in these cohorts and so is the rate of the passive, discouraged unemployed. A large proportion of these cohorts already retired in one of the various early retirement or invalidity programs. Participation of women is even lower, 21 percent (their retirement age was also lower - 57 in 2000).

Older generations leave the labor market earlier, younger ones enter it later. In the cohorts of age 20-24 only two-thirds of men and half of women can be counted as economically active. This is partly due to the expansion of higher education. The number of participants in third level education tripled in the 1990s (of whom 55 percent were women in 2000). This can not be the only reason, however. Unemployment is highest among the young cohorts, 24 percent between age 15 and 19, and 10 percent between 20 and 24.

Finally, the third indicator is the age-distribution of the passive or discouraged unemployed. About 40 percent of them are between 40 and 54, and another 23 percent between 30 and 39. Obviously, people in older active-aged cohorts are more likely to be discouraged. The social protection system has to use different methods to deal with this problem.

Inactivity shows a clearly regional pattern. Among the seven regions, Central Hungary and Western Transdanubia have 57 and 59 percent of activity, respectively. This compares with 49 and 48 percent activity figures of Northern Hungary and the Northern Great Plain region. These last two

regions also have the highest number of discouraged people, and the highest unemployment rates.

Income inequality increased in the 1990s, especially at the beginning of the decade. By taking the share of the equalized income by decile no great changes can be witnessed, while the share of the top decile increased and that of the bottom decile slightly decreased. Other measures underline this picture. There is small but constant gradual rise in inequality. It is important to note that the bottom tenth moved away from the median, while the top decile percentage point moved closer to the median. From the mid-1990s, the dynamics of income of the deciles show the following pattern: at the beginning of the period upper deciles were able to utilize their advantageous position, but in later years middle income deciles also gained income increases above average. The relative position of the bottom tercile did not improve.

The changes in the characteristics of income distribution mentioned above were also revealed in the changes of poverty rates. During the years examined, the proportion of poor people changed differently according to the applied definitions. Using half of mean income as the poverty line, there was a considerable drop in 1996-1997, followed by a slight increase and stability. Using half of median as a poverty line, there was a less pronounced decrease over the same period, but constant fluctuation over the last four years.

Cohabitation as an alternative to marriage became more frequent in the 1990s, but it is still rather low. In 1996, when the CSO Micro-census was conducted, 7 percent of couples had no marriage certificate. The rate of children born outside marriage grew rapidly in the second half of the decade, from 21 percent in 1995 to 29 percent in 2000. Another sign of the diminishing role of the traditional family is the growing divorce rate.

In 1996, 32 percent of families had no cohabiting children. This raw figure included those who had raised their children, so it combines information about the age of couples with their fertility. 34 percent had one child, 26 percent had two, and a bit less than 6 percent had three, the rest had four or more. Again, the number of children depends on the age of the parents, so these figures reflect cohort effects as well as declining fertility.

The proportion of single households grew in the last decades. In the 1980 census 20 percent of households counted just one member, in 1990, 24 percent and in the 1996 Micro-census, 26 percent. Most of those who live alone are elderly: in 1996, 58 percent of people living in a single-household were 60 years old or older.

## **1.2 How does the described background affect social protection?**

### **1.2.1 Forecasts and projections**

As for the medium term macroeconomic forecasts, the OECD (2000) projected a potential output growth of 4.75 percent per annum until 2005. The projection is based on assumptions such as the age and gender-specific participation rates converging to the Austrian levels, the natural rate of unemployment gradually declining to 5.5 percent by 2010, and total factor productivity growing 2.7 percent a year between 2000 and 2005. Alternative estimations such as Darvas and Simon (1999) of the National Bank of Hungary found a potential of 4.8 percent, whereas Hviding (1999) of the IMF estimated 5.1 percent. Actual growth rate was 5.2 percent in 2000, which, due to difficulties in the export markets, slowed down to 3.8 percent in 2001.

Current conditions in the labor market, however, bear the potential of hindering the expansion of activity due to a combination of low unemployment and high inactivity and to the fact that it is more difficult to drive back inactive people to employment. Moreover, a sharp rise of minimal wages in 2000 and 2001 is likely to reduce the employment of low-skilled workers and make it harder for new entrants to find a first job.

As for long-term predictions on demographic developments, contraction of the total population will continue over the next decades due to the low fertility. The Demographic Institute of the Central Statistical Office expects a 15-25 percent decline in 50 years, with 20 percent as the most likely value leading to a total population of 8.0 million. This number can be reached with the assumption of a slightly improving fertility (although the TFR is not assumed to reach the 2.1 value), and growing immigration.

As a consequence, age-dependency is expected to grow (see Figure 1 for expected cohort sizes in 2050). Youth dependency would slightly diminish (<15/15-65 from 0.25 to 0.23; <20/20-60 from 0.41 to 0.38). By contrast, old-age dependency would double (>65/15-65 from 0.20 to 0.41; >60/20-60 from 0.32 to 0.64). Unless improvements in health conditions allow a significant rise in the retirement age, there will be a heavy pressure on the pension burden.

### **1.2.2 Influence of economic, demographic and social developments on the social protection system**

Hungary started the economic, political and social transition with an extensive social protection system that focused on intergenerational transfers such as various family support programs, education and pensions. In some respect health care and housing also fall into this category since health expenses have an age-profile resembling to pensions, whereas participation

in housing programs is usually combined with the eligibility criterion of having children.

In contrast, the system was unprepared to deal with the problems of people in their active age having no job. In a labor market of a shortage economy that is typically a sellers' market such an institutional structure would have been redundant. The consequences of restructuring the industry came as a shock in the early 1990s so the government built its social protection strategy on existing structures, in particular the pension system. Practical retirement age fell far below the official retirement age. As a consequence, Hungary is facing difficulties mobilizing its potential labor force now, in the years of rapid economic growth. Unemployment is dynamically decreasing while participation rate is hardly improving.

As a likely consequence, the labor market may get overheated at a relatively low participation rate. Labor market rigidity is likely to compound in the near future due to a sharp rise in minimal wages. The institutional structure of social protection may impede economic growth which, in the other way around, could have eased the pressure on the social protection system.

### 1.3 Annex to chapter 1

*Table 1.1: Macroeconomic indicators*

	1995	1996	1997	1998	1999	2000
GDP (billion EUR)	34.5	36.1	40.5	41.9	45.1	50.3
GDP volume index, previous year=100	101.5	101.3	104.6	104.9	104.2	105.2
GDP volume index, 1989=100	85.5	86.6	90.6	95.1	99.1	104.3
GDP per head in PPS	8,100	8,500	9,200	9,800	10,600	11,500
Inflation rate	28.2	23.6	18.3	14.3	10.0	9.8

Source: Central Statistical Office.

Table 1.2: Social expenditures

<b>Social benefits in rate of GDP 1995-2000 (%)</b>						
<b>Types of benefits</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
Pension above retirement age	6,8	6,3	6,2	6,4	6,5	6,3
Widow pension	1,1	1,0	1,0	1,1	1,1	1,1
Benefits of old age non-insured agricultural workers	0,1	0,1	0,1	0,1	0,1	0,0
Pension under retirement age	1,2	1,1	1,1	1,2	1,3	1,2
Other benefits related to pension	0,4	0,4	0,3	0,3	0,2	0,2
Benefits of persons with reduced working ability	0,4	0,4	0,4	0,3	0,3	0,3
Pension from early retirement	0,2	0,2	0,2	0,3	0,2	0,1
Employer's pension under retirement age	0,2	0,2	0,1	0,2	0,1	0,1
Maternity allowance	0,2	0,1	0,1	0,0	0,1	0,1
Family allowances	1,8	1,4	1,3	1,2	1,1	0,5
Child-care fee	0,4	0,3	0,1	0,0	0,0	0,2
Child-care allowances	0,2	0,2	0,3	0,4	0,4	0,3
Child-care assistance benefits	0,1	0,1	0,1	0,1	0,2	0,7
Sickness benefit	1,0	0,7	0,7	0,6	0,7	0,7
Unemployment benefit	1,1	0,9	0,7	0,7	0,7	0,6
Other benefits related to sickness	0,1	0,1	0,1	0,0	0,0	0,1
Regular and non-regular assistance benefits	0,5	0,5	0,4	0,6	0,6	0,6
Scholarship and other grants	0,1	0,1	0,1	0,1	0,1	0,1
Cash benefits of non-profit institutions	0,2	0,1	0,2	0,2	0,2	0,2
Supplement to family allowance	0,0	0,0	0,1	0,0	0,0	0,0
Subsidy on interest of housing loans	0,1	0,1	0,0	0,0	0,0	0,1
Social benefits other than social transfers in kind	16,2	14,4	13,6	13,9	13,9	13,3

Table 1.2: continued

Social benefits in rate of GDP 1995-2000 (%)						
Types of benefits	1995	1996	1997	1998	1999	2000
Health care	5,5	5,3	5,2	5,3	5,1	4,9
Education	4,8	4,3	4,2	4,2	4,3	4,1
Cultural benefits	0,7	0,6	0,6	0,6	0,6	0,6
Sport	0,3	0,3	0,2	0,2	0,2	0,2
Recreational benefits	0,4	0,4	0,4	0,4	0,3	0,2
Social welfare benefits	0,8	0,8	0,7	0,8	0,8	0,8
Subsidy on public transport	0,6	0,7	0,6	0,7	0,7	0,6
Consumption of fixed capital of state owned dwellings	0,2	0,1	0,1	0,1	0,2	0,2
Other benefits in kind	0,4	0,6	0,5	0,5	0,5	0,6
Social transfers in kind	13,6	12,9	12,5	12,8	12,7	12,2
Social benefits, total	29,8	27,3	26,0	26,7	26,6	25,5
Public social expenditure as % of government expenditure	1995	1996	1997	1998	1999	2000
Health care	8.7	9.3	9.1	10.5	10.7	10.5
Education	7.3	7.1	6.9	7.9	8.5	8.3
Pension	14.7	15.7	14.7	18.3	19.4	18.7
Other*	2.7	2.7	2.4	3.2	3.4	3.3

\* Excluding income tax reductions for large families.

Source: Central Statistical Office

Table 1.3: Demographic indicators

	1995	1996	1997	1998	1999	2000
Total population (thousands)	10,246	10,212	10,174	10,135	10,092	10,043
Net population increase	33	38	39	44	49	38
Male	4,903	4,884	4,863	4,842	4,818	4,792
Female	5,342	5,328	5,311	5,293	5,274	5,251
Proportion of age groups in total population						
<15	18.3	18.0	17.7	17.5	17.3	17.1
<20	26.6	25.9	25.3	24.7	24.1	23.6
>60	18.3	18.4	18.4	18.5	18.5	18.6
>65	13.0	13.1	13.3	13.4	13.6	13.6
Age dependency ratios						
Young (<15/15-65)	0.27	0.26	0.26	0.25	0.25	0.25
Young (<20/20-60)	0.48	0.47	0.45	0.43	0.42	0.41
Old (>65/15-65)	0.19	0.19	0.19	0.19	0.20	0.20
Old (>60/20-60)	0.33	0.33	0.33	0.33	0.32	0.32
Fertility						
Birth rate per 1000 inhabitants	11.0	10.3	9.9	9.6	9.4	9.7
Total fertility rate	1.57	1.46	1.38	1.33	1.29	1.33
Net reproduction rate	0.75	0.69	0.66	0.64	0.62	0.64
Life expectancy (m/f) at birth	65.3/74	66.1/74	66.4/75	66.1/75	66.3/75	67.1/7
	.5	.7	.1	.2	.1	5.6
At age 60	14.8/19	14.9/19	15.0/19	15.0/19	14.9/19	15.3/2
	.5	.4	.7	.8	.6	0.0
Emigration (foreign and Hungarian* citizen)	3,173	3,642	2,822	2,011	1,792	1,926
Immigration	14,008	13,734	13,283	16,052	18,216	14,484
Immigration as percentage of population	0,17	0,14	0,13	0,16	0,18	0,14

\* Who report moves to the Ministry of Domestic Affairs.

Source: Central Statistical Office

Table 1.4: Labor market indicators

	1995	1996	1997	1998	1999	2000
Unemployment rate (%)	10.2	9.9	8.7	7.8	7.0	6.4
Labor force participation, men (%)						
15-74	61.7	61.1	60.4	60.0	61.4	61.9
55-59	45.1	46.2	44.2	40.0	45.9	51.8
60-74	8.1	6.2	5.8	6.1	6.2	6.9
Labor force participation, women (%)						
15-74	43.8	43.4	42.8	44.1	45.4	45.8
55-59	14.8	15.7	16.2	14.2	16.6	20.7
60-74	3.6	3.6	3.0	2.8	2.9	2.9
Labor force structure (thousands)						
Employees	3,063. 1	3,040. 2	3,058. 6	3,144. 3	3,243. 8	3,292. 6
<i>of which civil servants</i>	820.4	776.3	758	759.3	760.2	753.4
Self-employed	559.7	564.9	551.7	530.4	547.7	526.5
Labor force by gender (thousands)						
Men	2,049. 6	2,036. 3	2,043. 5	2,041. 7	2,103. 1	2,122. 4
Women	1,629. 2	1,611. 8	1,602. 8	1,656. 0	1,708. 4	1,726. 7

Source: Central Statistical Office

Table 1.5: Family structure

	1995	1996	1997	1998	1999	2000
Age of mother at first birth	23.4	23.7	23.9	24.3	24.7	25.0
Total divorce rate	0.34	0.32	0.36	0.38	0.39	0.38
Rate of extramarital birth	0.21	0.23	0.25	0.27	0.28	0.29
Percentage of one-parent families		15				
Percentage of single households		26				

Source: Central Statistical Office

## 2. OVERVIEW OF THE SOCIAL PROTECTION SYSTEM<sup>1</sup>

### 2.1 Overview of the organization

The social protection system consists of five main items. These are:

- Pensions,
- the family support system,
- health care,
- unemployment insurance,
- the social assistance system.

The institutions of the social security pension system were built up in the 1950s. Since then, coverage was extended continuously. A major extension was the inclusion of the agricultural population. Growing coverage and maturation of the system made this part the biggest in social protection. In the second half of the 1990s, a reform of the pension system was started, but some measures were frozen directly after their introduction. (See details later in this chapter and in Chapter 3.) The family support system also has a long history. At the start of transition this part of the system was in a relatively developed stage. According to some views this sector was overgrown compared to the economic performance of the country. An interesting point was at the middle of the decade, when as part of an economic stabilization package, means-tested forms were introduced for two important benefits, which were universal before. This experiment failed, because the next government withdrew these measures. The health care system is under the strongest pressure, due to the poor health conditions of the population, to demographic factors and the lack of reform. Unemployment insurance is a rather new institution, which is managed independently from the Social Insurance System. The peculiarity of the Hungarian labor market is the high level of inactivity combined with relatively low unemployment. The social assistance system is mainly run by local governments. These municipality institutions were formed in the early 1990s.

#### 2.1.1 Centralization/decentralization of the system

The Hungarian social protection system is rather centralized due to the principal role of the government, although the level of centralization varies. The two extremes are, the pension system on one hand, which is the most centralized and the social assistance on the other, with the most

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<sup>1</sup> This part of the paper is based on the relevant chapters of MISSCEO: Comparative tables of social protection systems in 18 member states of the Council of Europe, Australia and Canada 10<sup>th</sup> edition (situation on 1 July 2000) publication as the most comprehensive description of the social protection systems. Institutional changes after mid-2000 were incorporated.

decentralized structure. As mentioned before pensions up to the recent years were paid from a single fund, moreover, reform steps of 1997 were withdrawn in three major points:

- The rate of contribution paid to the second pillar was frozen (against the original plan) at 6 percent of gross wages. The new government that came into office in 2002 raised it from January 2003 to 7 percent.
- The mandatory participation of new entrants of the labor market was eliminated while the return period from the mixed system to pure social security was extended. The new government of 2002 returned to the original plan rendering participation for new labor market entrants again mandatory from January 2003 and closing the return period in December 2002.

According to the Law of 1993/III on Social Administration and Social Provisions (Social Affairs) social assistance regulation is in the hands of local governments; consequently a great degree of variation exists in the country.

It was a strong indication of moving towards a more centralized system that the government gradually eliminated the operation of tripartite interest reconciliation among employers, employees and the government after 1998, since 2000 this forum has become formal. The other example of centralization was the dissolution of self-governing type of bodies (pension insurance self-government and health insurance self-government) of the social insurance in July 1998. The role of the former self-governments was taken over by one of the political state secretariats of the Prime Minister's Office. For the clear picture it can be added that in case of the unemployment system self-government body is still in operation.

Non-profit institutions play only a minor role in social protection in spite of the booming of the NGO sector since the early 1990. Most of the NGOs operate in education, culture and currently 3,500-4,000 non-profit organizations provide social services, which is slightly less than ten percent of the total number.

### **2.1.2 Supervision**

Regarding supervision there were hectic changes in the last four years. At the beginning of the period, the political state secretary of the Prime Minister's Office was responsible for pension and health insurance. The Ministry of Social and Family Affairs supervised the unemployment insurance, family support and partly the social assistance system. Later the Ministry of Finance played a major role in the health care, than the Ministry of Health has been involved. For one or two years supervision for health insurance was shared between the Ministry of Health and the Ministry of Finance, the first being responsible for professional matters, the latter for

finance, but in 2000 supervision by the Ministry of Health became universal in this field. This example offers a clear picture of the still unstable institutional structure. The National Audit Office supervises the finances of the social security system.

## **2.2 Financing of social protection**

In case of pensions (old age, survivors, and disability) the first pillar is financed by the Pension Insurance Fund. Employees who contribute only to the first pillar pay 8 percent of their gross earnings. Employees who contribute to both systems pay 2 percent of their gross earnings to the first pillar and 6 percent to the second. Employers contributed 22 percent in 2000 of gross earnings. This level was reduced to 18 percent by 2002. There is no ceiling for employer's contributions but for employees the maximum contribution was HUF 5,520 per calendar day in 2000, which is HUF 6,490 today. For the second pillar, employees contribute 6 per but employers pay no contribution. The contribution ceilings are the same as for the first pillar. The government annually in an Act sets ceilings.

For health and maternity benefits employees pay 3 percent of gross earnings, employers contribute 11 percent of the same basis. Contribution ceilings were the same for pensions until the end of 2001. Since the beginning of this year, there has been no ceiling applied. For sickness benefit, employers are obliged to one third of the sickness benefit disbursed to any insured person during the sickness period. Besides this earning related contribution employer pay a poll-contribution, which was HUF 3,900 per month per employee, then raised to 4,200 in 2001, and to 4,500 in 2002.

Long-term care benefits were financed from the same sources.

For unemployment benefits, the contribution is 1.5 percent of gross earnings for employees except of old-age pensioners and disability pensioners. Employers pay 3 percent of gross earnings to the Labor Market Fund. No contribution ceiling is applicable of this benefit.

Since 1999, contributions have been collected by the tax office, which improved the efficiency. Before that, social security had a separate collection service.

No contribution system is operating in family allowances.

All above finances are guaranteed by government budget. In the case of family allowances and general non-contributory minimum benefits financing is entirely provided by the government.

## **2.3 Overview of allowances**

### **2.3.1 Health care**

Health care benefits were last re-regulated in 1997. The health care system covers insured persons for all risks, persons entitled only to health services and persons covered by international (bilateral) social security agreements. The health care benefits also cover the dependants of the eligible. Although pensioners do not pay health insurance contribution, they are entitled to health care. There is no qualification period for claiming health care benefits, that means eligibility starts on the first day of the month following the signing of the agreement. The commencement of benefits starts from the beginning of illness and there is no limitation on duration. Benefits are in kind with free choice of doctors on the primary level. They include hospital and non-hospital medical treatment, sanatoriums, dental treatment, pharmaceuticals, prosthesis, spectacles, hearing aids, treatment and nursing at home, transportation and cost of travel, medical treatment abroad, medical rehabilitation. In some co-payments are charged in dental services, pharmaceuticals and extra services during hospitalization. A recent analysis finally concluded that health care is financed in 23.5 percent from general taxes (income taxes, VAT, excise taxes), 61 percent from social health insurance contributions, and 15.5% out-of-pocket payments (including drug co-payment and expenditure on OTCs, informal payments, and other direct payments for health care services and medical devices).<sup>2</sup>

### **2.3.2 Sickness**

Sickness benefit covers persons insured for all risks except for those persons whose contributions are paid from the central budget. Claims for sickness benefit can be made in case of incapability to work due to illness, pregnancy in case of no entitlement to pregnancy-maternity allowance and nursing a sick child who is under the age of 12. The maximum duration of sickness benefit in case of illness is 1 year. For nursing a sick child it is varied according to the age of the child between 14-84 days in a year. The amount of the benefit is earnings related but depends on the length of the insured period. If the insured period is longer than 2 years the benefit is 70 percent of earnings, if less, the amount is 60 percent of earnings. The benefit is liable to taxation and social security contributions.

### **2.3.3 Maternity**

Maternity benefits cover insured persons for all risks, persons entitled only to health services and persons covered by international (bilateral) social insurance treaties. Maternity benefits include three cash benefits. Birth grant

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<sup>2</sup> See Szende, Dózsa, Janky, Szivós (2002): Equity in the finance of health care in Hungary (in Hungarian) *Egészségügyi Gazdasági Szemle* vol. 40. no. 3.

is for every woman who gives birth. Maternity allowance and child care fee (gyermekgondozási díj – gyed) are paid only for persons insured for all risks. The eligibility for birth grant is to complete at least four prenatal medical examinations (one, in case of premature birth). The benefit is one off lump-sum payment, 150 percent of the minimum amount of old-age pension. The condition of maternity allowance is that the insured parent has at least 180 days of insurance period in the last two years before delivery and delivery should be during the insured period or less than 28 days after. The duration of the benefit is 24 weeks of which 4 weeks before and 20 weeks after the planned date of birth. The amount of maternity allowance is 70 percent of the daily average earnings of the previous year. For child care fee the insured parent has at least 180 days of insurance period in the last two years before delivery and the child lives with the claiming family. Child care fee is until the child is 2 years old. (Child care fee and child car allowance are not cumulative.) The amount of child care fee is 70 percent of the daily average earnings of the previous year, the maximum amount was 200 percent of the minimum wage. While there has been a substantial rise in minimum wages (in 2001 from 25,000 to 40,000 HUF per month and in 2002 from 40,000 to 50,000 HUF per month) the upper limit of child care fee is set separately by law. Birth grant is tax-exempt but maternity allowance and child care fee are fully liable to taxation. Maternity allowance and child care fee are liable to pension contribution but birth grant is not.

### **2.3.4 Invalidity**

This is a social insurance based, earnings related benefit that covers all insured persons. Eligibility for disability pension starts from the day the disability is diagnosed in a report of the medical committee. The minimum insured period for claiming disability pension depends on the age of claimant when disability occurred: it is 2 years below age 22 increasing gradually for 20 years for persons 55 years and above. The amount of pension differs according to disability classes, age and insurance period. In Class III under age 35 the amount of benefit is 51 percent of the average monthly income if contribution period was less than 2 years. The amount increases by 0.5 percent for each additional year of service to a maximum of 25 years. In Class III above age 35 with at least 10 years of contributing period the amount varies between 37.5 and 63 percent of the average monthly income. In Class II the benefit is 5, in Class I 10 percent higher than in Class III. The calculation of the amount is based on net adjusted earnings for the period since 1988. There is a supplementary benefit for the surviving spouse. If the spouse is entitled to disability benefits in his/her own right he/she will receive 20 percent of the widow pension. There is a whole range of other benefits for disability such as free of charge medicine for disability Classes I and II, different temporary or regular disability annuity for those who are not entitled for regular disability pensions for different reasons. There is a special benefit for blind persons. There are various forms of

rehabilitation programs for persons with less than 50 percent incapacity for work.

### **2.3.5 Old-age**

The pension system was reformed in 1997. Its main elements are:

- first pillar: mandatory, social security pension, publicly managed and financed on a pay-as-you-go basis
- second pillar: mandatory, privately-run fully funded pension funds

The minimum contributory period is 20 years for social security pension. The retirement age for claiming full pension was 58 for women and 62 for men in 2000. Gradually it will be raised to 62 years for women by 2009 for both pillars. There is a possibility to claim early pensions but just for first pillar. This benefit is available for employees involved in activities that are hazardous to health. After 10 years for men and 8 years for women working in these conditions, retirement age is reduced by 2 years and further reduction is applicable for working longer in difficult conditions. There is a pre-retirement benefit, which is not strictly a pension but rather an employment regulation measure. The pre-retirement pension is based on a tripartite agreement between representatives of employers, the National Pension Fund Administration and employees. The pre-retirement benefit can be paid 3 years before retirement age. The employer reimburses the cost of the benefit to the Pension Fund in advance for the whole period when the pre-retirement actually starts.

The amount of pension in the first pillar depends on service years and previous earnings. After 20 years of service the amount of pension is 53 percent of average, monthly, gross income. The amount increases with additional 2 percent for each service year between 21 and 25 years, with 1 percent for each year between 25-36 years and 0.5 percent for each year between 36-40. In the second pillar the fund provides benefit in a form of annuity or lump-sum payment depending on the choice of members, however the latter can be chosen only if the contributory period is less than 180 months. In the case of pensioner's death the annuity is transferable to the survivors. The regulation guaranties minimum pension for the first pillar. The former state guarantee on second pillar pensions has been withdrawn. Old-age pensions, survivor's pensions and accident related benefits are indexed by a 50-50 percent combination of wage and price increases. Since January 2002 pension is fully tax exempt. The personal income tax paid by the active population can be deducted up to 25 percent of social insurance pension contributions for both pillars.

### 2.3.6 Survivors

Entitlement for survivors' benefit can be the surviving spouse, cohabitant, child or dependent parent insured for all risks. The amount of the benefit is determined by the pension to which the deceased person was or would have been entitled at the time of death. The form of the benefit could be temporary or permanent widow or parent pension. The temporary widow pension is 50 percent of deceased person's old-age or disability pension at the time of death. It is paid for 12 months, which could be extended to 18 month if the widow takes care of a child. The temporary benefit is continued permanently if the widow reached retirement age or disabled or takes care of two minor children entitled to orphan's benefit. The permanent widow pension is 50 percent if the survivor does not have pension on his/her own right, and 20 percent if the widow receives any kind of pension. The benefit terminates if the widow enters a new marriage before reaching old-age pension age. Survivor children are entitled to orphan benefit until the age of 16. In case of participating higher education the age limit is 25 years. No age limit is applied if the orphan is disabled. The amount of the benefit is 30 percent of the deceased parent's pension for each child in case of losing one parent. It goes up to 60 percent for losing both parents or if the surviving parent is disabled or the child is abandoned by the other parent. Parental pension is paid if the parent was disabled at the time of death of his/her child or reached the age of 65 and depended on the child in the year preceding the latter's death. Foster parents are only entitled if they raised the child for at least 10 years. Parental pension is equal to the amount of the permanent widow pension. Survivors' pensions are also tax exempt since January 2002.

### 2.3.7 Employment injuries and occupational diseases

Persons are entitled for these benefits if they are insured for all risks in social security. Employment injury is defined as an injury at work performed under an employment relationship or in relation to it. It covers also the travel to work and home. Occupational disease is that occurred in consequence of the specific hazard involved in an occupation. In the case of temporary incapacity several benefits are provided such as free choice of doctor or hospital for medical treatment. All costs of medical treatment are paid by the Health Insurance Fund with no time limit. Accident sick pay is also provided for maximum 2 years with the amount of 100 percent of the average income. In case of permanent incapacity two kinds of benefit are available:

- accident disability pension if the reduced capacity for work is at least 67 percent
- accident annuity if the reduced capacity for work is at least 16 percent.

The accident disability pension is paid according to the same three classes of disability pension. The amount of benefit is 70 percent of the monthly

average earnings in Class I, 65 percent in Class II and 60 percent in Class III. The accident annuity is 8 percent of the monthly average earnings between 16-25 percent reduced capacity, 10 percent between 26-35 percent, 15 percent between 36-49 percent and 30 percent between 50-66 percent loss of working capacity. There is a possibility to review the level of incapacity after 2 years. Accident disability pension terminates if the recipient works on a regular basis and his income is less than 20 percent lower than his income prior to disability. There are special promotions for employers to employ handicapped persons in a form of earnings and contribution reimbursement.

### **2.3.8 Family benefits**

Various family support programs exist in Hungary. Family allowance (családi pótlék) is a universal benefit for all children under age 6 financed by the government budget. Education support scheme is the same kind of benefit paid during compulsory primary and secondary education up to 20 years. The amount of family allowance is different according to the number of children in the family, the number of parents. Disabled children receive higher amount. Basically family allowance is paid until school age is reached, then educational support is paid for those who attends educational institutions. (It was explained by the fact that there was certain social groups which did not take enough attention for their children's education. But in fact there was not major differences between the number of beneficiaries of old and new schemes.)

Child care allowance (gyemeg gondozási segély – gyes) is paid for parents who stay at home with their children under age 3 (under age 10 for disabled children). The monthly amount is equal to the minimum old-age pension. This benefit is not cumulative with child care fee discussed under maternity.

Child raising support (gyermeknevelési támogatás – gyet) is a benefit for families raising three or more children and the youngest child is between age 3 and 7. The monthly amount is equal to the minimum old-age pension. This benefit is also not cumulative with child care fee.

Regular child protection support (rendszeres gyermeknevelési támogatás later kiegészítő családpótlék) is a benefit for families where per capita income is equal or lower than the minimum old-age pension. The monthly amount is at least 20 percent of the minimum old-age pension.

Irregular child protection support is paid for families facing temporarily cash flow problems or emergency situations that could effect their standard of living. This benefit is provided and fixed by the local government on a case by case basis.

Home maintenance support is a means-tested benefit provided by the local government for those whose living conditions are under a specified

minimum level and have no income to cover maintenance costs. It is paid if the cost of living exceeds 35 percent of total monthly income or the cost of heating exceeds 20 percent of income or the per capita income is less than twice the minimum old-age pension.

Family allowance and education allowance are tax-exempt but other benefits are subject to taxation.

### **2.3.9 Unemployment**

Unemployment benefit covers all employees who work under employment contract except for self-employed who work under civil code contract. This benefit is financed by the unemployment insurance system. The eligibility of the benefit is paying contributions for at least 200 days during the previous 4 years. The amount of the benefit is 65 percent of the previous average earnings but no less than 90 percent of the minimum old-age pension and no more than twice the minimum old-age pension. It is paid for up to a maximum of 270 days.

There is a special benefit called pre-retirement unemployment assistance providing help for the unemployed close to retirement age. Persons are eligible for this benefit within five years of reaching pension-age and paid social security contribution for at least 20 years. The amount of benefit is calculated the same way as the old-age pension but until reaching pension-age the benefit is reimbursed by the National Labor Fund to the National Pension Fund. People having unemployment benefit could be involved in income earning activity if the sum of earnings does not exceed 50 percent of official minimum wage. The unemployment benefit is subject to taxation and social security contribution.

### **2.3.10 Minimum resources/social assistance**

According to the Law on Social Affairs, vulnerable persons can apply for benefits at the local government. The latter is obliged to issue regulation on entitlement. There is no general non-contributory minimum scheme operating but some specific minimum benefits are available. One of them is old-age allowance to ensure a minimum income level for older people. The benefit is an income supplement calibrated so as to reach 80 percent of minimum old-age pension per capita in couples and 95 percent for singles. This benefit is financed in 75 percent by the central budget and 25 percent by the local government.

The same kind of social assistance is available for working-age invalid persons who lost 67 percent of working capacity or are eligible to the blind allowance. The income supplement of per capita income is up to 80 percent of old-age pension. The source of financing is the same as for old-age allowance: 75 percent government budget, 25 percent local budget.

A third kind of benefit is provided for the unemployed. If an unemployed person's entitlement for unemployment benefit has expired and his/her income is lower than 70 percent of the old-age minimum pension, the income supplement guarantees the 70 percent level. Finances of the scheme are the same as for the above mentioned benefits.

For all kinds of pensions (old-age, survivors, disability) and for unemployment benefit there are minimum levels.

## **2.4 Summary**

The current social protection system is a result of the historical development and most recent responses to the challenges of the economic and social transition. Social protection in Hungary, as well as in other countries, is a collection of measures to improve or protect human capital, ranging from labor market interventions, publicly mandated unemployment or old-age insurance to targeted (means-tested or group targeted) income support. Social protection interventions assist individuals, households, and communities in order to manage the income risks that leave people vulnerable. Specifically:

- to reduce the vulnerability of low-income;
- to allow households to shift income efficiently over the life-cycle, thus financing consumption when needed;
- to enhance equity in particular for those who are exposed to adverse shocks.

Social protection interventions contribute to the solidarity, social cohesion, and social stability and support sustainable economic development. As such, government constantly reviews tax and benefit systems, removing poverty traps in order to provide the right incentives to work, and eliminate disincentives for older workers to remain active in the labor market. There is also an objective to improve accessibility and coverage of the social protection system. The process of review, the institutions of monitoring depend on the policy of the government, so the mandate and power of different ministries, other government bodies and committees change time to time. However, currently there are two councils devoted to social protection issues, one is the called Social Council, other is the Council of Issues of the Elderly. The first one aims to maintain discussion between NGOs and the government, represents different interest groups, exchanges information and opinions, and is involved in the decision making process on social issues. The mandate of the other council is narrower than the previous one, it is a tool for interest representation of the elderly population.

Concerning the future objectives and actions, it is clear that the reform of the pension system will continue and there are certain signs of a major

health care reform. It is also clear, that the reform steps on health care are obviously not without economic and political risks, therefore before actions a consensus have to be built.

### 3. PENSIONS<sup>3</sup>

#### 3.1 Evaluation of current structures

The predecessor of the current pension system, established in 1929, collapsed in World War II. After the war it was redesigned as a pay-as-you-go financed unfunded scheme which became practically universal in the process of maturation. Step-by-step it replaced the alternative institutions, the family in particular, in providing old-age income. It was significantly reformed in 1998 when a mandatory, privately managed, funded pillar was set up.

##### 3.1.1 Public-private mix

The social security system plays an eminent role in old-age income security. It largely crowded out traditional intergenerational family transfers, replaced other institutional forms of old-age income, such as occupational pension schemes, and it is unrivaled by labor market income for the elderly.

*Table 3.1: The role of social security pensions: income sources for the elderly*

Income source	labor market	capital market	government transfers	family transfers	total
%	20.5	2.0	76.4	1.0	100.0

Source: Own calculation using data from Medgyesi (2001)

Table 3.1 shows the relative importance of different income sources for the elderly (in this case 61 years old and older). Government transfers make three-quarters of the total amount (63.5 percent old-age pensions, 11.1 percent other social security pensions and 1.8 percent other government transfers). The only other source that makes some significance is the labor market providing one-fifth of the income of the elderly (15.1 percent wages and 5.4 entrepreneurial income including revenues from small scale agricultural business).

The public pension system has over 3 million beneficiaries that is more than 30 percent of the total population. A bit more than half receive an old-age pension (see Table 3.2). Their number slightly increased in the second half of the 1990s. The combined number of disability pensioners also grew with a moderate speed, although their composition of above versus under retirement age changed due to an increase of the age limit.

<sup>3</sup> This chapter draws on papers of the author written on similar subjects, such as Gál (1999a, 1999b, 2000), Gál, Simonovits and Tarcali (2001) and Gál and Tarcali (2002).

Table 3.2: Number of beneficiaries of social security pension programs (in thousands)

	1995	1996	1997	1998	1999	2000
old-age	1,600	1,621	1,647	1,652	1,665	1,671
above-retirement-age disability	386	393	402	397	334	344
under-retirement-age disability	332	352	365	380	424	419
other*	692	693	690	710	761	711
	3,010	3,059	3,104	3,139	3,184	3,145

Source: Statistical yearbooks of the Central Administration of the National Pension Insurance (CANPI). Figures for January in each year.

\*Survivor benefits and other retirement provision programs.

Apparently, the social security pension system dominates the provision of old-age income. Families and employers can almost be overlooked. Capital market provision was also missing for decades. Supplementary pension funds were opened in 1994. Since then they attracted 1.1 million members and collected a rapidly growing amount with a typical quarterly periodicity that produces an end-of-the-year rush in contributions. The total assets reached EUR 1.2 billion by the end of 2001. The funds are still in the accumulation period. The pensions, either lump-sum or annuity, they paid in 2000 did not reach 1 percent of the amount of social security annuities.

An analysis of the social composition of voluntary fund members (Gál 1999b) showed that they have about 60 percent higher per capita household income than non-members. The income difference appears significant in every 10-year cohort so it cannot be fully traced back to the age-earnings profile even though fund members are 6 years older on the average than the rest of the non-pensioned adult population.

Contributions are supported by tax-exemptions. 20 percent of life insurance fees, 30 percent of supplementary pension fund contributions and 25 percent of mandatory contributions (only the part paid by employees, but including social security contributions) can be deduced from taxes. There are ceilings, though, HUF 50,000 (about EUR 200) for the life insurance fees and HUF 100,000 (about EUR 400) for supplementary fund contributions.

Another tax incentive targets employers. About two-thirds of voluntary pension fund revenues come from employers supplementing the contributions of their employees. This fringe benefit is exempt of social security contributions. According to some estimations 75-85 percent of voluntary pension fund contributions would have otherwise been paid as tax or social security contribution to the government.

The public-private mix will be significantly changed in the next decade due to the partial privatization of the mandatory social security pensions in 1998. Starting from about the mid-2010s a growing number of new retirees will receive about one-quarter or more of their pensions from privately managed pension funds. We will return to the details of the pension reform in section 3.3.1.

### 3.1.2 Benefits

In this subsection we give a brief analysis of pension expenditures based on a decomposition technique. This method offers a chance to sort out the dynamics of benefits from other trends such as demographic changes and labor market developments that are crucial for the macro-level figure of overall expenditures. Nevertheless, the attention will be focused on benefits.

Pension expenses depend on the number of participants, pensioners and contributors, and the amounts they receive from or pay to the system, pensions and contributions. Accordingly, the trend of expenditures relative to the GDP can be decomposed to the system dependency, which compares the number of pensioners to the number of contributors, and the individual pension burden, which measures the average benefit against the amount of GDP produced by an average employee. System dependency can be further decomposed to old age dependency, which is a demographic factor comparing the retirement age population to the active age population, to coverage, that stands for the number of pensioners over the retirement age population, and to activity, which gives the proportion of those in active age who are actually working. The individual pension burden can be separated to the replacement ratio, that compares average pension to average wage, and wage efficiency, which measures the units of GDP produced by a unit of wage.<sup>4</sup>

We will discuss issues of coverage and retirement age under the umbrella of system dependency. Details of the benefit structure such as changes in the benefit formula, indexation, pension distribution, adequacy of pensions and their effect on reduction of poverty will be covered in the paragraphs devoted to the pension burden of the individual producer.

There are three major sources of pensions and retirement provisions, the Pension Insurance Fund (PIF), the Health Insurance Fund (HIF) and the government budget. The PIF covers old age and survivor pensions, and also

<sup>4</sup> Formally:  $B/Y = P/M' \cdot P/P' \cdot M'/M \cdot b/v \cdot v/(Y/M)$ , where  $B$ : aggregate pensions;  $Y$ : GDP;  $P$ : pensioners (including recipients of disability and survivors' pensions and some smaller pension type plans);  $P'$ : pension aged population;  $M$ : employed;  $M'$ : active aged population (15 years old and above up to the retirement age);  $b$ : average pension;  $v$ : average net wage. The first three components make the system dependency ratio ( $P/M$ ), the other two make the individual pension burden ( $b/(Y/M)$ ). For methodological notes see Simonovits (1999).

provides benefits for above-retirement-age disability pensioners and class 1 and 2 under-retirement-age disability pensioners. It had 2.4 million clients in 2000. The responsibility of HIF is class 3 under-retirement-age disability. About 0.4 million people fall into this category. Finally, the central government finances a group of retirement programs that contains approximately 30-40 services, a part of which are explicitly pensions (early retirement, pre-retirement, miners' pension), the other part largely functions as pension in the current labour market situation (temporary benefits, regular social benefits), while a few were grouped incidentally among these expenditures (blind person's benefits, war veteran care, diabetes benefits, etc.). These programs covered 0.3 million people in 2000. Since many under-retirement-age pensioners are suspected to leave the labor market due to poor chances of finding employment rather than to ill health there is an ongoing debate among experts of what should be considered a pension. Below, in the analysis of benefits, we will examine the extended pension system that includes all pensions and retirement provisions irrespective of its source as well as the narrower, PIF-defined, pension system.<sup>5</sup>

Pension expenses taken in the broadest sense decreased from 10.9 percent to 9.4 percent of GDP between 1992 and 2000. By the PIF-definition, the corresponding figures are just 8.6 and 7.6 percent (only benefits, excluding operation costs).

By contrast with the small, 1.5 percentage point, change in the overall trend, its components moved rapidly, and sometimes dramatically, in opposite directions. System dependency grew alarmingly from 67 percent in 1992<sup>6</sup> to 81 percent (i.e. one of the highest in the world) in 2000. (According to the PIF-definition, the increase was somewhat less dramatic, from 54 percent to 62 percent). This was mainly due to a rush of older workers to the pension system, which simultaneously cut the activity rate and drove up coverage. This was mostly counter-balanced by a drop of the individual pension burden. While in 1992 the average benefit, including all forms, made 16 percent of GDP produced by an individual employee, it fell to 12 percent by 2000. These trends are set out in detail in the upper panel of Table 3.3 which is based on figures of the system in the broader sense.

Demography, which is frequently a problematic factor in pension systems, supported rather than damaged the pension budget during the 1990s. The old age dependency ratio decreased from 0.38 to 0.32. Post-war baby-boomers and the large cohorts born during the anti-abortion campaign of the early 1950s were still active, and their children had reached the labor market.

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<sup>5</sup> For an alternative definition of the system based on the economics of pensions rather than institutional considerations see Gál and Tarcali (2002).

<sup>6</sup> We use 1992 as base year, for the pension budget was separated from the health budget in that year.

Table 3.3: Dynamics of pension expenditures, 1992-2000

Decomposition of pension expenditures								
	pension expenditures /GDP (%)	old age dependency	coverage	activity	system dependency	replacement	wage efficiency	individual pension burden
1992	10.9	0.381	1.198	0.677	0.674	0.624	3.84	0.162
2000	9.4	0.318	1.546	0.609	0.806	0.591	5.07	0.117
Individual effects of components (How would pension expenditures have changed if the component in question had not changed?) (percentages)								
2000	9.4	11.3	7.3	8.5	7.9	9.9	12.4	13.1

Source: own calculation based on CSO Statistical Yearbooks and CANPI figures. The table covers all pensions and retirement provisions.

old age dependency: pension age population / active age population

coverage: pensioners (all forms of old age, survivor and disability) / pension age population

activity: employed / active age population

system dependency: pensioners / employed (= coverage • old age dependency / activity)

replacement rate: average pension / average net wage

wage efficiency: GDP per employed / average net wage

individual pension burden: average pension / GDP per employed

Another reason for the improvement in old age dependency was the raising of the retirement age.

Raising the official retirement age can improve old-age dependency but it does not necessarily affect system dependency unless the effective retirement age also goes up, that is, unless activity grows with the retirement age but coverage does not. Through the process of maturation the number of pensioners, including also recipients of disability and survivor benefits, pre-, miner- and early retirement pensions and beneficiaries of other smaller pension-type programs, increased dynamically after 1950 and equaled the number of the entire population above retirement age by 1985. In 1992 the proportion of these various categories of pensioners was 120 percent. This figure continued to grow, reaching 155 percent by 2000. Since the PIF covers a significantly smaller group of people, a narrower definition of the pension system leads to an increase of coverage of 97 percent in 1992 to 120 percent in 2002. Note that the speed of growth is high in both definitions.

This high level of over-coverage is partly due to an almost universal coverage of the true old, those above the retirement age. For the Hungarian pension system, under-coverage is less an issue of potential beneficiaries or contributors, rather it is a matter of coverage of wages. We return to the issue of tax avoidance and exemptions in the next section. The other reason of over-coverage of beneficiaries is the relative inefficiency of the retirement age to separate the active cohorts from the older inactive cohorts. Unfortunately, the CANPI has not published the actual age of new retirees. Moreover, the gap between the official retirement age and the actual age of new old age retirees do not reflect the number of disability pensioners who leave the labor market for their market position rather than their poor health.

By 2000, the expansion of coverage alone was responsible for a part of the pension budget equal to 2.1 percent of GDP. If its already high level had remained the same as in 1992, pension expenditures would have been only 7.3 percent of GDP against the actual 9.4 percent. These percentages can be found in the lower panel of Table 3.3 where the results of calculations of what could have happened if only one component had changed are shown. In the narrower PIF-system the drop would have been 1.4 percent of GDP, in addition to the 1 percent measured by the PIF, so pension expenses would have decreased to a mere 6.2 percent.

The growth in coverage was intentional. After the collapse of trade among ex-communist countries and the liberalization of the economy, entire sectors of the economy were erased. The institutional framework of the pension sector that had emerged from past circumstances was put under intense pressure to cope with changing demands, while alternative services to manage unemployment were still in the making. Moreover, the immediate political costs of allowing older active generations to leave the labor market are lower than forcing them to find new jobs.

The replacement rate (average pensions over average net wages)<sup>7</sup> was 62 percent in 1992, which is relatively high in comparison with international rates (see Palacios and Pallares-Miralles 2000). Replacement for lower-than-average wages could have been even higher. In 2000, the corresponding figure was somewhat lower, 59 percent. Without cutting pensions more than wages and keeping them at the 1992 level of replacement, the pension budget would have grown to about 9.9 percent of the GDP by 2000, 0.5 percentage point higher than the actual figure.

These figures again reflect the pension system taken in the broadest sense. PIF-clients, who make a significant subgroup of all pensioners and retirees, had a slight growth of the replacement rate from 61 to 62 percent (even though the full provision of old-age pensioners, the most important group, that includes their proper old-age pension as well as other supplementary provisions slightly declined compared to net wages from 61 to 60 percent between 1992 and 2000).

The pension formula was adjusted several times. It is defined benefit and it has the following shape:

$$P = g(L) * f(I), \text{ where}$$

$I$  is individual net wage, and

$L$  is total length of service (including accepted non-contributory periods).

Before 1992,  $f(I)$ , the base income to settle new pensions was the best three of the previous five years. Since then, all wages earned in 1988 or later count. From the same year, 1992, an insurance ceiling limited  $f(I)$  in order to avoid excessively high public pensions. These resulted from basing the calculation of  $f(I)$  on a too short period, thereby rewarding extreme income gains in the last active years with very high pensions.

The high inflation rate of the 1990s made indexation of previous wages (called 'valorization') necessary. However, valorization is partial. Wages of the year of retirement and the year before are not included in the formula. This hit entry pensions severely in the years of high inflation. Moreover, inflation was not simply high in some years but it had several peaks. That led to inconsistencies. All too often people with longer labor market history got lower entry pensions than people with a shorter employment history, other factors being equal if, they retired in the "wrong" year (Toldi 2000).

The pension scale is not linear. For the first 10 years of service  $g(L)$  is 33 percent, for the next 15 years it grows 2 percent a year, for the next 11 years, 1 percent a year, above 36 years of service, 1.5 percent a year. The calculation of  $f(I)$  is degressive. It is calculated stepwise from the individual's net income and higher income brackets contribute less to it. Income falling into the lowest bracket is weighted with 100 percent, the next

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<sup>7</sup> Benefits are tax-exempt and calculated from net earnings.

with 90 percent and so on until the highest that has a weight of 10 percent. Degressiveness produced an oscillating effect through the 1990s, since degressiveness brackets were not automatically adjusted to the dynamics of wages. Nevertheless, the trend in degressiveness was decreasing. Since the 1998 pension act, the brackets grow annually 8 percentage point faster than the average net wage so degressiveness will gradually evaporate some time between 2005 and 2010.

The other cause of the decrease in the replacement rate is the fall of the indexation of pensions below inflation. Before 1992, indexation was ad hoc. Since then pensions are indexed by the nominal wage index. Between 1992 and 1995 and since 1999 indexation was forward-looking. Between 1996 and 1998 the PIF used backward-looking indexation. The switch between backward-looking and forward-looking calculation cut into pensions in 1996 as well as in 1999.

The amount received by the average old-age pensioner was HUF 41,000 (about EUR 170) in January 2001. For under-retirement-age disability pensioners it made HUF 33,160 (about EUR 135). These amounts contain the main benefit and supplementary benefits as well.

Pensions are less dispersed around the average than wages. Major and Martos (2000) compare the relative standard deviations of old-age (and above-retirement age disability) pensions to that of the wages that are used by the pension administration to calculate pensions (that is, after-valorization net wages). They found that the relative standard deviation of pensions was lower both in 1988 and 1997 (37 and 32 percent, in the respective years) than that of wages (45 and 38 percent, respectively). This measure of dispersion decreased both for pensions and wages.

Pensions are largely adequate to protect the elderly of poverty. If poverty line is taken at the 60 percent of the median income 7 percent of people 60 years old or older fall into the group of poor against 12 percent of people in their active age. If the poverty line is taken at 50 percent of the median, these figures drop to 3 and 8 percent, respectively (Medgyesi 2001, Table 2.7). Among all chapters of social spending pensions give an escape from poverty for most people (Szivós and Tóth 2000).

The last component of the decomposition exercise, wage efficiency, grew especially fast in 1995 and 1996 when the government's austerity program slashed real wages by some 15 percent while the economy as a whole kept growing. If it remained the same as in 1992, the budget of the extended pension system would have reached 12.4 percent of GDP in 2000, an exceptionally high share and 3.0 percentage points higher than the actual figure. (In the narrowly defined PIF-system it would have been 10.1 percent, 2.5 percentage points higher than it really was).

### Intergenerational redistribution

Pension systems are about to arrange transfer flows from the active to the old generations. Redistribution among generations appears if some cohorts are net winners while some other cohorts are net losers of the transfer flow. There seems to be a strong case that unfunded, pay-as-you-go financed social security systems tend to redistribute in favor of the first generations (Gál and Tarcali 2002).

Figure 1: Net life-time contributions by cohorts



Source: Gál, Janky, Simonovits and Tarcali (2002)

The Hungarian pension system is no exception. Figure 1 shows the estimated average net life-time contributions by cohort. Clearly, the first 50 year-groups born after 1880 are winners of the pension system. For those born in the 1880s every forint invested in the system yielded at least 55. However, the first cohorts had a short period of accumulating accrual rights so their gains were large only relative to what they invested. The real winners are the next cohorts which, by financing the small pensions of the first-comers through their active years, collected a long service history. Consequently, the net gain was growing for the first 20-25 cohorts. Then it went on to decrease but still to offer net gains for up to the cohorts 70 years old now. For all cohorts born later the system is making net losses.

#### 3.1.3 Financing of the pension system

The rate of contribution revenues to the GDP can change over time due to several reasons such as changing rules, declining capacity of the government

to collect contributions or the drop of wages relative to other income components. Accordingly, the trends can be decomposed so as to capture the individual effects.<sup>8</sup> Here we offer an analysis of the pension system defined in the narrow sense, that is PIF pensions, that cover old-age and survivor pensions, above-retirement-age disability pensions, and class 1 and 2 of the under-retirement-age disability pensions. It does not cover, however, a number of smaller retirement programs that are financed by the HIF or the government. Consequently, the figures of Table 3.4 do not compare directly to the expenditure figures in Table 3.3.

The most relevant rule of the pension regulation that governs pension revenues is the contribution rate. The official contribution rate was 30.5 percent of gross wages through the first half of the 1990s, 6 percent paid by the employee and 24.5 percent by the employer. Subsequent governments tried to cut it, so it decreased to 30 percent in 1997 and to 28 percent in 2001. In 1998, the rate grew provisionally as part of a shift of the burden from the employer to the employee (the former had to pay 24 percent in 1998, 22 percent in 1999 and 2000, and 20 percent in 2001, whereas the latter was charged 7 percent in 1998 and 8 percent since 1999).

The other component in the decomposition of the dynamics of pension revenues is the coverage of wages. It measures the part of wages that is within the reach of the tax office. It is the ratio of the covered wage bill over the total wage bill. The former gives the wage bill that would occur should all forints of wages have contributed to the pension budget with the official rate. In other words, it produces a theoretical wage bill that appears for the authority which collects social security pension contributions. It is calculated from the official contribution rate and the contribution revenues.<sup>9</sup> In the beginning of the 1990s, the covered wage bill was not far below the average of the rich OECD countries (see Palacios and Pallares-Miralles: 2000). Its 30 percent rate to the GDP ranked with the percentages of Belgium and Italy and it was above those of Spain and Portugal. By 2000, however, the ratio fell to 25 percent of GDP. As a consequence, the coverage of wages declined from 77 to 72 percent through the 1990s (see Table 3.4). This component is solely responsible for 28 percent of the overall decrease of the proportion of the contribution revenues in GDP (see the lower panel of Table 3.4). Due to growing difficulties of the government to deduct payroll tax from the legal wages the pension system lost about 0.5 percent of GDP a year of revenues.

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<sup>8</sup> We use the following equation for the decomposition:  $R/Y = \tau \cdot C \cdot W$ , where  $R$  is standing for contribution revenues and  $Y$  for GDP,  $\tau$  is the official contribution rate,  $C$  is the coverage of wages and  $W$  is the share of labor in the GDP. Palacios and Rocha (1998) provide an alternative method of decomposition.

<sup>9</sup> This calculation slightly overestimates the covered wage bill since for incomes above the ceiling no additional contribution is levied. However, for the ceiling applies only to contributions paid by the employee but not to the part paid by the employer, a much larger share, this overestimation is marginal.

However, the main reason of shrinking relative contributions was a rapid decline in labor share. Whereas in 1992 the wage bill was still as high as 40 percent of the GDP, it dropped to 34 percent by 2000. That alone explains about two-thirds of the fall of contribution revenues.

Table 3.4: Dynamics of contributions collection, 1992-2000

<b>Decomposition of the ratio of pension contribution revenues to GDP</b> (percentages)				
	pension contribution revenues / GDP	official contribution rate	coverage of wages	labor share
1992	9.2	30.5	76.5	39.6
2000	7.4*	30.0	71.9	34.4
<b>Individual effects of components</b> (How would the contribution revenues /GDP ratio have changed if the component in question has not moved?) (percentages)				
2000	7.4*	7.5	7.9	8.5
<b>Individual effects of components</b> (How much does a component explain alone of changes in the contribution revenues / GDP ratio?) (percentages on a logarithmic scale)				
2000/ 1992	100.0	7.5	28.0	64.5

Source: own calculation from CSO National Accounts.

coverage of wages = covered wage bill / wage bill

labor share = wage bill / GDP

\* Including government compensation for contributions lost to the mandatory private funds.

## Deficit

A comparison of Tables 3.3 and 3.4 suggests a large and growing deficit in the pension budget. This picture is partly misleading. As indicated above, the two decomposition exercises were based on different data sources.

In 2000, the PIF budget was 7.8 percent of GDP (7.6 percent benefits, 0.2 percent operation costs) about 0.4 percentage point above its contribution revenues. However, as mentioned before, the PIF budget does not cover all expenses that could be taken as part of the pension system, neither did it contain all contributions. The social security tables of the CSO yearbook present pensions and other retirement provisions reaching 9.4 percent of GDP. This amount includes all expenses in the left side of Table 4.5 but administrative costs. By contrast, on the expenditure side, the PIF budget did not calculate with disability pension paid from the HIF and other retirement provisions financed by the central budget.

Table 3.5: Pension budget, 2000 (% of GDP)

Expenditures		Revenues	
old-age pensions	5.3	contributions, PIF	6.8
disability pensions, PIF	1.3	contributions, HIF*	1.0
disability pensions, HIF	1.0	other contributions-like revenues, PIF	0.1
survivor benefits	1.1	compensation for contributions lost to MPPFs (PIF)	0.5
other retirement provisions	0.8	other government transfer	0.3
administrative costs	0.2	government transfers financing other retirement provisions	0.8
<b>total</b>	<b>9.6</b>	<b>total</b>	<b>9.6</b>

\* Only contributions covering disability pensions are considered here.

PIF: Pension Insurance Fund. HIF: Health Insurance Fund. MPPFs: mandatory private pension funds.

Sums may not add up due to rounding.

If we take all pensions and other retirement provisions into account as well as the administrative costs, the pension budget grows to 9.6 percent of GDP, of which only slightly more than 7.9 percent is covered by contributions or contribution-like revenues (and an additional 0.5 percent which is owed to the PIF due to revenues lost to the private funds and should not be considered a deficit). The rest is financed by the government as a provider of a number of retirement programs.

### 3.1.4 Incentives

The social security pension system is in the focus of arguments of its incentive effects on contribution discipline, savings, labor supply and fertility. Although the public debate leading to the 1998 pension reform centered around these issues very little is known about these effects in Hungary besides anecdotal evidence. Clearly, many of the pensioners, in particular disability pensioners, have regular income from the informal economy but the true figures are uncertain. Balestrino, Cigno and Rosati (1997) found a positive relation between the level of coverage by public pensions and household savings, but a negative effect of deficits in pension budgets on savings for the period from 1975 to 1994. They also found negligible relation between growing eligibility and fertility. Micklewright and Nagy (1995) analyzed the ways people follow when their unemployment benefit expires. However, their attention was not limited to older employees so the use of the pension system and the disability programs in particular as an escape route from the labor market is not in the focus of the analysis.

Tóth (1996) used survey data to measure the suction effect of retirement and found it strong. In the cohort before the official retirement age, 40 percent of the respondents wanted to retire under the official age, and every eighth out of these 40 percent had already applied for it.

### **3.1.5 Coverage**

We discussed the problem of coverage of people in subsection 3.1.2 and the coverage of wages in subsection 3.1.3.

## **3.2 Evaluation of future challenges**

### **3.2.1 Main challenges**

In subsection 3.1.2, the old-age dependency of the system was illustrated. Demography supported rather than undermined the pension sector. Raising the retirement age in 1996 to 62 for both genders postponed the expected financial problems due to the retirement of the post-war baby-boomer generation. However, after 2010 the demographic conditions will quickly deteriorate. The predicted age-distribution of the population was discussed more in details in Chapter 1.

### **3.2.2 Financial sustainability**

Rocha and Vittas (2000) made long run predictions for the Hungarian pension system without and with the 1998 pension reform. They calculated with a growing life-expectancy, stagnating (2000-2030) and later declining employment (-0.3 percent p.a. between 2030 and 2070), and also declining population (-0.2 percent p.a. between 2000 and 2030, and -0.3 percent p.a. between 2030 and 2070). They had a 3.0 percent annual real wage growth and a 3.0 percent, later 2.7 percent annual real GDP growth. Unemployment was set at 7.0 percent.

Under these assumptions the unreformed system is expected to generate an ever growing if fluctuating deficit, 6.5 percent of GDP in 2070. The projected fluctuation closely follows the old-age dependency ratio. The latter is expected to grow from the current 0.38 to 0.65 by the end of the period in question. Balancing the pension system would require a contribution rate above 55 percent or a reduction of the replacement ratio to below 35 percent against the current 59 percent. They also simulated the potential effects of the 1998 reforms. We will return to that in subsection 3.3.1.

Gál, Simonovits and Tarcali (2001) conducted a generational accounting in the pension system. The essence of generational accounting is to break down net contributions by cohorts, and to project these values, the current age-contribution profile, into the future. Given a few additional assumptions on the growth of productivity and the discount rate, as well as population

forecasts, the level of contribution levied on future generations by the present net contribution profile projected into the future can be determined so as to meet the inter-temporal budget constraint. The latter is simply a zero-sum constraint stating that someone (descendants in the absence of others) must defray possible over-spending of the present. To put it more precisely: the present value of future net contributions of current and subsequent generations has to be equal to the present value of current debts and future expenditures.

The calculations suggest that the Hungarian public pension system was unsustainable in the long-term without the comprehensive reform package of 1998. The per capita account of future generations is \$18,950, while that of the new-born is about \$1,130 (see the *no reform* column in Table 4.6). This difference provides the most important index of generational accounting, the so called generational imbalance. If deficits in the system are devolved entirely on to the as-yet unborn, they will be burdened with making \$17,820 more lifetime contributions than those who are already in the system but have their whole careers ahead of them. Note that the unreformed system is inefficient even for the newborn. The results of generational accounting are sensitive to the net contribution-age profile. These results were based on the budget plan of the PIF of 2000. Since the actual budget proved to be more favorable than expected the imbalance is likely to be less pronounced, even though the long term deficit is still present in the system.

### **3.2.3 Pension policy and EU accession**

#### **Equal opportunities for both genders**

The social security pension act explicitly requires equality between the genders. The actuaries of the new pension funds must apply a fund-specific unisex life table. However, Augusztinovics et al (2002) point out inconsistencies in the law. For instance, it is stated that the insurance companies as annuity providers have to offer specific products developed directly for pension fund members. Yet, insurance companies are not obliged to use unisex life tables. Since the new mandatory pension funds will pay pensions only in the future this inconsistency can be corrected.

#### **Preparations for the accession to the European Union**

The personnel of CANPI was educated in a Phare-project (2001-2002) so as to be able to apply the rules of Regulation 1408/71. There exist bilateral social security agreements with the most important labor market partners of Hungary, Germany (2000) and Austria (2001). These agreements regulate the mutual acceptance of service years and eligibility in bilateral relations.

### **3.3 Evaluation of recent and planned reforms**

#### **3.3.1 Recent reforms and their objectives**

##### **The 1998 pension reform**

A comprehensive reform package (Law on Eligibility and Contributions to Social Security and Private Pensions 1997/80 Law on Social Security Pensions 1997/81 and Law on Private Pension and Private Pension Funds 1997/82) was passed in 1997 and came into effect on January 1, 1998.<sup>10</sup>

By the contributions law, employers' pension contributions were to decrease from 24 percent of gross wages to 23 percent by 1999 and 22 percent by 2000. In contrast, employees' contributions were to increase from 6 percent to 7 percent by 1998, 8 percent by 1999 and 9 percent by 2000. The social security administration was instructed to establish a personal contribution register from 1999.

The social security pensions law enacted reforms in the first pillar. It changed several elements of the old-age entry pension formula. Degressiveness in the imputation of earnings to the pension base will be phased out gradually. The accrual rates in the pension scale will be made linear from 2013, with 1.65 percent of lifetime earnings for every service year for those who stayed in social security with full contributions and 1.22 percent for those who partially opted out. According to the transition rule, the reduction in the accrual rate from 1.65 percent to 1.22 percent was calibrated to the rate of partitioning of contributions ( $1.22/1.65 \approx 1-(8/31)$ ). However, benefit reduction has been extended to include service years earned prior to the reform, when all contributions were paid to social security. In this way, in addition to the obvious elimination of a sizable part of the implicit pension debt, the legislators wanted to assure that the actual age limit of switchers would be low.

Also from 2013, the pension base will be shifted from net to gross earnings while pensions will be made subject to income taxation. As for established pensions, the net wage indexation was to be replaced by the so-called Swiss indexation after a transition of two years (in 1999 100 percent of net wage index, in 2000 a 30-70 percent mix of consumer price index and net wage index, and finally from 2001 a 50-50 percent mix of the two indices). Rules of the survivors' benefits also changed. In addition to the own right pension, a widow has also been eligible for the widow benefit since 1998 which is 20 percent of the pension of the deceased spouse. The law also confirmed the raising of retirement age legislated but suspended before. According to the new rules, the retirement age for men was raised

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<sup>10</sup> An analysis of the 1998 reform see in Simonovits (2000).

from 60 to 61 in 1998 and to 62 in 2000, whereas for women it was raised by one year every second year and will reach 62 in 2009.

The private pension law established a new pre-funded and defined contribution type of tier managed by private companies. Fund membership was made optional for those who had earned pension rights in the old system but mandatory for new entrants to the labor market. The option was left open for 20 months. Voluntary switchers were allowed to return their full contributions to the social security. The funds were to get about 20 percent (6/31) of the contributions of those who switched, which should have grown to about 25 percent (8/31) in two years. So no full opting-out was allowed. The second pillar covers only longevity risk. Fund members who get disabled can return to the first pillar by returning their savings to the social security. By this, they can fully recover their eligibility in the first pillar. Alternatively, they can also leave their savings in the fund. In this case, however, social security pays only 75 percent of what would have been paid otherwise as disability pension.

Hungarian pension funds have a special property rights structure. They take the form of mutual savings associations, so members are not clients but co-owners of the fund. Funds are managed by the board of directors and supervised by the board of supervisors. Both bodies are elected by the general assembly of the members. Funds can be either open or closed but the same set of regulation applies to both types. The funds release quarterly and annual report which are partly standardized by regulation. They are obliged to give annual information to the fund members on the state of the personal accounts. The funds are also controlled by external actors such as a custodian and the State Financial Supervisory Authority which can release and withdraw fund licenses.

### **Expected effects**

Rocha and Vittas (2000) simulated the expected effects of the pension reform. They found that the transition losses of partial privatization will be limited because the reform package cut future spending in the pay-as-you-go pillar. After 2035 the pay-as-you-go balance would be less negative with reform since social security should pay less pension to those who switched to the mixed system. The net effect taking both social security and the private funds into account would be negative in the first years of reform but would grow to an annual surplus of around 2 percent of GDP by 2011 and reach its peak in the 2020s. After 2035, the new pillar reaching maturation, the annual surplus would stabilize at about 1 percent of GDP.

Gál, Simonovits and Tarcali (2001) found similar effects. In Table 4.6 the results of the generational accounting exercise are presented without reform and with several reform scenarios. The pension reform considerably reduced the severe imbalance originally prevailing in the system (see the *complete*

*reform* column in the table). Approximately three quarters of the net losses which were awaiting future generations were wiped out in consequence of it. The deficit fell from \$18,950 to \$5,510. Another important conclusion is that in spite of the significant changes the system still falls short of a clear balance. Newborn and future generations are expected to remain net contributors to the system, i.e. their contributions will produce negative real returns. The same caveat applies here as above: this calculation was based on the planned budget of the PIF for 2000 which proved to be too pessimistic. The final budget suggests a more modest deficit in the long run. The signs and the relative magnitudes of the calculation as well as the conclusions do not change, however.

### **Implementation**

The 1998 pension reform was the result of a number of compromises. However, political dispute concerning the pension system has not ceased and the rules have kept changing even after the legislation in particular as the incoming government, elected in 1998 just after the new funds were set up, voted against the reform a year before while it was still in opposition.

In 1999 the indexation differed from what was originally planned. Backward-looking indexation was replaced by forward-looking indexation, which was unfavorable for pensioners. In 2001 and 2002, however, pensions were raised faster than dictated by the indexation rule. Contributions were also reduced from 31 percent of gross wages in 1998 to 28 percent in 2001, 26 percent in 2002 and 26.5 percent in 2003.

As for the second pillar, contributions paid to the private funds were not raised to 8 percent of gross wages after two years but were frozen at 6 percent without adjusting the accrual rates in the transition rules. From January 2003 the distribution of contributions between the two pillars were re-regulated again due to another change in government. Currently 7 percent go to the funds. The new government also promised to raise this level to 8 percent from 2004.

The official projection suggested about 1.3-1.5 million mandatory pension fund members, while the true figure was about 2 million, roughly 50 percent of the economically active population (including the unemployed), of whom 93 percent were voluntary members and 7 percent were mandated (new entrants into the labor market). The deadline of voluntary switching was August 1999, however from January 2003 those under the age of 30 can again opt out to the mixed system (for new entrants of the labor market it is mandatory). Although voluntary members were allowed to return to the social security with their full contributions till December 2000, and this deadline was prolonged to December 2002, the number of those who returned remained marginal. New entrants are mandated to choose a fund, although for one year, in 2002, membership for the newcomers was made

optional. In the same year, mandatory members were also allowed to return to social security. The return option is still open to those who were new labor market entrants in 2002 and joined a fund in that year but it will be closed by December 31, 2003. Due to the contribution rate frozen at a lower-than-planned level the larger-than-expected number of fund members did not raise much the transition costs.

36 mandatory funds started its operation in 1998 but this number has been reduced by mergers and acquisition to 21 by 2001. The market is rather concentrated which is typical in markets dominated by open funds. Funds with a backing of large banks or insurance companies had the best chance of survival.

Table 3.6: Separate effects of components of the 1998 pension reform (generational pension accounts in thousand dollars)

age of cohort	no reform	Swiss indexation	completed retirement age adjustment*	phasing out progressiveness from pension formula	new scale of accrual rates	partial pre-funding	complete reform
future	19.0	11.1	14.3	20.2	17.1	15.6	5.5
0	1.1	3.3	1.8	0.9	1.5	1.1	3.3
10	2.9	5.0	3.7	2.7	3.3	2.7	4.8
20	5.4	7.5	6.4	5.2	5.9	5.1	7.5
30	3.9	6.2	5.3	3.6	4.5	3.6	6.7
40	-2.0	0.3	0.0	-2.5	-1.1	-2.0	1.7
50	-11.0	-8.9	-8.6	-11.7	-11.0	-11.1	-7.2
60	-21.3	-19.7	-20.9	-21.6	-21.3	-21.3	-19.6
70	-16.9	-16.1	-16.9	-16.9	-16.9	-16.9	-16.1
80	-11.0	-10.7	-11.0	-11.0	-11.0	-11.0	-10.7
90	-6.4	-6.3	-6.4	-6.4	-6.4	-6.4	-6.3
Absolute generational imbalance	17.9	7.8	12.5	19.3	15.6	14.5	2.2

Note: discount rate: 5%. productivity growth rate: 1.5%. real interest rate: 4%. population projection: Central Statistical Office Demography Research Institute; contribution to private funds is 6% of gross wage.

\* completed: the calculation started from 2000, so it does not take into account the effects of previous retirement age increases

Source: Gál, Simonovits and Tarcali (2001).

### 3.3.2 Political directions of future reforms

In 2001 the center-right government initiated a new reform in the social security pillar. The defined benefit nature of the pension formula was meant to be replaced by a notional defined contribution (NDC) or notional account formula. Individual contributions would have been credited on individual accounts and indexed by a technical rate of interest. The notional amounts accumulated in this way would have served as the basis for calculating social security annuities. The general elections in 2002, however, concluded to another change in government. The socialist-liberal coalition which stood up for the mixed system reform in 1998 is likely to proceed with stabilizing the new funds but it is unclear if they intend to devote resources to the NDC reform of the first pillar.

### 3.3.3 Conclusions

The Hungarian pension system succeeded in protecting the old from utmost poverty after the transition. While pensions lost value relative to wages, and while real pensions decreased substantially, other sources of income for the inactive declined much faster. Consequently, the relative income status of pensioners improved significantly through the 1990s.<sup>11</sup> This made the pension system very attractive for older workers: the actual retirement age dropped due to early retirement and the loss of control over disability retirement. The rapid growth of coverage in a shrinking economy diminished the range of pensions creating further disincentives to work.

The administration of pensions also proved successful. While most firms changed ownership in the process of mass privatization, and the number of companies exploded, the pension agencies managed to collect and redistribute a significant part of GDP although with declining efficiency. There was a decline in the relative size of the wage bill accessible to the tax collector, the so-called covered wage bill, compelling the government to cover the deficit.

Indeed the system proved to be too successful in some sense. Being the only institutional system settled and at the reach of policymakers, it absorbed a disproportionate part of the labor market crises of the early transition years. It offered an escape route to hundred thousands of workers from the labor market who cannot be redirected to the labor market any longer. This undermined the long term stability of the system and induced an extensive reform in 1998.

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<sup>11</sup> See Spéder (2000).

## **4. POVERTY AND SOCIAL EXCLUSION**

### **4.1 Evaluation of current profile of poverty and social exclusion**

#### **4.1.1 Social exclusion and poverty within the overall social protection system**

The 1960s and early 1970s were a period when Hungary climbed out of an underdeveloped status, and, due to the improving economic performance and some social policy measures, living standards of the majority increased substantially. Yet, sporadic research showed that poverty remained a real problem. The situation changed dramatically after the transition started.

The notion of poverty was a taboo until the early 1980s. Under the strict ideological control of the regime just a few researches were allowed in this field. Not only politics but the public discourse abandoned this topic. However, poverty did not become a central issue even in the 1990s, when the political control over the public media disappeared, for the following reasons:

1. Important and fundamental political issues overshadowed this topic.
2. It was widely accepted that under a major economic transition process widening income inequality and growing poverty level were a natural consequence.
3. The social protection system partly absorbed the pains of transition. A new unemployment insurance system was built up; other sections of the former system were used as an escape route (disability and old-age pension).
4. The growing informal sector played another way for many to maintain former income position.
5. Interest representation was weak, trade unions were considered as institutions of the old regime.

When in 1995 an economic stabilization package was introduced, which, among others, shifted some benefits from universal to means-tested, the issues on poverty and social protection got closer to the wider public. There was no social consensus about the austerity measures. The next government withdrew these measures and set up a policy that favored middle-income groups rather than the poor.

In October 2000 a survey was conducted on what makes people poor and rich.<sup>12</sup> According to this opinion poll, the society traces the main determinants of poverty back to personal, inner characteristics (such as lack

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<sup>12</sup> TARKI Social Research Institute Omnibus 2000/10.

of ambition or diligence) and to the lack of acquired ability (e.g. low education). Respondents assigned far less importance to social and demographic characteristics.

Until recently not only the public, but also government did not consider poverty or social exclusion a category that the strategic plans or concepts stand on. After the negative public reaction of the public in 1995 there was no national action plan designed, but in these days of the advanced phase of EU accession talks this becomes the basis of the activities of the relevant ministries.

#### **4.1.2 National definition of poverty and social exclusion**

Income inequality increased in the 1990s, particularly in the first half of the decade. Take the share of the equalized income by decile for instance: no significant changes can be seen, whereas the share of the top decile increased and that of the bottom decile slightly decreased. Other measures underscore this: there is small but consistent gradual rise in inequality. It is important to add that the income 10th percentage point at the income ladder has moved away from median, while the 90th percentage point has moved closer to the mid-point.

The Monitor survey shows that income inequality has increased again recently. The income of the bottom decile has grown the least — the lag behind the average is the highest it has been in the period examined — while the income of the top strata have grown the most. This means that the ratio of the top income decile to the bottom income decile has increased from 8 to 8½ times, which is the highest value in the 1990s. This indicator of income inequality, which stood at 6–6½ at the beginning of the decade, is now approaching the value characterizing European countries with high rates of inequality.

In the period of economic growth, beginning in mid-90s, the dynamics of income of the deciles shows the following pattern: at the beginning of the period in question upper deciles could utilize their advantageous position, however, in latter years, middle income deciles also produced above average income increase. The relative position of the bottom tercile has not improved.

Table 4.1: Income inequality measures

	1995	1996	1999	2000	2001
P10/P50 percent	53	48	49	51	50
P90/P50 percent	203	191	191	193	184
P90/P10	3.83	3.95	3.86	3.78	4
S1 percent	3.3	3.2	3.4	3.3	3.2
S5+S6 percent	17.0	17.5	17.3	17.3	0.0
S10 percent	24.7	24.3	24.9	24.8	24.3
S10/S1	7.4	7.5	7.2	7.6	7.7
Robin Hood Index	21.3	20.7	20.3	21.2	20.9
Éltető-Frigyes index	2.39	2.32	2.33	2.37	2.34
Gini coefficient	0.304	0.300	0.302	0.306	0.304

Source: Tóth (2002)

The social protection system does not apply a nation-wide poverty line. There exists no administrative poverty definition. For centrally regulated social benefits minimum old-age pension serves as a base of comparison. However, much of the social assistance programs are the responsibility of local governments, and they have an extensive discretion to set their own poverty line. In order to keep the system coherent, they also frequently use minimum old-age pension for determining different kind assistance benefits. Beside the minimum pension, sometimes the minimum wage and even the amount of family allowance are taken as cut off points. Since the radical growth of the minimum wage in 2000, its role as eligibility criterion has been almost eliminated. Local governments almost exclusively examine per capita income, application of equivalence scale is unusual.

As a reference value, the Central Statistical Office (CSO) calculates a so-called subsistence minimum annually. This minimum value is defined as a normative model of satisfying everyday needs at a low level. It calculates the costs of survival at different stages of life and that of keeping contact with the society. Subsistence minimum is the sum of values of a prescribed subsistence food basket, allowances for housing costs and other non-food expenses. Nutrition defined food basket is combined with survey data of the CSO Household Budget Survey (HBS) so as to estimate the socially acceptable minimum living standard by different types of households.

According to a calculation based on the Household Income Survey of the CSO in 1995 poverty rate was 34.6 percent by absolute poverty line and 12.1 percent by minimum pension, while in 1997 these figures were 37.2 and 13.5 percent respectively. In 1999 the corresponding figures were 26 percent and 11 percent (CSO, 2002). In 1995 income of the poor, defined by

minimum pension, fall 25 percent below this poverty line, and fall 29 percent, defined by absolute poverty line. In 1997 those figures increased to 28 and 31 percent, respectively (UNDP, 2000).

*Table 4.2: Minimum pension and subsistence minimum (HUF/month), 1995-2000*

	1995	1996	1997	1998	1999	2000
Minimum pension (1 January)	8,400	9,600	11,500	13,700	15,350	16,600
Subsistence minimum (household of a single retired person)	14,792	17,483	21,338	23,943	26,424	29,566

Source: CSO, 2002

Changes of income distribution mentioned above also appeared in the development of poverty rates. The proportion of poor people changed differently according to the definition applied. Using half of mean as poverty cut off there was a considerable drop in 1996-1997, than a slight increase and stability. Using half of median as a poverty line, there was less pronounced decrease in the same period, but constant fluctuation over the last four years.

The poverty head count is only one measure of poverty. Additional information is provided by measures that show the distribution of income among the poor. The average poverty gap<sup>13</sup> has been in the range of 25-30 percent in recent years. This value is higher than an earlier result reported in World Bank 1996, which was based on the HBS. That report described poverty in Hungary as ‘shallow’. The difference between the two results can be traced back to the data sources: the HBS is based on a larger sample but covers a significantly smaller range of income, whereas the TARKI data come from a relatively smaller sample but cover a much more complete set of income sources.

The depth of poverty is not simply a statistical or sociological question. The third section of Table 4.3 shows the poverty deficit<sup>14</sup>. Raising the

<sup>13</sup> The simplest measure is the poverty gap: the difference between individual incomes below the poverty line and the poverty line itself. Expressing this difference (the amount by which the income of a given person falls below the poverty line) as a percentage of the poverty line yields the poverty-gap rate. Unlike the incidence of poverty, this indicator shows the depth, not the extent of poverty. The higher the value of the indicator, the ‘further’ below the poverty line the poor are.

<sup>14</sup> Subtracting the aggregate income of the individual poor from the poverty line multiplied by the number of poor gives the amount of money required to ensure that all the poor have an income that reaches the poverty line. This is called poverty deficit—the gap that needs to be filled if the poor are to reach the poverty line. Comparing this poverty deficit with the incomes of the non-poor yields a measure that further refines

lowest incomes to the upper limit of the bottom quintile would need a redistribution of about 1-3 percent of the total income of the non-poor. The Sen-index and the FGT-index are also displayed in Table 4.3.

*Table 4.3: Trends of various poverty indices using different poverty lines*

	Poverty line		
	50% of mean	50% of median	Upper limit of bottom quintile
	Incidence of poverty: the proportion of persons with a per capita income below the poverty line (%)		
1995/96	18.3	12.8	20.0
1996/97	17.8	12.4	20.0
1997/98	12.8	9.1	20.0
1998/99	13.8	10.3	20.0
1999/00	14.6	9.1	20.0
2000/01	14.4	10.3	20.0
	Depth of poverty: the average income gap of the poor below the poverty line (%)		
1995/96	29.8	29.9	31.2
1996/97	31.1	32.6	30.8
1997/98	29.2	30.7	27.8
1998/99	27.6	25.3	26.7
1999/00	25.3	26.3	25.5
2000/01	27.3	26.8	26.7
	Proportion of the poverty deficit to the total income of the non-poor (%)		
1995/96	2.8	1.7	3.4
1996/97	3.0	1.8	3.5
1997/98	2.0	1.3	3.6
1998/99	2.0	1.2	3.3
1999/00	2.0	1.1	3.1
2000/01	2.1	1.1	3.3

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the description of poverty. This shows what redistribution of income from the non-poor is needed to bring all the poor up to the poverty line.

Table 4.3: continued

	Poverty line		
	50% of mean	50% of median	Upper limit of bottom quintile
	Sen index * 1000		
1995/96	77.8	55.7	87.5
1996/97	78.0	55.8	87.5
1997/98	53.8	39.5	80.5
1998/99	52.4	36.7	75.8
1999/00	52.9	33.7	72.8
2000/01	55.8	39.1	76.5
	FGT(2) *100		
1995/96	2.60	1.90	2.97
1996/97	2.64	1.93	2.94
1997/98	1.76	1.31	2.54
1998/99	1.52	1.01	2.21
1999/00	1.52	1.01	2.09
2000/01	1.68	1.17	2.28

Source: Gábos and Szivós, 2001

Tensions between consumption aspirations and true consumption can be used as an indicator of subjective poverty. However, such measure is not just an indicator of poverty. The figures in Table 4.4 show that subjective poverty rose clearly but not much in the middle of the decade.

Table 4.4: Changes in subjective poverty, 1995–7 (%)

Poverty indicators	1995	1996	1997
End-month financial difficulties:			
Every month	25.1	28.1	29.2
Never	40.9	31.2	37.4
Spent nothing or less than necessary on clothing	71.1	75.2	74.3

It is clear that poverty was on the increase till 1996-97 according to all the approaches applied but the situation became far better in the second part of the decade. However, the extent of the changes depends strongly on which measurement approach is applied.

### **4.1.3 18 EU indicators of social exclusion**

Below we present a list of indicators of social exclusion recently used in order to describe European societies. First we discuss its relevance for Hungary then we provide those of them that are available.

According to the first estimations, published a decade ago, the magnitude of the informal economy was about 35 percent of GDP. Since then its relative volume has declined, and latest estimations put it around 25 percent. This reflects a decrease, but the rate is still high enough to take into consideration when measuring income and calculating indicators. Survey data do not capture this income. The distributional shape of this kind of income is unknown by the nature of the subject, but according to expert estimations it has a J like shape by income hierarchies. Another methodological issue that might have an impact on indicators is the problem of non-cash incomes. Especially health and education services in kind have strong redistribution impact by income and by age. Moreover, the usual problems of income measurement apply to Hungary as well: Overall nonresponses and item nonresponses have serious quality impact on the data. Surveys can capture 65-70 percent of macro income, consequently the level of income is seriously underestimated by Monitor Survey and more severely by the CSO's Household Budget Survey.

Concerning the indicators the labor force information is based on the Hungarian Labor Force Survey of the CSO, uses EU standard. Demographic data also stand on a solid basis. However, according to information from one of the CSO executives, a systematic set of indicator on poverty and social exclusion has not been prepared so far. There is some information provided to the Eurostat, but comprehensive indicator set based on commonly agreed definitions are not available at the moment. We, therefore, generated the requested indicators from the TARKI Monitor Survey of 2001<sup>15</sup>, and published CSO data.

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<sup>15</sup> Similar sets of TARKI surveys made the empirical background of World Bank and UNDP analyses on poverty situation of Hungary in 1990s. See UNDP, 1999 and World Bank, 2001

## 1. Low income rates after transfers

## 1a. Low income rate after transfers breakdowns by age and gender (%)

	Male	Female	Total
0-15	23.3	23.5	23.3
16-24	14.2	14.5	14.5
25-39	11.2	14.3	12.8
40-59	10.4	8.9	9.6
60-	3.2	8.9	6.8
Total	12.5	13.5	13.1

## 1b. Low income rate after transfers breakdowns by most frequent activity status and gender (%)

	Male	Female	Total
Employed	6.6	6.5	6.6
Self-employed	6.0*	4.8*	5.7
Unemployed	35.3	41.1	37.6
Retired	7.8	9.2	8.7
Inactive-other	21.6	22.1	21.9
Total	12.6	13.5	13.1

\* low cell frequencies

## 1c. Low income rate after transfers breakdowns by household type (%)

1 person household, under 30 years old	9.5
1 person household, 30-64	22.3
1 person household, 65+	8.8
2 adults without dependent children, at least one person 65+	2.0
2 adults without dependent children, both under 65	6.7
other households without dependent children	6.7
single parents, dependent child 1+	46.0
2 adults, 1 dependent child	14.8
2 adults, 2 dependent children	15.4
2 adults, 3+ dependent children	32.8
other households with dependent children	16.4
Total	13.1

*1d. Low income rate after transfers breakdowns by tenure status (%)*

Owner or rent free	12.5
Tenant	22.2
Total	13.0

*1e. Low income thresholds (annual equivalent values)*

	EURO	National currency (HUF)	Low income thresholds as percentage of national threshold (%)
National threshold	1234	324630	100.0
Single person household	1066	280451	86.4
Household with 2 adults, two children	1186	311908	96.1

*2. Distribution of income*

S80/S20	4.42
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*4. Relative median low income gap (%)*

Relative median low income gap	23.2
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*6. Long term unemployment rate (%)*

male	3.0
female	2.2
total	2.6

Source: CSO

*9. Life expectancy at birth (years)*

Male	68.15
Female	76.46
Total	72.32

Source: CSO

*11. Dispersion around the low income threshold (%)*

40% of median national equivalised income	4.4
50% of median national equivalised income	8.2
60% of median national equivalised income	13.1
70% of median national equivalised income	21.4

*12. Low income rate anchored at a moment in time (%)*

Relative low income rate in 2001	13.1
Relative low income rate, using the 60% of the median of 1999 multiplied by the inflation factor of 1999/2001	9.1

*13. Low income rate before transfers (%)*

	Male	Female	Total
Income excluding all social transfers	41.3	45.7	43.6
Income including retirement pensions and survivor pensions	27.9	26.7	27.3
Income after all social transfers	12.5	13.5	13.1

*14. Gini coefficient*

Gini coefficient	0.304
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*16. Long term unemployment share (%)*

male	47.9
female	43.6
total	46.2

Source: CSO

*17. Very long-term unemployment rate (%)*

male	1.5
female	1.0
total	1.2

Source: CSO

Indicators are not presented here will be prepared by the CSO, as well as income based indicators. We had no access to LFS micro data, therefore we were not able to compute some indicators, and due lack of recent panel data longitudinal information is not provided either.

UNDP recently published (UNDP, 2002) Human Development Indices (HDI) that takes the following values for Hungary:

Life expectancy index      0.77

Education index              0.93

GDP index                      0.80

The overall HDI is 0.835, which put the country to rank 35 against the 27<sup>th</sup> place in the rank order of GDP per capita. As the above figures suggest the Life Expectancy Index is far worse than others, indicating a gap between economic performance and health conditions.

## 4.2 Evaluation of policy challenges and policy responses

### 4.2.1 Inclusive labor market

Both internal differentiations on the labor market and exclusion strengthened during the 1990s. The latter of these has the decisive influence on chances of poverty. The poverty chances for the unemployed and ‘other dependants’, a category includes that many previously unemployed increased; it is ever more likely that they will become poor. This reflects again that not unemployment but rather non-employment is the main issue in the Hungarian labor market. There has also been a rise in the incidence of poverty among the recipients of child-care benefits.

Table 4.5: Poverty rates by labor market position (%)

	2000/01			1999/2000		
	50% of median	50% of mean	Upper limit of bottom quintile	50% of median	50% of mean	Upper limit of bottom quintile
	Economic activity of the household head					
Employee	4.3	7.2	13.8	2.7	6.0	12.5
Entrepreneur	2.0	3.9	11.4	4.8	7.8	17.7
Casual worker	41.3	64.1	64.1	45.9	45.9	45.9
Working pensioner	n.a.	n.a.	7.7	n.a.	2.6	2.6
Child care leave	73.8	78.6	78.6	5.6*	22.2*	66.7
Unemployed	34.3	43.3	57.0	24.2	36.9	54.5
Pensioner	6.1	10.6	19.0	5.9	9.8	17.0
Dependent	24.9	26.6	42.0	31.1	42.3	52.4
	Number of economically actives					
0	16.6	22.6	33.7	19.2	19.2	28.4
1	10.5	16.0	27.1	15.2	15.2	25.9
2	2.6	5.0	9.3	5.9	5.9	12.5
3+	0.3	0.7	3.8	2.5	2.5	4.1

Source: Gábos and Szivós, 2001

\* low cell frequencies

So in general, having a job decreases the chance of becoming poor. Among those yet having a job the least qualified—the semi-skilled and unskilled—and those working in agriculture have the highest chance to be poor. (Table 4.5)

Unemployment and especially the inactive status of the household head have a strong impact on rising poverty risk. Households with an unemployed head have 3-4 times higher odds than their equivalents with employed head. The difference is even higher, 4-5, in the inactive vs. active heads comparison (Tóth, 2001). From the other angle, the activity rate is significantly lower, the unemployment rate is higher among the poor.

The risk of unemployment is higher than average among the young (under the age of 25), among those who have low level of education (completed only 8 classes), live in the economically deprived North–Eastern region of the country, and among males. The rate of unemployment of women is lower than that of men (5.0 and 6.3 percent, respectively, in 2001). The tendencies are similar, although somewhat less marked, in case of heads of households. If the circumstances of the whole household are also taken into account, unemployment is less frequent in households with many children than in childless households. Budapest has the best local labor market. Among poor households the Roma have a higher than average rate of unemployment (60 percent as against 40 percent of the non-Roma poor). The gap between Roma and non-Roma unemployment has been growing through the time.

All unemployment provisions were introduced after 1990. A three-tier system evolved until 1998, consisting of an insurance benefit, an income replacement after the termination of the insurance, and a means-tested assistance in case of lack of entitlement for the income replacement income. From 1999 the income replacement was tied to workfare and the entitlement period of the unemployment benefit was cut back. The conservative government of 1998-2002 had introduced a policy shift from passive to active measures. It supported public work and other schemes linked to training and retraining for the long-term unemployed. Importance of preventive training was also emphasized as well as personal development courses and communication trainings were supported by local the employment services. Many cases these programs involve NGOs.

There is still no evidence of the efficiency of these active measures. In a qualitative essay Frey (2001) questions the impact of public work programs on the future employment of participants. However, work-test has become an important element of entitlement of certain social provisions recently. She also finds the current form of labor market counseling problematic, as it is not efficient in tying supply and demand of labor. There is a shift towards active programs but the incentive effects of these programs are under-researched so far. Galasi, Lázár and Nagy (1999) report on the rate of reemployment after participation in different active programs. The best

chances are offered by direct programs such as support on self-employment (92 percent of participants found job within six months), wage support to the employer (71 percent), whereas indirect measures are less successful. Retraining offered just 45 percent reemployment and public work only 25 percent.

In 2000 and 2001, in two steps, the government doubled the minimal wage from HUF 25,500 to HUF 50,000 (with a cumulated inflation in the two years of about 17 percent). This measure was meant to increase labor market income and in this way fight poverty among the working poor. On the other hand, lifting the minimal wage bears the potential of making the low-skill segment of the labor market more rigid. In a recent analysis Kertesi and Köllő (2002) found evidence that indeed employment decreased in the North Eastern region among the unskilled workers.

Another measure of government in 1999 was to reduce the spell of the unemployment benefit from 18 months to 12 months and to substitute workfare for the original income replacement. The newly introduced workfare attached income replacement to participation in public work. Galasi and Nagy (2001) tested the effects. They found that reemployment of the unemployed slightly grew, whereas the increase of public work was much more substantial. The rate of those who applied for workfare after their eligibility to the unemployment benefit expired decreased significantly compared to the previous rate of applicants for the income replacement. The combined effect of these developments led to a drop-out of the system: The rate of those who either got income replacement or participated in public work shrank from 61 percent to 46 percent among men and 59 percent to 41 percent among women.

#### **4.2.2 Guaranteeing adequate incomes, resources**

The Hungarian social protection system does not guarantee a standard minimum income level for those in need, however the Law on Social Affairs obliges local governments to provide help for those whose life is in danger. "Social rescue operation" provisions can be applied. The social assistance system, described in detail in Chapter 2, is fragmented by the eligibility criteria (income level, assets, housing conditions, age, children etc.) and by territorial units, because defining criteria, decision-making and partly financing are the responsibility of local governments.

More indirect instruments are built into the tax system. VAT rates bear some welfare components. Drugs, schoolbooks, certain tools for blind or disabled persons are tax-exempt. For basic food it is 12 percent against the standard rate of 25 percent, which is higher than in most EU countries. In personal income taxation, there is no tax-exempt bracket; the lowest rate is 20 percent. Nevertheless, due to tax deductions the minimum wage is practically income tax-free. Currently the minimum wage is at the level of

half the average, in gross term. In an analysis of progressiveness of taxation, Kovács (2002) found that the efficient income tax rate grow rapidly by income deciles whereas VAT and sales taxes are regressive relative to net household income.

An even more indirect "measure" that has a strong effect on the living standard of the poor, is the liberal attitude of the authorities towards informal commodity markets. There is a significant segment of retail trade that provides cheap tax-free goods and services the extent of which is unknown. Consumer protection is non-existent in such market.

#### 4.2.3 Combating education disadvantage

Low educational attainment significantly correlates of poverty and social exclusion, mainly through disadvantaged labor market position. Currently higher education is a guarantee against poverty. The differences according to level of schooling completed are pronounced. The chances of poverty varied widely according to education even in the early 1990s, which variation decreased, but the level of differences is still remarkable. There has been a noticeable deterioration in the position of those with lower secondary (skilled worker) qualifications, and an improvement in the situation of those with tertiary (university or college) degrees. (Table 4.6)

Table 4.6: Poverty rates by education level (%)

	2000/01			1999/2000		
	50% of median	50% of mean	Upper limit of bottom quintile	50% of median	50% of mean	Upper limit of bottom quintile
	Educational attainment					
0-7 class	15.2	20.9	33.1	8.8	13.8	22.8
8 class	10.9	16.1	25.9	11.2	17.2	27.4
Vocational	6.5	11.0	18.7	5.2	9.3	18.7
Secondary	3.0	5.3	10.0	2.5	5.1	9.5
Tertiary	1.9	2.0	3.8	2.0	3.3	4.3

Source: Gábos and Szivós, 2001

As far as gender dimension concerned women are over represented in higher education. In 1998 tertiary net enrolment of female was 24 percent higher than that of males. At the secondary level female advantage was only 2 percent. This over representation is not the case in the top hierarchical positions: 34 percent of senior officials, managers are women, while 61 percent of professionals and technical workers. (UNDP, 2002)

During the 1990s demand for higher-level skills and knowledge has increased. The government responded by raising the enrolment from 15 to almost 40 percent of a cohort to tertiary education and by vocational training. The number of training institutes increased, both on the secondary and tertiary level. Curricula were redesigned so as to have later specialization, and lower dropout rate.

#### **4.2.4 Family solidarity and protection of children**

All researches on income and poverty pointed out that the impoverishment of children sped up considerably in the 1990s, although the process has started back in the 1980s. Children and families with children are among the losers of economic changes occurred since the beginning of transition. All age groups under 15 became considerably more vulnerable. This applies especially to the very young babies and infants. (Table 4.7)

Presence of child or children in the family is strongly determining income level of the household. Per capita income of a three children family is half of the single households', and 60 percent of the two adults with two children type of households. These ratios were more or less constant throughout the decade. Presence of a child or children in the family is strongly determining poverty risk. It is especially high among families with 3+ children and lone parent families. Most recent trends are unclear, while in 2001 poverty rates of families with children is decreased if defined by quintile limit, but increased, if half of mean is applied. This picture is less marked if equivalence scale is taken into consideration.

Single parent households are in a fragile situation since their narrow channel to the labor market results in a low income generation potential. Their poverty risk is among the highest. These two characteristics make them one of the main target group of social policy.

Table 4.7: Poverty rates related to children (%)

	2000/01			1999/2000		
	50% of median	50% of mean	Upper limit of bottom quintile	50% of median	50% of mean	Upper limit of bottom quintile
	Age of persons					
0-2	17.3	23.3	33.0	13.8	20.7	36.8
3-6	16.4	22.6	33.8	11.5	19.2	28.9
7-14	14.8	21.0	31.9	12.6	19.5	30.8
15-19	15.5	19.0	29.1	12.6	18.9	28.9
20-29	7.0	11.0	15.1	7.7	11.1	19.3
30-39	9.8	13.9	22.5	7.5	12.2	20.4
40-49	7.1	10.7	17.6	8.1	12.5	19.3
50-59	6.6	9.9	16.1	5.5	9.8	17.6
60-69	3.8	6.0	13.1	3.1	6.1	12.8
70+	2.2	6.1	17.1	2.4	5.3	10.6
	Number of children					
0	4.2	6.8	13.4	3.0	5.7	11.6
1	7.9	12.4	18.4	8.6	13.6	21.6
2	10.6	16.4	25.8	10.4	17.1	25.9
3+	28.2	33.8	50.0	23.0	31.8	52.0
	Household type					
Single	9.7	13.9	22.3	7.4	11.6	19.3
Couple	2.6	4.2	12.9	2.5	5.6	11.7
Couple with 1 child	9.5	14.2	19.4	3.8	7.7	17.1
Couple with 2 children	6.6	13.9	24.5	10.2	14.9	22.2
Couple with 3 children	16.7	21.3	41.2	12.1	21.3	38.2
Couple with 4+ children	41.0	46.2	59.0	25.3	41.3	52.0
Single parent	36.3	44.2	52.2	23.8	36.9	55.4
Other household with children	11.1	15.3	22.8	13.1	19.5	30.9
Others	3.4	6.2	10.9	3.2	5.6	10.6

Source: Gábos and Szivós, 2001

Family benefits are one of the largest part of cash social transfers. Eligibility criteria for child and family related benefits were changed several times in the 1990s. Benefits were made universal in 1990, than became means tested in 1996, and were made universal again in 1998. The largest single family related benefit is the family allowance, but its real value suffered a significant decline through the decade. In 2002 an important step was made in order to recover the value of family allowance. A new package was introduced, which included a 20 percent increase of the monthly amount and introduced the 13<sup>th</sup> month of payment. This measure shows a clear choice of the current government in the long lasting discussion on cash versus tax benefits.

These types of benefit constitute the second largest source of income for 13 percent families with children next to income from work (71 percent). The role of this type of transfer income is more pronounced in poor families, there it constitutes 40 percent of total net income. Family allowance has very strong positive impact on the income of families with schooling age children, maternity benefits affect families with younger children. (Table 4.8)

*Table 4.8: Poverty rates including and excluding family allowance (%)*

	<b>Total income</b>	<b>Less family allowances</b>
1994/95	9.0	14.8
1995/96	12.7	18.0
1996/97	12.4	16.5
1997/98	9.1	12.4
1998/99	10.3	12.5
1999/00	9.1	13.0

Source: Gábos-Szivós, 2001

#### **4.2.5 Accommodation**

Accommodation problems can be considered a factor of social exclusion in two ways. First if housing uses a disproportionately large resources relative to one's income, and second if the lack of dwelling determines the way of life. A recent survey (TÁRKI, 2002) shows that almost one third of the households have some problems of month-by-month maintenance. Ten percent of the households is in serious difficulties being their disposable income too low compared to maintenance costs. Among them, families with many children and households with young head are over-represented. Other factors are low income earning capacity (low education and weak link to the labor market). Targeting of the in kind and cash support programs seems to be inefficient. While half of the benefits go to those not in serious need, only

8 percent of vulnerable families receive benefits aimed at mitigating housing problems.

Before the transition the issue of homelessness was practically not existent. It was made latent by state owned firms providing workers hostels for their employee in a labor market with no unemployment and low inactivity. It became visible in the early 1990s. A drop in activity and withdrawn labor related social services and the workers hostels, as well as new practice on psychiatric institutions resulted in a growing number of people living in the streets. Young people leaving state-run residential education institutes contributed to the increase. Drug abuse and alcoholism is another factor behind homelessness. Due to sever distortions in the housing and rental market, a marital or family break-up can also lead to homelessness. Currently the estimated number of homeless people is around 40-50 thousand, which is 0.4-0.5 percent of the total population. (World Bank, 2001)

Reactions to the situation were twofold. In 1993 the Law on Social Affairs obliged local governments to provide services for the homeless. Settlement with more than 20000 inhabitants must offer daytime shelter, while larger towns had to establish overnight shelters as well. A large number of NGOs was founded, church and civic, and they play an important role in organizing services, frequently as subcontractor of local government.

Homelessness is the most severe in the capital, Budapest, where more than half of the homeless live. The institutional system here has 3500 beds for homeless (roughly half of the country's total). Beside night shelter, nursing care, health care, meals, hygiene facilities and information are also provided by 20-25 NGOs in the capital. However, in wintertime it is a continuous difficulty that the capacity of accommodation is not enough for all. (World Bank, 2001)

#### **4.2.6 Ethnicity**

Poverty and social exclusion has a strong ethnic segment. The estimated number of the Roma is in a range around 500 thousands, representing about 5 percent of the total population (Kertesi and Kézdi 1998). Their demographic characteristics are different from the rest of society: fertility is higher, life expectancies are lower (Bíró, 1996). The number of the Roma is growing, while the total population is decreasing. The Roma live all over the country, in an uneven distribution. Most of them speak Hungarian as a first language, not one of the Romany languages. (Kapitány, 2002)

The ethnic nature of poverty and social exclusion is far the most important among the dimensions in concern.

Table 4.9: Poverty rates by ethnicity (%)

	2000/01			1999/2000		
	50% of median	50% of mean	Upper limit of bottom quintile	50% of median	50% of mean	Upper limit of bottom quintile
Roma	61.3	68.0	75.3	53.9	64.5	85.2
Non Roma	6.1	9.9	17.8	5.2	9.5	17.0

Source: Gábos and Szivós, (2001)

The incidence of poverty is 5-10 times higher among the Roma population than in the rest of the population. The lower the poverty threshold the higher the difference. (Table 4.9) All poverty factors such as the poor educational attainment, weak attachments to labor market, high unemployment and inactivity and high number of children strongly coincide in this social group. However, a logistic regression analysis shows that the odds are 4 times higher in Roma headed households than in non-Roma households to fall into the lowest equivalent income quintile even if the effects of all other factors are filtered out (Tóth, 2001). This component of poverty is present in every annual Household Monitor even though its strength is not robust.

Only one-third of Roma children are enrolled in secondary school, against 90 percent of the non-Romany, and only 1 percent in higher education (KÜM 2002). In contrast, their representation in the auxiliary primary schools with special curriculum is disproportionately high and growing (26 percent in 1974/75 against 43 percent in 1992/1993) making the gap even deeper (Pik 1999). A section of the Socrates-program, the Comenius 2 program, devoted about 40,000 for new initiatives in the education of immigrants, guest workers and the Romany (OKI 2000).

The Romany lost ground in the labor market through the 1990s. Kertesi (2000) states that they lost their financial background for the second time in a century. In the first half of the 20<sup>th</sup> century the nomadic communities dissolved and the traditional markets for typical Roma products slowly disappeared by the industrialization. In the 1990s their activity rate fell from about 65-75 percent in 1984 to about 30 percent in 1993.

#### 4.2.7 Regeneration of areas

Both the size of the community and regional position leave an impact on the risk of poverty. A review of settlement types in early 1990s showed that villagers had a greater chance of poverty than others (Andorka, 1992). The difference between Budapest and towns on the one hand and villages on the other hand just grew through the decade. There is almost one-and-a half

times higher the chance of poverty among villagers as among inhabitants of provincial cities. For Budapest the chance is only a seventh of the national average. At least as strong, if not stronger, has been the regional change. At the beginning of the decade, only the Northeastern part of the country was relatively underdeveloped. The incidences of poverty in all other regions were around the national average. The Northeast and Northern Transdanubia represent the extremes. Those in the Northeast have several (6–9) times higher the chance of being poor. Differences also appeared among the other regions. The situation in Northern and to some extent Southern Transdanubia appears to be improving, while Central Hungary (without Budapest) remains about average. So both settlement and regional differences have deepened. (Gábos and Szivós 2001)

There are employment differences within the large regional units as well. Kertesi (2000) and Köllő (2002) demonstrated that the relatively high costs of commuting add to the unemployment in villages. The wage differentials paid for identical labor clearly depend on commuting distance and time, deteriorating the chances of potential commuters to find new jobs.

#### **4.2.8 Other factors influencing poverty and social exclusion**

Low income generating ability and weak labor market links were identified as major determinants of poverty. Health and disability are considered important factor on social exclusion. The overall health status in Hungary has been in decline for more than thirty years. Average life expectancy at birth for the population is well below the European Union average, and also lower than corresponding data from neighbouring Central and Eastern European nations. The mortality rate for middle-aged males is particularly high, even in worldwide comparisons.

As a response to this situation a National Public Health program was introduced in 2001. One of the 17 programs aiming to reduce the number of people consuming excessive amounts of alcohol by 30 percent by 2010 and to reduce the number of drug users as well. (EÜM, 2001)

There is a network of firms that employ people in social need due to poor health, considerably reduced working ability or even serious disability that renders them incapable of being properly and economically employed on a regular business term. The network is small, the number of employees is around 3,000, almost two third of them live in Budapest. Average earning is slightly above the minimum wage level. Another network constituted from firms subsidized by the state in order to provide rehabilitative employment for workers of reduced working ability. Number of persons employed by such organization is around 19,000, with a salary level of minimum wage. (CSO, 2001)

Another challenge is the revolutionary improvement of information technology. Telecommunication and information infrastructure is being digitalised and is going through an extraordinary rapid development that affects the different sectors of economy and changes the everyday life of people. However, the penetration speed of info-communication technologies (ICT) varies greatly by different segments of the society. It creates new gaps between social, demographic and labor market groups, economic sectors, etc. The digital literacy of the labor force is of key importance in the so-called knowledge-based economy, and, if successfully developed, it enables the enterprises of formerly peripheral countries to better integrate to the world economy. The development of information infrastructure is an important task not just because of economic reasons, but also from the perspective of social integration. Information and communication technology creates new prospects for the inhabitants of underdeveloped regions to catch up to the more developed regions both on a national and international level.

#### **Determinants of ICT use - and of the digital divide**

<b>Generation and knowledge:</b>	age groups, schooling, ICT skills, cultural capital
<b>Inter-personal networks:</b>	relatives, friends, acquaintances, workmates, network size
<b>The world of work:</b>	labour market participation, manual or non-manual work, personal income, economic branch
<b>Status-presentation and consumption patterns:</b>	cultural and media consumption, prestige and image of ICT instruments,
<b>Attitudes, values and preferences:</b>	technological attitudes, interest, relevance

#### **4.2.9 Administration, access to, and delivery of services**

It is the central and the local level of public administration that have social responsibility. The mid-level, counties, that are smaller than NUTS2 regions, have hardly any decision-making responsibility in social affairs. In the central level policy areas like education, health and social protection are in competition for resources. Only in that high level there is coordination among areas, lower level coordination is weak. Local programs, such as primary and secondary educations, health care institutions and social assistance are mainly financed through normative type of financial regulation that reduce the possibility of cross financing, even though municipalities occasionally surpass this regulation.

Beside the changing role of local government, the other new phenomenon in social protection is the appearance of NGOs. Currently 3,500-4,000 non-profit organizations provide social services, which is less than ten percent of the total number. Almost thousand organizations help disabled persons, the second most frequent activity being child protection. One third of these organizations deal with the poor, supporting individuals and families in a form of cash and in kind. Half of the NGOs' income is from the state, which supports programs with specific objectives. Voluntary activity is not as widespread than in European countries. Most of the NGOs helping the socially excluded are in Budapest and larger towns (CSO 2001). The cash benefit programs of NGOs make no more than 0.6 percent of the total public budget of social benefits (CSO 2002).

### **4.3 Evaluation of future challenges**

#### **4.3.1 Main challenges**

In 2001, there were on average 3.86 million employed persons in Hungary, while the number of the inactive of employable age was 2.23 million. These figures clearly show why the increase of the rate of employment is one of the most important objectives and challenges. To raise the employment rate, it is necessary to improve the flexibility of the labor market and to create an employment-friendly environment. Sustainable growth and an improvement in economic competitiveness are conditional upon human resources development, hence the comprehensive employment policy and development strategy regards it as a priority. Also from the social protection point of view it has top priority.

There seems to be an almost universal consent that the Roma problem is the most severe issue in the field of poverty and social exclusion in the Hungarian society. There are some measures with limited results. Recently Commissioners were appointed to the Ministries of Education and Employment, and a Roma Coordination Council has been established headed by the Prime Minister. A Political State Secretariat was created dealing with Roma affairs and implementing strategic plans for social integration. However the Roma policies are not integrated into general social programs, but mainly run as parallel projects. (KÜM, 2002)

#### **4.3.2 Links to other social protection policies**

We expect major reforms neither in the pension system nor in employment policies. After the recent change in government will result in an increase of the part of social security pension contributions to mandatory private funds from 6 percent of gross wages to 8 percent. In addition, fund membership will be again mandatory for new entrants of the labor market after only one year of free choice. These steps, however, will not make much influence in the short run.

A large-scale reform of property rights in health insurance and services has been several times planned and postponed in the last decade. There seems to be a fear of the short run costs of such a step including doctors' unemployment and a driven out of high risk groups, the elderly in particular.

#### **4.3.3 Political directions of future reform**

The sometimes hectic changes in the institutional system of social protection, for instance, in case of the new private pension funds, the real value of family allowances, the debate on income tax deduction versus cash benefits or the means-testing in maternity benefit, clearly reveal a systematically different view of the role of social policy between the consecutive socialist-led and conservative coalitions. These differences however do not always follow the ideological line of what one would expect of the parties. It was a socialist-led government that privatized a part of the pension system and introduced means testing whereas a conservative government tried to withdraw these measures as much as they could. In the field of social protection issues, the main target group of the socialists is pensioners whereas the center-right parties try to attract middle-income families with children.

#### **4.3.4 Social exclusion, poverty and EU accession**

The impacts of the EU accession on poverty are not expected in the institutional system of social protection system, but in the labor market. Employment, wages, work flexibility and mobility of labor seem to be the main issues.

Currently there is a large gap between wages in the EU and Hungary. The average wage is around 10 percent of the EU's applying exchange rate, and about 30 percent applying the more feasible purchasing power parity. Per capita GDP is around 50 percent of the EU level in PPP (Gács, Hárs and Hüttl, 2001). Such a gap between relative wages and per capita GDP may induce a rapid growth of wages, whereas the difference between local and European wages can lead to migration in some segments of the labor market in particular. Surveys show that the Hungarian migration potential is not particularly high, 10 percent of the adults expressed intention to work for short terms in EU countries. Previous experience suggests that the potential for long-term employment is well below that level (Sik and Simonovits, 2002). The traditional target of Hungarian employees is Germany and Austria.

Another potential effect of the EU accession is the growing importance of atypical forms of employment, mainly part-time employment, which has currently marginal importance. Self-employment might be another tool to raise the low level of employment in the early 2000s.

Earlier experiences of accession of relatively underdeveloped countries reveal strong generational effects. The young and better educated gained most of the shift from the planned economy to the market economy. The current accession process might have the same impact.

#### **4.3.5 Conclusions**

After the transition, poverty significantly increased and the chance of social exclusion became much more of a real danger for many than before. A more demanding labor market sorted out a large segment of the former labor force mainly on the ground of age education and ethnic background. We consider the most serious challenge for the Hungarian society in the field of social protection the large extent of exclusion of the Roma minority. Despite the importance of this question there seems to be no general consent of the true nature of the problem and the necessary means that has to be devoted to mitigate this problem.

## 5. HEALTH CARE

### 5.1 Evaluation of current structures

#### 5.1.1 Organization of the health care system

The Hungarian healthcare system operates on a comprehensive, centralized, compulsory, employment-based national health insurance scheme that provides close to universal coverage both in terms of treatments and in terms of population.

The organizational structure of the Hungarian health care system has changed significantly during the last decade during the transition process from a formally socialist block country to a Newly Associated State to the European Union.

#### Health care system and the transition period

Being a socialist country, Hungary had an integrated type of health care system before the transition period. A comprehensive range of health care services were offered to the population for free of charge at the point of delivery. The system was financed out of general taxation. Services were provided by salaried employees in mainly publicly owned hospitals and general practices. Health care providers were financed by annual budgets received on historical basis. Management and resource allocation was controlled centrally by the Ministry of Health. An extensive informal payment system has emerged since the 60ies. Small official private sector supplemented the publicly dominated system. Private providers included few specific treatments such as those provided by small dental surgeries, or publicly employed doctors in out of office hours, or some of the GPs who operated private surgery. Table 5.1 summarizes the most important differences between the health care system before and after the reforms.

*Table 5.1: The main aspects of the health care reforms*

	<b>OLD SYSTEM</b>	<b>NEW SYSTEM</b>
<b>FUNDING</b>	General state revenues	Mainly social insurance
<b>ENTITLEMENT</b>	Universal	Shift to contribution-based but near universal coverage
<b>FINANCING PROVIDERS</b>	Fixed budget	Mixed financing methods

Reforms have been gradually implemented after 1989. Main changes included the establishment of *earmarked funding* of the health care, *cash-limited* finance of health care providers, and the introduction of performance-based finance methods.

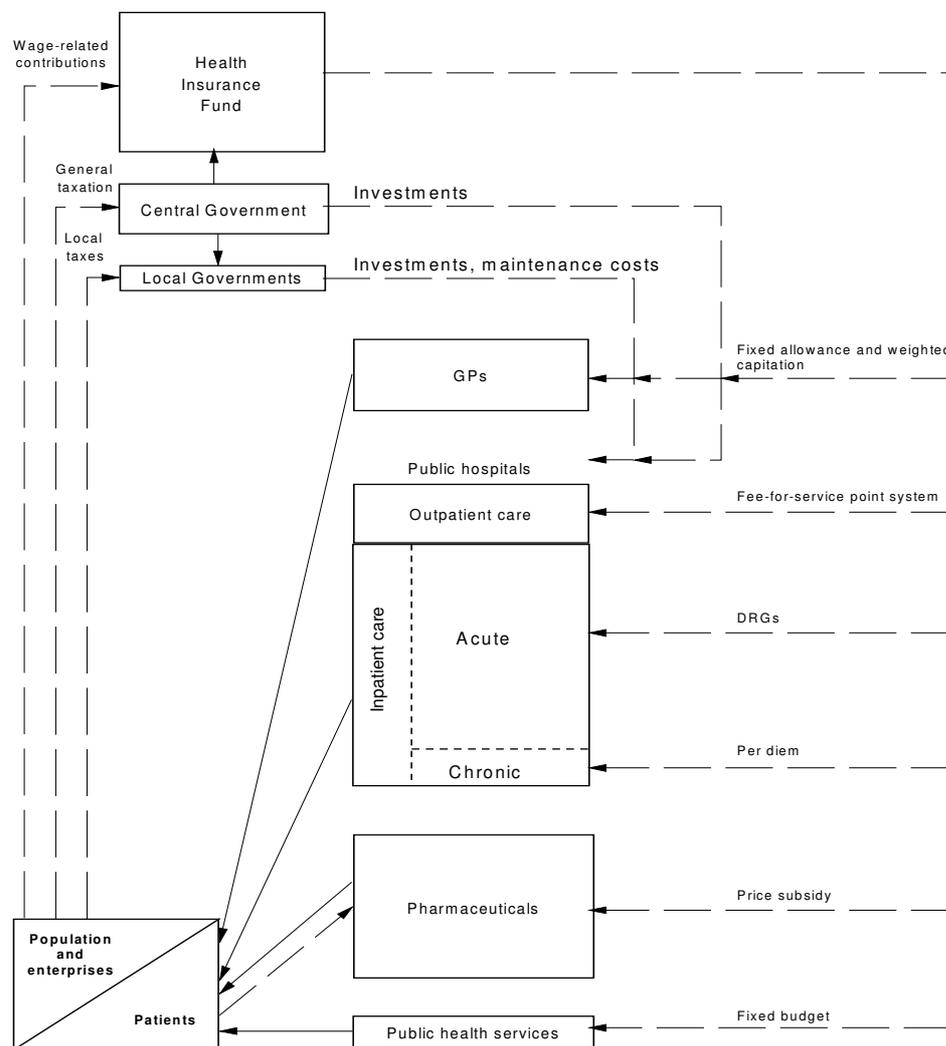
### **Organization of the health care system after the reforms**

Today, the responsibility over the health care system is shared between the Ministry of Health, the Health Insurance Fund, the Ministry of Finance, and the local governments.

Overall health policy is determined by the government with the Ministry of Health in conjunction with the Health Insurance Fund proposing and implementing reforms. Reforms on the financial aspects of the system (such as payment rules, central budget contributions to health care, and annual budget of the Health Insurance Fund) are proposed and drafted by the Ministry of Finance in consultation with the Health Insurance Fund and are decided and promulgated by the parliament. The management and supervisory structure of the Health Insurance Fund has changed several times. Currently the Ministry of Health, Family and Social Affairs supervise the Health Insurance Fund Administration, with the exception of budgetary issues, which are still supervised by the Ministry of Finance. The general director of the National Insurance Fund is nominated by the Minister of Health, but appointed by the Prime Minister. (See chapter 2.1.3 for further details of the supervisory structure of health insurance.)

The Ministry of Health operates the National Public Health and Medical Officer Service which is, in turn, responsible for the licensing, accreditation and supervision of healthcare providers in addition to its traditional health surveillance, immunization logistics, (e.g. supplying vaccines), environmental safety, food and water safety, health promotion, hygiene, school health services and epidemiology functions. The local governments are normally the owners of the health care provider institutions, such as hospitals, outpatient clinics, and (until very recently) general practices. In this function, local governments are responsible for the everyday management of health care institutions and for the finance of their maintenance costs. Running costs of health care providers are financed and monitored by the national Health Insurance Fund and its network of 19 County Health Insurance Fund Offices (Orosz and Burns, 2000). Figure 1 illustrates the detailed structure of the Hungarian health care system. Flows of services are shown as solid lines and flows of finance as broken lines.

Figure 5.1: The Hungarian health care system: organization and finance



The remainder of this section describes the details of the organizational structure of the health care system with respect to provision of services.

### Provision of health care services

In Hungary, health care is provided at three main levels of care: primary care (general practitioners), outpatient specialist care, and inpatient care.

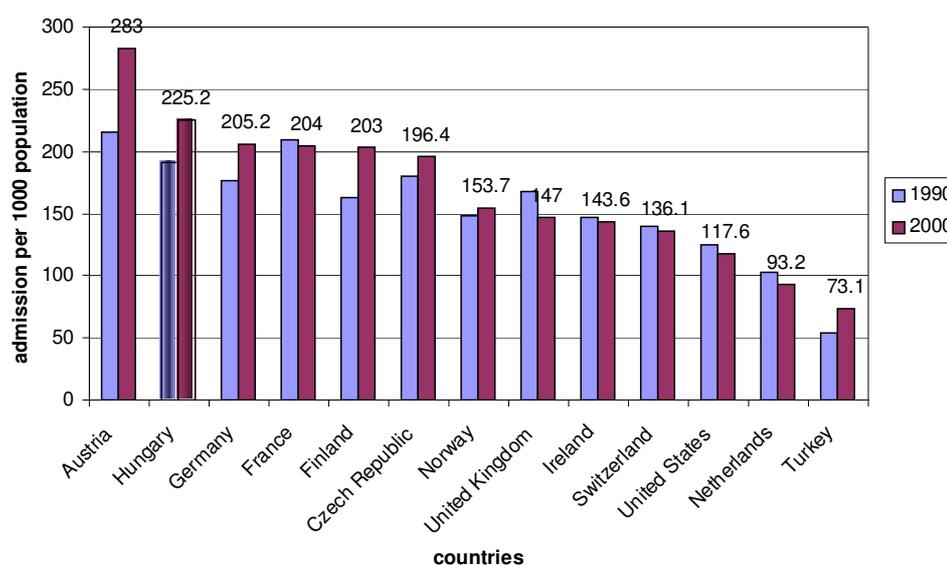
General practices can be owned and/or organized on a private basis or can be operated by the local government. Citizens have *free choice about the GP* they want to register with. Individuals are free to change their GPs, but choice is very limited in rural areas, and GPs have the right not to accept patients living in districts other than the one in which the practice is located. Consultations with GPs are free of charge but informal payment to doctors is regular.

General practitioners enjoy clinical autonomy, which includes the freedom to prescribe and the freedom to refer patients for diagnostic tests or consultations with specialist hospital departments. No budgetary restrictions limit GPs, however, an information system has been developed by the Health Insurance Fund to monitor variations in drug prescription rates among different practices.

General practitioners can refer patients to a hospital or outpatient clinic for specialized diagnosis or treatment. The strict referral system has been relaxed, however. In the case of certain diseases (such as mental disorders, sexually transmitted disorders, dermatological and gynaecological problems) GPs' referral is not necessary. Due to the scarcity of some highly specialized services such as diagnostic imaging (CT/MRI, ultrasound exams), angiographies, coronarographies, psychotherapy, hip replacement, etc. waiting lists exist in hospital and outpatient care settings.

Despite several policy efforts to increase the preventive and gate-keeper role of primary care, health care in Hungary is still hospital based. There are excess capacities in acute hospital care and oversupply of specialists, which in combination with a performance-based finance system results in high health care utilization of hospital level care. Figure 2 shows that admissions to acute hospital care is the second highest in Hungary among those OECD countries where these data currently exist.

Figure 5.2: Admissions to acute hospital care (annual cases per 1 000 population) in selected OECD countries in 1990 and 2000



Source: OECD Health (2002)

Social care is not clearly separated from health care services. A significant part of the chronic inpatient services are substituting social services. New and more specialized institutions such as nursing homes and respite homes are to be created in the future by both local municipalities and private providers (including charity organizations). Private medical care has a small complementary role to the mainly public system, offering a better choice of doctors, avoidance of long queues in the surgeries, better privacy of care, and a better doctor-patient relationship as no inconvenient feelings of informal payments are present.

In addition, the ratio of the privatized health care providers (in terms of ownership of practice) has been gradually growing. Today, 87 % of the GPs are micro-enterprises. Outpatient specialist services are also increasingly run by one-person micro-enterprises or by small groups of specialists (for example in the form of an ltd.). Most of these enterprises have an outsourcing contract with the local government or the main health care provider of the given catchments area. More than two third of the hemodialysis providers are owned by private owners (mainly affiliates of multinational private providers), and the majority of the CT and MRI services are run by private companies. In 2000, 98 % of pharmacies, about 90 % of homecare providers, and around 70 % of dental service providers had private owners.

The structure, ownership, contracting conditions and management responsibilities of public (contracting with the public insurance company) hospitals are planned to be regulated by a new, comprehensive act parallel to a new act on the legal status of health professionals (working hours, contracts, employment rules, etc.). The aim of the new legislation is to support the regional cooperation of the county and town hospitals, to have a better control on the health expenditures and guarantee the care of patients.

Similarly to the Former Soviet Union countries and other countries of Central and Eastern Europe (Ensor 2000), the presence of *informal payments* has been a key feature of the Hungarian health care system. Due to its informal nature, very little empirical evidence exists. In the late 90ies, however, more open discussions have started. In 1998, the government of Hungary set up the Informal Payment Committee to analyze the situation and to suggest ways of eliminating informal payments from the system (Report on Informal Payments, 2000). The report explicitly described the informal payment system from a historical and sociological perspective. A chapter by Tóth looked at informal payments from a sociological perspective and concluded that the emergence of the whole informal payment system was mainly due to the fast introduction of a general social insurance scheme replacing a mainly direct payment system after the second World War. Furthermore, having a large proportion of doctors coming from the working class has changed the medical ethics substantially. Balázs discussed informal payments within the context of society and medical ethics.

According to him, the emergence of informal payments was in close relation to the low respect of the medical profession within the society. At the same time, the strict hierarchy within the medical profession enabled doctors to reinforce informal payments. Bondár and Bordás examined the economic aspects of informal payments in the report. They argued that informal payments would exist until doctors can differentiate in the services they provide. Differentiation in services may include better quality of care or shorter waiting lists. They advised that several methods should be simultaneously used to eliminate informal payments. These included better incentives through official payments, better quality control in care, legal tools and the introduction of formal co-payments. Although the report highlighted several important aspects of the informal payment system and increased the transparency of its public discussion, it failed to come up with an agenda to eliminate problems and lacked a political will. The committee was dismissed in 1999 without replacement.

In 1999 the TARKI Social Research Centre (Bognár et al., 1999) conducted a general population survey about the size and nature of the informal payment market. This survey was part of a research lead by János Kornai with the original purpose of understanding if there is a need in Hungary for formal private health insurance as an alternative to the current informal payment system. According to the results, the estimated amount of informal payments were 30 billion Hungarian Forints (HUF), which corresponded to 4,6% of total health care expenditures. Informal payment is more widespread in gynaecological, surgical hospital services, than internal medicine or mental services. Informal payments are less frequent in outpatient specialist services (e.g. diagnostic services). The amount also varies significantly by specialty groups. According to the survey, a GPs home visit involves about 3 – 3.5 Euros, a gynecologist after child delivery 40-78 Euro, while a cardiac surgeon receives about 117 - 197 Euros for an operation<sup>16</sup> (Bognár et al., 1999). Despite their relatively low share in health care expenditures, informal payments may have important impact on efficiency and access to health care. Informal payments may also be a contributing factor to the increasing lawsuits against health providers. Because of the relatively high amount of informal payment they give to providers – in the hope of better care – patients have higher expectations from the services they get. However, the informal payment system alone cannot be blamed for the increasing number of malpractice lawsuit cases. These started to appear along with the consumer rights movement in health care and the increasing number of lawyers specialized in medical malpractice law who actively induce demand for legal actions among patients.

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<sup>16</sup> Exchange rate used was 1 Euro = 248 HUF

### **5.1.2 Benefits**

The Hungarian health care system provides an almost complete range of health care services for free of charge at the point of delivery of care. Exceptions are limited to certain treatments, such as particular dental care services, e.g. inlays and crowns, bridges with expensive materials, or expansive obstacles and cosmetic interventions.

The mandatory health insurance package has changed several times in the last few years. In 1992 a „full package” was offered to the citizens, in which the preventive care as well as the whole range of therapeutic services was covered by public financing. In 1995 the occupational health services were taken out, and transferred to the responsibility of employers. At the same time, special dental care, the non-medical services of in-patient rehabilitation was placed on a co-payment basis. In 1998 a definitive list was set up on the services, which are not available in the frame of social insurance. During the last four years most of these services were re-included into the insurance package, and consequently, there is only a tight room for complementary or private health insurance.

Payments for out-of-hospital pharmaceuticals and medical devices are, however, shared between the Health Insurance Fund and the patients. Public subsidies depend on the drug prescribed but vary between zero and 100 percent (and can be 0, 50, 70, 90, 100 %). In average, about 32% of drug prices are paid by the patient and about 68% paid by the Health Insurance Fund.

Due to the fact that almost a full range of health care services are covered under the compulsory scheme, from which opting out is not allowed, currently there is very little demand for private health care services or private health insurance. In addition, due to the unpredictable morbidity and mortality conditions of some age groups of the population (such as males over 45) private insurance companies are not offering even supplementary health insurance packages to these high-risk age groups. Act XCVI of 1993 on Voluntary Mutual Insurance Funds opened the market for non-profit insurance plans, which is very similar to the model of ‘mutualité’ movement. Purchasing voluntary health insurance from mutual funds enjoys tax rebate up to a certain limit. Since 1994, mutual health funds are allowed to operate. The Supervisory Authority of Financial Services supervises them. There are about 30 voluntary mutual health insurance funds, but their role is marginal at the moment. These mutual funds had recruited about 61 000 members by the end of 2000. Most of them are employment-based, and tax-favored. The voluntary health insurance fund’s health related expenditure was less than 1 billion HUF (4 million Euros) in 2000, so their role in healthcare financing is limited (about 0.1 % of the total health expenditure) (Schneider, 2000.). Therefore, without any major changes in the health care system of Hungary, the role of private health insurance is likely to remain little in the near future.

### 5.1.3 Financing of the health care system

As Figure 1 illustrated, both raising revenues for health care and the finance of providers are based on a mixed system. This section first describes how health care is funded in Hungary, before summarizing the main methods of financing providers.

#### Raising revenues for health care

As the Hungarian health care system operates on a social insurance scheme, the majority of revenues are raised through compulsory health insurance contributions paid by employers and employees. Table 5.2 describes the three components of the health insurance contributions and the payment rules in 2002<sup>17</sup>.

Table 5.2: Payment rules for health insurance contributions in 2002

Component of contribution	Payment rule
<i>For active (non-pensioners) individuals</i>	
Income-related contribution paid by the employer	11% of gross salary
Income-related contribution paid by the employee	3% of gross salary <sup>18</sup>
In-kind related contribution (company care) for the employer)	e.g. 25 % of the compulsory care tax,
Fix component (EHO) paid by the employer to the Health Insurance Fund	4500 HUF per month from 2002 <sup>19</sup> .
<i>For pensioners, who are employed</i>	
Income-related contribution paid by the employer	11% of gross salary
Fix component (EHO) paid by the employer to the Health Insurance Fund	4500 HUF per month from 2002 <sup>20</sup> .
Income-related contribution paid by the employee	0 % of gross salary

Largely due to the complex organizational structure of the health care system described in Chapter 5.1.1, finance of health care is not exclusively raised through the health insurance system. The identification of finance

<sup>17</sup> See also chapter 2.2 for payment rules.

<sup>18</sup> There was a ceiling above 1.9 million HUF (approximately 7661 Euro), which has been removed from the financial year 2001.

<sup>19</sup> This fix contribution is 18.2 Euros (exchange rate 1 Euro=248 HUF). According to the Government plan, the fix health insurance contribution will be reduced to 3450 HUF (13,9 Euros) in 2003.

<sup>20</sup> According to the Government plan, the fix health insurance contribution will be reduced to 3450 HUF in 2003.

sources is a complex task that is described in Table 5.3. The calculations excluded cash transfers (e.g. maternity-related benefits) made by the health insurance fund.

Table 5.3: Funding health care: description of finance sources, data sources, calculation methods and results

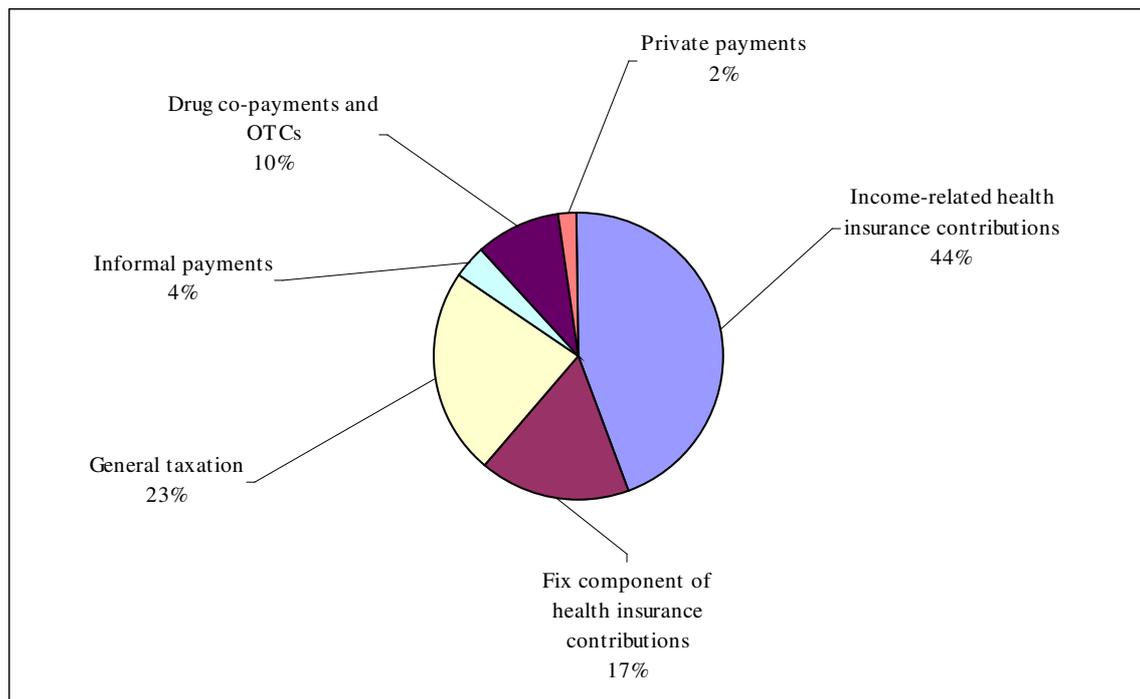
Payments	Data source	Calculation method
General tax revenues		
Contribution from the central budget to the Health Insurance Fund	Health Insurance Fund (Balance sheet, 1999)	Two items are involved: planned contribution to the Health Insurance Fund for the year 1999 and the deficit of the Fund during 1999 supplemented from the central budget. These were 30 and 48 billion HUF, respectively.
Operating costs of the Ministry of Health and national institutions (including tertiary hospitals, public health and ambulance services)	Central Budget (Balance sheet, 1999)	Annual income of these institutes was taken (82 billion HUF) minus finance for operation of hospitals received from the Health Insurance Fund (27 billion HUF).
Hospitals operated by other ministries (MoI, MoD, MoTTW, MoE (universities))	Estimate based on number of hospitals	Estimate was based on number of such hospitals and the average annual budget of one hospital in Hungary (a total of 10 billion HUF)
Depreciation, infrastructure maintenance costs and service development (investments) spent by/or financed through local governments	APEH-SZTADI (Annual report, 1999)	Maintenance is the responsibility of the owner of hospitals and general practices, which is normally the local government. The majority of income of local governments comes from the reallocation of central revenues. Maintenance cost items covered GP, outpatient care and hospitals and included investments awarded by the Ministry of Internal Affairs (a total of 26 billion HUF).
Revenues raised through the national health insurance system		
Income-related contributions paid by the employer (11%) and the employee (3%) and the fix "EHO" component (3600 HUF per month) paid by the employer	Health Insurance Fund (Balance sheet, 1999)	Only that part of total revenues were taken that was spent on the provision of health care (such as medical care and drug subsidy). This total sum of 447 billion HUF, therefore, did not include transfers (such as sick leave payments) financed by the health insurance fund.

Table 5.3 continued

Out-of-pocket payments		
Drug co-payments and OTC drugs	Health Insurance Fund (Balance sheet, 1999)	Drug co-payments were calculated by multiplying total expenditures on drugs by the average co-payment rate (35%), resulting a total amount of 70 billion HUF.
Informal payments	TARKI informal payment survey (Omnibusz 1999/2 survey)	Total amount of informal payments was estimated from the informal payment survey that covered over 1000 people from the general population and asked about informal payments at each level of health care. The estimation for the total population of Hungary was an average of 30 billion HUF.
Payments for private care and medical devices, spa	Household Budget Survey (1998)	Households reported their spending on medical care and medical devices. 1998 prices were transformed to 1999 by using health-care specific price index, resulting a total amount of 15 billion HUF.

As Figure 3. summarizes, 61% of revenues for health care are raised through the health insurance system and 39% are raised through other finance sources. 23% of funding comes from general taxation. General taxation includes four main components: value-added taxes (VAT), exercise taxes, corporate taxes, and personal income taxation. The major part of private payments are generated through drug co-payments and a small part includes informal payments for the use of public health care and formal payments for the use of private care.

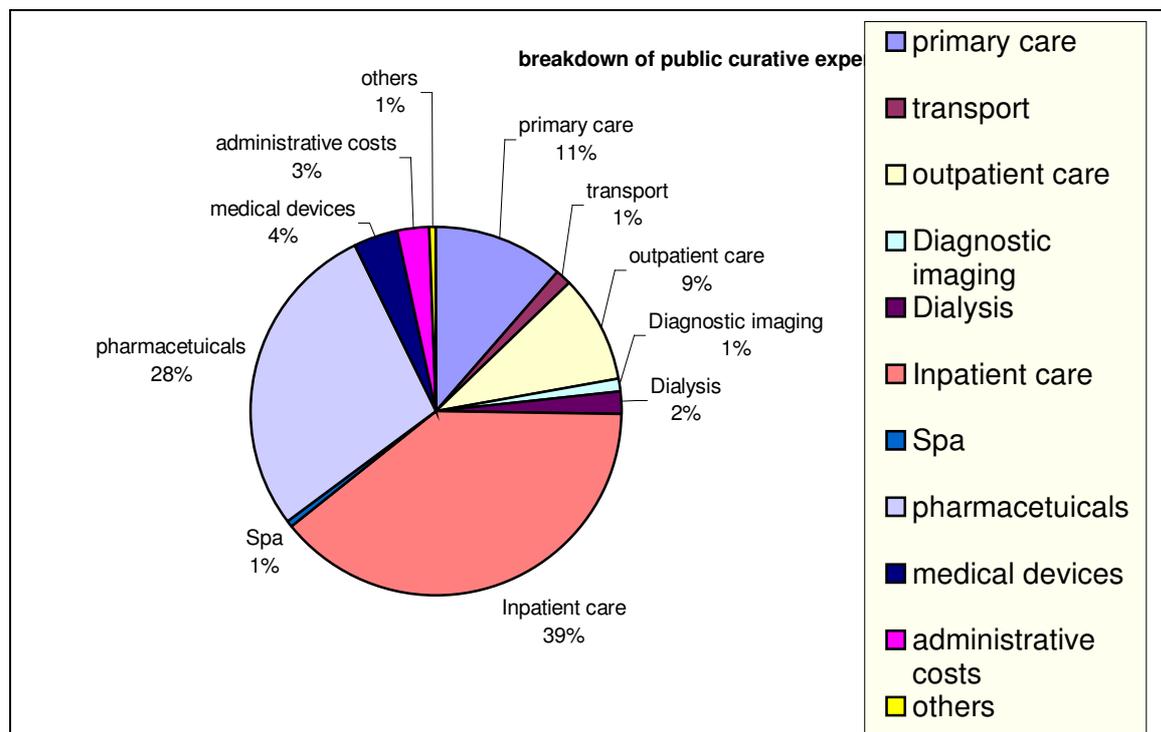
Figure 5.3: Share of different finance methods in total health care revenue



With the exception of private payments, it is not possible to specify the share of each type of revenues in the finance of particular health care services. The reason for this is that revenues (such as the various components of general taxation) are not labeled with respect to their use for health care.

Figure 4 illustrates the share of each type of health care from the total expenditures. Primary care account for 11% of in-kind health care expenditures, whereas specialist care (outpatient specialist, inpatient acute, or inpatient chronic care) account for 48%. A large proportion of in-kind benefits include pharmaceuticals (39%).

Figure 5.4: Relative share of in-kind health care services in 2001



Source: Health Insurance Fund data, 2001

Finally, table 5.4 illustrates that while the GDP of Hungary has been gradually increasing in the last couple of years, health care expenditures as proportion of the GDP have decreased slightly (Orosz, 2001). Expenditures on pharmaceutical were the only exception that could follow the growth of the GDP.

Table 5.4: Trend in health care expenditures as percentage (%) of the GDP

	1991	1995	1996	1997	1998	1999	2000
Primary, secondary and tertiary care	3.9	3,4	3,3	3,2	3	3	2.8
Pharmaceuticals and medical devices	1.4	1,5	1,4	1,4	1,5	1,4	1.4
Investments	0.6	0,5	0,3	0,4	0,4	0,3	0.3
Other	0.6	0,8	0,7	0,5	0,6	0,6	0.7
<b>Total public</b>	<b>6.5</b>	<b>6,3</b>	<b>5,9</b>	<b>5,6</b>	<b>5,6</b>	<b>5,4</b>	<b>5.2</b>
Private out-of-pocket expenditures (including pharmaceutical co-payments)	0.8	1,2	1,3	1,3	1,2	1,3	1.3
<b>Total</b>	<b>7.3</b>	<b>7,5</b>	<b>7,2</b>	<b>6,9</b>	<b>6,8</b>	<b>6,7</b>	<b>6.8</b>

### Relationship between third party payers and providers

Financing providers in Hungary is based on the following dual financing structure:

- running costs of health care providers are financed by the Health Insurance Fund, while the
- maintenance costs are supposed to be paid by the owners of providers, i.e. usually the local government.

The main experience with this dual financing system is that revenues of health care providers for maintenance are very low. This is mainly due to the scarce resources of local governments. Large part of the *investments* is financed by the central government directly to the providers. The allocation of investments is not determined by any formula or explicit priority setting.

The finance of the different levels of health care provision is based on a mixed system. Table 5.5 summarizes the key finance methods with respect to the various health care providers.

Table 5.5: Finance of health care providers

Health care service	Methods of finance
General practitioners	Weighted capitation from 1992 and fixed allowance depending on the size and location of the practice, plus fee-for-service for certain preventive activities and a case payment for attending non-registered patients. Capitation payments are adjusted to the age structure of the patients, the qualifications of the family physicians.
Home care and spa	Fee-for service
Outpatient care	Fixed budget and fee-for-service point system (each activity has a point value. The actual value of the points is calculated in the following way: all the points sum up nationally and the monthly budget divided by the total points. ("floating" or relative point systems)
Community specialist care (mental health services, pulmonary and STD service)	Yearly fix global budget and partly fee-for-service point system.
Acute hospital care	DRGs (or HDGs Homogenous Disease Groups)
Chronic hospital care (incl. rehabilitation)	Weighted per diem (complexity adjustment)
Few tertiary care services (such as transplantation)	Case based
Certain public health care tasks	Fix budget

From the table it can be seen that Hungary adopted various financial methods, including the American origin DRG system in the acute inpatient care, the German point system in the outpatient care, the per diem base system in the case of the chronic inpatient care which was operated for example in Canada or Japan. These finance methods have in common that they are all "performance-based" and reflect the "money follows the patient" principle.

In order to avoid escalation of expenditures due to the introduction of the new payment methods, Hungary started to operate a cash-limited (relative) financing system (using capped budgets for inpatient and outpatient care). This means that the actual fees for health care provision depend on both the available budget and the total number of services provided in a certain period of time. All provided services are aggregated at the country level, and the available budget is divided by the volume of services (sum of provided units), which finally gives the financial value of one provided unit. The available budget is then allocated among providers according to the volume of their health care provision. In this floating fee or point payment system, if there is an increase in the provision of services then the budget is divided between an increased volume of health services, and therefore the fee after a particular provided service would be smaller. This floating point system is used for reimbursing outpatient and acute hospital services as well as diagnostic imaging, diagnostic laboratories, and renal replacement therapy.

#### **5.1.4 Incentives**

There are a number of incentives built in the organizational and the finance methods of the health care system in Hungary.

Most importantly, the introduction of the performance-based reimbursement methods has led to the increased provision of services. Particularly in the acute inpatient care, there is a strong incentive for hospitals to admit patients and report as serious diagnosis as possible in order to maximize the income of the hospital. This phenomenon, which is also known as the "DRG creep", has been present in the health care system and resulted in the devaluation of the value of one unit health care provision.

In addition, the oversupply of specialists result in a situation where patients are treated at a higher service level, which may not be provided in a healthier professional structure. Currently Hungary has the highest number of specialists (2.7 per 1000 population) among all OECD countries where the average value is 1.2. The number of GPs (0.7 per 1000 population) is slightly below the OECD average (0.8). Finally, the number of nurses (4.9 per 1000 population) is among the lowest in the OECD countries where the average is 7.7. This distorted structure of health care professionals leads to the inefficient use of resources.

Informal payments also have perverse incentives to provide services inefficiently and in an unjust manner.

### 5.1.5 Coverage of the system and access to care

Prior to the reforms *entitlement* for free health care was universal, based on citizenship from 1973. After the introduction of the health insurance system entitlement is determined by paying contributions. Act LXXX of 1997 on Social Insurance determines the entitlement for in-kind and cash benefits, as well as the rules of paying the contribution. As a general rule, entitlement for health insurance benefits is linked to paying contribution, however certain population groups are exempt such as pensioners and the unemployed. However, still almost all the population is covered as the central and local government pay the contributions for the insurance of the unemployed and people in social need. Pensioners are exempted from payments. The Government pays contribution as a bulk sum for the unemployed, people in social need, and the pensioners.

The coverage is practically universal. About 1% of the population is not covered. (HIT report, 1999) They usually work in the unofficial market and therefore they are not registered with the Health Insurance Fund. They might not apply for free entitlement on social basis at the local government, or if they do then the local government is to decide about the eligibility. The local government and the social security system gained some responsibility in bringing back people who suddenly got outside the health care system.

### 5.1.6 Public acceptance of the system

The perception of the public about the health care system is not well understood yet. Until recently, surveys that measured patients satisfaction with health care showed extremely high satisfaction. There was always a suspicion though that these results were flawed due to methodological problems (patient filled in the questionnaire prior to departure from hospital). Recently, however, a survey showed that only 55.7 % might be satisfied with the current health care system.<sup>21</sup> Resent patients and elderly population prefer more the current system, than the rest. The current system is less favorable among the young and wealthy groups. (Janky, 2000) This result is in the line with the EU average (Mossialos, 1997)

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<sup>21</sup> The following question was asked: After an average insured individual 16000 HUF contributions is paid by the employer. Your contribution could be less or more. What do you chose if you could determine whether your insurance contribution should be paid to the current (state owned) health insurance fund or a private insurance fund, what you would choose?

## 5.2 Evaluation of future challenges

### 5.2.1 Main challenges

#### Growing inequalities

Comparatively low income inequalities during the socialist era (especially the sixties and seventies) ensured a fairly high level of well-being and social security. The Gini coefficient increased slightly in Hungary between 1988-1995. During the transition, the poor disproportionately suffered. (Grun and Klasen, 2001). The EBRD Transition Report shed light on the increasing income inequalities (measured by the Gini coefficient) was 30.5 in 1992, and 34.8 in 1997. There is substantial evidence on that increasing socio-economic inequalities are reflected in increased inequalities in health status. Therefore one of the major challenges of the Hungarian healthcare system (within a wider social policy context) is to tackle the growing income-related inequalities in health status.

#### Excess capacity - low salaries – informal payments

Hungary has more physicians for its population than most European countries, and the number of physicians per 10000 citizens still increasing.

Compared to the employment in the whole economy, where it fell substantially between 1991 and 1997, there were insignificant downsizing in the healthcare sector. It can be explained partly by the public servant status of the healthcare professionals that offer them some protection, and partially by difficulties in career change. At the same time the number of first-year medical students increased with 40 percent since 1990, and the older physicians have incentives to work after retirement to supplement their low pension. It is expected that the number of general practitioners will increase in the next decade. It will further exacerbate the current relative physicians underemployment status, performing tasks that in EU countries usually delegated to nurses or administrators, and create a barrier against manpower substitution. (Orosz, 2000)

*Table 5.6: Number of general practitioners and hospital beds per 10000 population in Hungary*

Number of practicing physicians and hospital beds per 10000 population in Hungary							
Year	1970	1980	1990	1995	1999	2000	1999/1990
Physicians	20,2	25,1	31,8	33,9	36,2		114 %
Hospital beds	82,9	89,2	101,5	90,7	83,6	83,2	82 %

Source: NHIFA yearbook, 2000

During the last decade the health professionals' salaries remained low compared to the private sector, and earnings were falling in real terms, which contributed to the survival of the informal payments in Hungary. Physicians' salary are generally about 130 % of the workforce average still in 2002. (Orosz, 2000)

One of the pledges of the new government is to increase the salaries of the healthcare professionals. The government has increased the salaries of health professionals about 50 % in October 2002. The government allocates the necessary budget according to the new national salary scale for health care professional. The insurance fund transfers the money separately as an earmarked sum to cover the salary increase. From the next year it will be integrated into the regular payment scheme (e.g. DRG). One of the expected results would be that regional differences would be reduced by this mechanism. Due to the increased revenue of the insurance fund the deficit of the fund is expected to remain the same (about 17 billion HUF (1.7 % of the total expenditures of the National Health Insurance Fund))

### **Inappropriate incentives**

Most family physicians are paid through capitation, which does not motivate them to improve the quality of the services and provide more definitive care. Ambulatory specialists care is reimbursed according to the service provided (fee-for-service, using the German point system). Fee-for service is used to reimburse the inpatient services (DRG and day-base payment). Fee-for-service remuneration created a perverse incentive to provider moral hazard. Over-provision is most striking in the outpatient sector, but observable in the hospital sector too. The majority (68 %) doctor-patient encounters occur in outpatient specialist clinics, and Hungarians have the highest (21.1) number of medical visits per capita among the OECD countries, but not with dentists.(see tables below)

The Health Insurance Fund tried to put capped budget for the ambulatory diagnostic services, where over-provision was the highest. Still further regulation is necessary to motivate providers to improve quality and provide more appropriate care.

Table 5.7: Trend in number of consultations with physicians

Doctors' consultations - Number per capita					
	1980	1985	1990	1995	2000
Austria	5.4	5.5	5.9	6.3	6.7
Czech Republic	12.4	12.9	11.8	12.5	12.6
Germany	11.4			6.4	
<b>Hungary</b>	<b>10.5</b>	<b>11</b>	<b>11.7</b>	<b>14.8</b>	<b>21.9</b>
Poland	6.5	6.4	5.8	5.4	5.4
Portugal	3.7	2.8	3	3.2	
United Kingdom	5.2	5.1	6.1	6.1	

OECD Health Data 2002

Dentists' consultations - Number per capita						
	1970	1980	1985	1990	1995	2000
Austria	1.2	1.3	1.3	1.3	1.3	1.3
Czech Republic	2	2.1	2.2	2.1	2.2	2.1
Germany					1.4	
<b>Hungary</b>	<b>1</b>	<b>1</b>	<b>0.8</b>	<b>1.1</b>	<b>0.8</b>	<b>0.8</b>
Poland	1.3	1.6	1.4	1.3	1	0.7
United Kingdom	0.4	0.6	0.7	0.6	0.7	0.7

OECD Health Data 2002

### Structure of capacities

Compared with European countries, Hungary has relatively few hospitals but they have one of the highest numbers of beds among the OECD countries. Former literature reviews concluded, that the optimal size of the hospitals is between 200-400 beds, and dis-economics of scale could happen in hospital above 400 beds. Someone might argue that Hungary can improve the efficiency of the hospital sector by reducing the beds per hospitals down to the optimal range. (Effective Healthcare Bulletin, 1996, Sowden, 1995, Posnett, 1999)

Table 5.8: Number hospitals and hospital beds

Country	Acute hospital beds per 100 000 population	Number of acute hospitals per 100 000 population	Number of beds per hospitals
UK	204	2.71	84
Portugal	338	2.16	149
<b>Hungary</b>	<b>661</b>	<b>1.59</b>	<b>472</b>
EU average	446	3.78	109
CEE average	723	2.24	332

Source: NHIFA, 1999

Hungary has a particularly large number of acute hospital beds per 100 000 population compare to Europe, and very few nursing-home beds.

### East-West life expectancy gap

The life expectancy gap between Hungary and Western Europe started to grow from the early 1960s. In many currently developed countries the life expectancy in 1930 was lower at birth than in Hungary, such as in Japan (44.8 years) or in Spain (48.4). At age forty life expectancy in Japan was 25.7 years, but in Hungary 29.1 years. (Orosz, 1994) After mid-1960s life expectancy at birth stagnated and later deteriorated. These trends were the same for all the former socialist countries (Velkova, 1997). Broadly speaking the health status of the Central and Eastern European countries roughly similar with Latin America and the Caribbean. (Preker, 1995) The probability of surviving of the Hungarian men between 35-65 was slightly worse in 1994 than in 1920/21. (Mortality Studies, Hungarian Central Statistical Office, 1996) The widening gap in life expectancy and mortality between East and West is particularly striking in middle-aged adults. "In the communist countries, death rates for males aged 45-48 years increased, with 7 percent in the GDR, and 131 percent in Hungary between 1965-1989, while they decreased in the highly industrialized countries. The risk of death between 15-59 years old men in the late 1980s was higher in Hungary than in Zimbabwe. (Preker, 1995) Further the life expectancy of Gypsies in Hungary is ten years less than the Hungarian average. It means their situation is even worse than the general picture about the East-West difference. (Bíró, 1996) In Hungary women also showed increasing mortality rates during the last two decades. Women's mortality rate improved in all part of Europe, except Hungary. (Watson, 1995) These figures improved very slightly in the late 90s.

Table 5.9: The East-West life expectancy gap

	1960	1970	1980	1985	1990	1995	1999	2000	2000 / 1990	2000 / 1960
Austria	68.7	70	72.6	73.9	75.6	76.8	78	78.3	104%	114%
Czech Republic	70.7	69.6	70.3	71.1	71.5	73.2	74.8	75	105%	106%
Germany	69.6	70.4	72.9	74.8	75.2	76.5	77.7		103%	112%
<b>Hungary</b>	<b>68</b>	<b>69.2</b>	<b>69.1</b>	<b>69.1</b>	<b>69.4</b>	<b>69.9</b>	<b>70.7</b>	<b>71.4</b>	<b>103%</b>	<b>105%</b>
Japan	67.8	72	76.1	77.6	78.9	79.6	80.5	81.1	103%	120%
Poland	67.8	70	70.2	70.7	71	72	73.2	73.9	104%	109%
Slovak Republic	70.6	69.8	70.6	70.8	71	72.4	73	73.2	103%	104%
United Kingdom	70.8	71.9	73.2	74.7	75.7	76.6	77.4		102%	109%

Source: OECD Health data 2002.

## 5.2.2 Financial sustainability

### The revenue and expenses of the health insurance fund

In the last decade the public health expenditures could not respond quickly to the changes of the economic growth. This relatively slow reaction was responsible for the deficit of the Health Insurance Fund. With the stable economic growth, if the public healthcare expenditures will grow slower than the revenues, the Health insurance fund will get more fiscal stability (see Table 5.10).

Table 5.10: The deficit of the health insurance fund in real terms

The deficit of the health insurance fund in real terms (1992=100%)									
	1993	1994	1995	1996	1997	1998	1999	2000	2001
Revenue	96.8	110.7	96.3	85.5	77.8	75.9	80.4	81.2	84.1
Public expenditures	96.8	106.1	92.8	85.6	79.2	78.2	79.0	78.7	77.9
Deficit	96.3	57.2	54.9	86.5	94.6	103.5	63.8	51.5	11.2
Deficit as % of the GDP	0.7	0.4	0.4	0.6	0.7	0.7	0.4	0.3	0.1

Source: Orosz, 2001b

In 2002 employers paid 11 % of the gross salary plus HUF 4500 to the State Health Fund, while employees' contribution was 3%. The government plans to reduce the health insurance contributions with 1 or 2 percent, but stable economic growth can compensate this reductions.

About 25 % of the total healthcare expenditures are out-of-pocket expenditures including informal payments (Bognár et al, 1999) One of the election pledge of the new government was in 2002 that medicines for cardiovascular diseases and osteoporosis should be free at the point of utilization. It can reduce out-of-pocket expenditures, if all the new patent very expensive medication will be 100 percent reimbursed, but will increase public pharmaceutical expenditures.

According to the Central Statistical Office the percentage of the elderly (older than 65 years) will reduce slightly in the next five years and the proportion of the children (younger than 19 years old) and the elderly will not change significantly. Economic studies conclude that only a small proportion of increasing healthcare expenditures is due to the aging (Barros, 1998, Gerdtham 1993, O'Connell 1996, Tielen, 1998, Zweifel, 1999). Some expert expected increasing demand and expenditures in the next decades due to the aging of the Hungarian populations (Orosz, 2000)

*Table 5.11: The proportion of the elderly and the children in the next 15 years*

<b>The proportion of the elderly and the children in the next 15 years</b>				
	<b>2000</b>	<b>2005</b>	<b>2010</b>	<b>2015</b>
Percentage of the elderly (over 65 years)	14.6	14.1	14.3	14.8
Percentage of the children (younger than 19) and the elderly together	38.2	38.7	38.8	38.9

Source: KSH, 2001

The introduction of fix budgets for outpatient and inpatient care plus the capitation-based payment for GPs were very effective instruments of cost containment mechanism since 1994. The government introduced separate fix budget for laboratory diagnostic procedures in 2002. Previously outpatient specialist services and outpatient laboratory diagnostic services was financed from the same capped budget. Between 1994 and 2000, the laboratory diagnostic providers generate 4.2 times increase in their yearly activity (measuring in German points) while the rest only 2.1 times increase. Preventing further crowding-out and decreasing the financial incentives for unnecessary care, the government decided to split the budget into two separate one. A laboratory budget was set up using historical laboratory expenditures. The capped diagnostic budget also prevents cost shifting between inpatient and outpatient budget (several outpatients clinics owned

by the hospitals. It is expected that the separate budget will further strengthen the cost-containment in the future. CT and MRI budget have already been separated since 1993, but have been capped since 1997. After the implementation of the capped budget, the volume of the services provided increased slightly faster than the budget, and MRI continued to increase its market share in value compare the CT scans (as shown in table 5.12). One might argue that capped CT/MRI budget is an efficient measure at the macro level, but should be accompanied by micro-level interventions such as clinical guidelines and utilization review/audit.

Table 5.12: CT and MRI examinations in Hungary

	1994	1995	1996	1997	1998	1999	2000	2001
Annual increase in CT examinations	100 %	113%	104%	98%	118%	96%	128%	112 %
Annual increase in MRI examinations	100 %	283%	344%	173%	152%	99%	138%	126 %
Annual increase in total examinations		120%	128%	118%	131%	97%	133%	119 %
Total expenditures (billion HUF)	1.88	2.99	4.57	5.41	6.21	6.48	7.05	7.84
Annual increase (previous year = 100)		159%	153%	118%	115%	104%	109%	111 %

Data source: Public Expenditure Report, 2002

One of the major expenditure-driver will be the diffusion of new technologies and the upgrading of the very old (30-40 years old medical equipments X-rays) and hospital infrastructures according the legal standards (bigger place, better heating system, more equipments, etc)

The private or public quasi-managed care organizations, mainly experimental in nature, started to operate from 1999 in Hungary. The NHIFA pays providers as usual, but at the same time compare spending with the age and gender adjusted capitation budget. If there is a surplus, the quasi-managed care organization can keep it, and use it for improving the service infrastructure and to reward good performance of doctors and nurses. If they run to deficit the Insurance Fund able to withdraw the managed care status. This structure provides strong incentive to monitor and influence

patient care pathways. The overall objective of the pilot is to improve efficiency and quality at the same time.

The few quasi-managed-care organizations recruited about 484,8 thousand citizens in 2001 it (approximately 5 % of the population). The 307 general practitioners and several specialists who belongs to these managed care organizations, have incentives to use more cost-effective technologies and provide definitive care (complete the patient treatment without referring them to specialist care or hospitals). Presently 7 quasi-managed care organizations are in Hungary, one of them is polyclinic-led, two are hospital-led and four of them are primary care-led. Preliminary results of this project shed light on the possibilities how to improve effectiveness and efficiency in health care (e.g. reducing unnecessary and expensive examinations (CT/MRI), reducing spa and medical device utilization, and reducing long term hospital admissions, unnecessary referrals, using generic drugs more frequently and explore patient education to reduce A&E hospital admission). At the same time this managed care organization has spent more on home care, sometimes on pharmaceuticals if it reduce the hospitalization rate. These organizations developed their local guidelines and running continuous in-house professional development programs to promote cost-conscious prescribing. In general, these organizations were able to generate 5-10 % savings compare to the national average. The current government plan to expand the pilot up to 2 million populations (20 % of the population). If these organizations will become widespread in Hungary, it can slow down the expenditure growth.

### **Pharmaceutical, medical device and spa budget**

The most influential factors behind increasing healthcare expenditures are the following: (a) rapid market entry of new health technologies, (b) increased utilization, (c) increasing intensity of care and (d) switching to more expensive but not cost-effective technologies (Casado Marin, 2001). An example for switching to not cost-effective treatments was that Hungary increased the number of MS patients receiving publicly reimbursed interferon or glatiamer acetate medications, while the NICE (UK) guideline recommended not to use these medicines due to its high costs and low effectiveness. The key to long-term sustainability is proper regulation of utilization, reimbursement and diffusion of new health technologies.

During the transition new strong interest groups / stakeholders have been emerged in the healthcare arena, such as pharmaceutical companies, the medical device industry, private providers and private insurance companies, (Orosz, 2001) Their influence on healthcare spending became obvious in the last couple of years.

The fast diffusion of new health technologies represents a crowding-out effect inside the healthcare budget. For instance dialysis treatment for end

stage renal disease patients show a crowding-out phenomenon as their share in health insurance expenditure rose from 1.0 % to 1.9 % between 1994 and 2002. Other privatized and liberalized sub-markets, such as pharmaceutical, medical device or spa expenditures show same trends. (General spa treatment receives 85 % reimbursements, special spa treatment receive 100 % reimbursement.) As a result of these trends, the pharmaceutical, medical device and spa budget are practically uncapped, or suffering from significant deficit. (Schneider, 2000)

The introduction of the fourth hurdle (cost-effectiveness) in the determination of the subsidy levels will help to reduce expenditure growth rate, especially if reimbursement decisions are accompanied by cost-conscious clinical guidelines and clinical audit. The Ministry of Health has recently published the methodological guideline for health economic evaluations. From 2000, Government Decisions, i.e. 2329/2000 (XII. 21) and 1052/2001 (V.30) require that cost-effectiveness should be considered prior to granting public reimbursement to products at 90 and 100% reimbursement level. In practice, however, there is a lack of evidence how much role cost-effectiveness considerations actually play in the decision-making process.

In the managed care organization most physicians have an indicative budget, regular peer review and utilization review. It helps them to reduce the drug budget below the national average.

### **Impact of salary increase on liquidity**

The government increased the salary of health professionals by 50 %. Liquidity problem could arise especially in long-term if the government will further substantially increase the salaries of the healthcare professionals. The salaries in Hungary increased in real term in 2002; therefore the revenues from insurance contribution also increased, and the government increased its contribution to the Fund with 160 %. According to the modified 2002 state budget plan, the overall revenue of the fund increased with 11.4 %. The expected deficit will be less than 2 %. However the interim financial report in august 2002 showed considerably higher figures.

Without downsizing and structural reform the government might not be able to close the salary gap between the private sector and the public healthcare sector. If the salaries would go up to the private sector average, the public healthcare expenditures could increase with an additional 14 – 15 %. In this case the insurance fund without additional resources (contribution from the central government budget) would suffer from about 10-12 % deficit.

In long-term salary increase could impede liquidity partially due to the high recruitment into the medical schools. At the same time the turn over of the healthcare professionals expected to decrease, and more non-practicing

physician want to start medical practice. Without a strategic human resource planning the salary increase would lead a long term deficit and healthcare cost escalation in Hungary, because most of the newcomers can be employed in the secondary or the tertiary care and they could increase the intensity and utilization of relatively expensive health technologies.

The Health Insurance Fund could cope with the increased deficit due to the salary consolidation only if it exercises tough cost-containment methods in the reimbursement of pharmaceuticals, medical devices and diagnostic services and contract selectively for some services.

### **Executive management structure could hinder liquidity and impede necessary reforms**

The responsibilities between the Ministry of Health, the Health Insurance Fund, and the Ministry of Finance has never been well defined, as a result of which, there is poor co-ordination and regional planning, which led and could lead to parallelism and excess capacities.

### **Potential new role of private insurance companies and mutual funds**

Private health insurance might have a bigger supplementary role if the statutory health insurance reform will lead to a well-defined basic package, or rely more on cost-sharing and / or private insurance will cover variety of "comfort" (non-essential) services. In this case the private health insurance will have larger share in healthcare financing, but politicians avoided explicit rationing in the last decade. Explicit rationing always provoke widespread ethical, social and political debate, therefore defining what kind of services should be financed by the statutory system and what should be excluded, seems to be politically infeasible in the next couple of years. (OECD, 2001)

### **5.2.3 Health care policy and EU accession**

Health care systems of individual countries of the European Union vary substantially. Several countries such as the United Kingdom operate a National Health Service based on general taxation, while others; such as France or Germany operate a health insurance based system. Large variations are largely due to the fact that the organization of the health care system falls under the responsibility of individual member states. However, a few important areas in health care that are affected by the EU enlargement should be pointed out.

A particular problem is related to the cross-border access to health care. Since inpatient treatment, spa treatment, drugs and certain dental services are reimbursed at a flat rate by the Hungarian Health Insurance Fund, after the country will have become an EU member, Hungarian citizens will have

the opportunity to access these services in other member states. Currently most of the EU member states have generally higher quality care, but patients face the extra charges (paying the difference out of their pocket).

The expenditures of foreign in-kind tertiary services (mainly in Austria and Germany), which are fully reimbursed such as transplantations, cancer treatment, show a gradual increase in real term, and as percentage of the public healthcare expenditures (see Table 5.13).

*Table 5.13: Foreign tertiary care treatments reimbursed by the Insurance Fund*

	1998	1999	2000	2001
Foreign treatment	373	445	578.5	737.6
as % of the total in-kind expenditures	0.08%	0.09%	0.10%	0.12%

At the same, time it is possible that citizens of other EU member states will use certain services in Hungary, if the Hungarian provider is able to demonstrate that the services comply with EU standards. Thus, increased utilization might be expected in spa treatments, physiotherapy, dental services, ophtalmological services, probably some plastic surgeries. Cross border patient care is relatively frequent in the western part of the country, especially in dental care. It might be that the lower Hungarian prices will create financial incentives, because patient would not have to make co-payment, due to the lower prices.

However, potential negative effects might also be possible, since services used in massive amounts in foreign countries might endanger the economic viability of Hungarian providers, that might lose economy of scale, or if they are unable to see appropriate numbers of cases, the quality of their services might deteriorate.

The other negative effect would be the health professionals' migration especially nurses into Austria and Germany, or physicians into other countries too. If the government will not effectively tackle the "salary problem", the migration of the health professionals could become a permanent phenomena. Currently, no accurate data are available about the migration of health professionals.

Hungary has two bilateral agreements: Social security agreement between Hungary and Germany, promulgated by Act 30 of 2000 and applied as of 1 May 2000, and Social security agreement between Hungary and Austria, promulgated by Act 123 of 2000 and applied as of 1 January 2001. This agreement can be seen as test, which can facilitate the smooth acquisition, since the implementation of both bilateral social security agreements rely on forms and procedures that are used in the EU. These two social security

agreements are of very high importance as these prepare Hungary for the harmonization of its social security procedures for EU enlargement.

The adaptation of the EU law also creates some challenges for health care within Hungary. Although, EU regulations in most areas, such as those on medical training or drug regulatory procedures, have already been adapted, the practical and full implementation of the EU competition law in the health system requires further changes. An important example is the implementation of regulations on working hours and overtime. Currently, some smaller hospitals with shortages in staff may not be able to meet these regulations in the short run. The EU regulations affecting the operation of hospitals, however, might also be seen as an opportunity by the Government to reduce excess capacities and provide better working conditions for the medical professionals, and consequently better care for the patients.

### 5.3 Evaluation of recent and planned reforms

#### 5.3.1 Recent reforms and their objectives

The following table provides a brief chronology of reforms since 1987 until today. The table highlights the year of the reform steps, a brief description of the reform, and the objectives that the reforms intended to achieve.

*Table 5.14: Chronology of health care reforms in Hungary*

	<b>Reform steps</b>	<b>Aim of the reform</b>
1987	Experiment on HDG launched in 26 hospitals, National Health Promotion Program announced Reform Secretariat set up	Fee for service reimbursement
1989	Private practice authorized	Market liberalization
1990	Switch from tax-based funding to compulsory insurance	To secure earmarked funding for health care and to introduce a split between purchaser and providers
	The 1990 Local Government Act changed the division of responsibilities between central government and local government. The ownership of the primary care surgeries, outpatient clinics and hospitals was devolved from the central government to local government. Central government retained ownership of some tertiary services such as University hospitals, National Institutes, Blood Provision Services, Public Health and Infection Control.	Decentralization

Table 5.14 continued

	<b>Reform steps</b>	<b>Aim of the reform</b>
	New system of consensus management in hospitals introduced	Increase efficiency
1991	Establishment of National Public Health Service (responsibility for local hygiene stations transferred from local governments)	Improve public health services
	Ministry of Welfare issues "Action Program" in June to supplement Government's National Renewal Program	Facilitate transition.
1992	Social Insurance Fund separated into a Pension Fund and a Health Insurance Fund	Increase transparency and accountability
	Parliament accepted the public servant act, which create similar protection than the civil servants position for employees working in the state administration.	Stabilization
	Parliament eliminates universal entitlement to healthcare and defines conditions for eligibility	Insurance system
	Insured people are entitled to freely choose their family doctor.	Enhance consumer choice
	Family Physician Service is created and capitation-based payment introduced. Postgraduate training for general practitioners became compulsory.	Strengthen primary care services
1993	Voluntary non-for profit mutual health insurance funds (supplementary insurance operated by non-profit institutions) were authorized	Strengthening the insurance market.
	First election of members of Self-Governments of Social Insurance Fund with employer and employee representation	Expand electoral system to health care administration
	Outpatients care remuneration based partly on a fee-for-service scheme, and acute inpatient services reimbursed using DRG.	Performance-based finance system to increase efficiency
1994	The Act on the Hungarian Medical Chamber	Market regulation
	New National Health Promotion Strategy is adopted by the government	Improve the health of the nation
1995	Hospital capacity reduction program initiated	Cost-containment
	The economical stabilization package introduced in 1995–1996 increased cost sharing (e.g. dental services became 0% reimbursed)	Cost-containment

Table 5.14 continued

	<b>Reform steps</b>	<b>Aim of the reform</b>
1996	<i>Act LXIII of 1996 on norms of hospital capacity</i>	Hospital capacity reduction, 18 000 beds (15% of bed capacity) were removed
	<i>Decree No. 19/1996. (VII. 26.) NM of the Minister of Welfare on the Minimum Standards of Certain Institutions Providing Health Services</i>	Quality improvement
1997	The 1997 <i>Health Act</i> .	public health approach, strengthening patients rights
	The 1997 <i>Health Insurance Act</i>	Redefine entitlement, and coverage policy
1998	Abolition of the Health Insurance Self-government	Improve efficiency of the administration
	Separated the Ministry of Social affairs and the Ministry of Health	Provide more attention to social affairs
1999	Pilot project on managed care launched	Financing reform
	<i>Act XLII of 1999 on the Protection of Non-Smokers</i>	Improving health of the nation
2000	Privatization of the practices of general practitioners	Improving efficiency
2001	New 10 years Health Promotion and Prevention Program started.	Health promotion
	Hospital and outpatient centers privatization	Allow hospitals to transform into public –utility companies
2002	Depreciation costs gradually will be introduced, starting in primary care.	Improve management
	Publication of the methodological guideline for economic evaluations in Healthcare	Improving efficiency and value for money

### 5.3.2 Political directions of future reforms

#### Informal payments

It is possible that government will tackle informal payments system, because it is undeclared (untaxed) income, makes few senior physicians very rich. Usually these small proportion of physicians could obstruct any reform which targeting informal payments. Informal payment system, as a fee for services payment system created incentives for provider moral hazard, where it is afforded (mainly surgical interventions, and expensive diagnostic technologies, where significant waiting lists exists). Salary increase itself will not solve the problem, because informal income of a surgeon could be

three or four times higher than a salary equal the private sector average. (Bognár et al, 1999)

### **Strengthening pharmaceutical and medical device regulations**

Cost escalation could not be prevented if the government avoid tackling the informal payments and substantial individual sponsorship (business trips, expensive gifts, etc) to the senior physicians offered by the industry.

The current 3-year contract (a contract between the government and the pharmaceutical manufacturers signed for years 2000-2003. This contract regulates the price increase (less than 70 % of the annual inflation), but also contains reimbursement rules). According this contract between the government and the pharmaceutical industry, there is less opportunity of price competition between the generic and the patent products (It is required that the new generic product should have minimum 5 % market share for becoming a reference product). It is expected that in the future government will not automatically renew the contract with the same conditions.

It is possible that pharmaceutical and medical device exempt scheme will be revised. The former government (1998-2002) elaborated a new system, but implementation was postponed. The local government who is meantesting the entitlement has no incentives to ration the entitlements. Providers criticized the scheme because usually low-price rather than cost-effective drugs are on the lists.

According to the EU harmonization, the government plans to put VAT on pharmaceuticals. The current significant opposition by interest groups made the implementation deadline for 2004. VAT increase the drug prices with 8-12 %, and could increase cost sharing in this market. As a result utilization could reduce with 1-2 % (depending on the price-demand elasticity of the products).

### **Expanding the quasi-managed care organizations**

In the last two years quasi-managed care organization in Hungary were able to generate savings compare the non-managed care organizations. It is expected that the government will relax the current limitations (maximum number of enrollee is 0.5 million, and set a ceiling at 2 million population). The limit should be approved by the parliament. It is expected that the modification will be submitted by the end of this year to the parliament. The Insurance Fund will call for proposals at the beginning of the 2003. Quasi-managed care organizations apply and the best applicants contracted with the insurance fund. The Advisory Board, encompass delegated members of the Ministry of Finance and Health as well as from the Insurance Fund, selects the best applicants using preset criteria and allow eligible applicants to start their operations.

**Reducing the medical school admission rate**

The long term cost-containment and structural reform make it necessary to reduce the unnecessary overproduction of physicians. At the same time, it is equally important that nurses are trained and kept in their profession.

**5.3.3 Conclusions**

Since 1989, a number of important changes have been implemented in the Hungarian healthcare system particularly in relation to its finance structure. The current Hungarian healthcare system at the macro level is very similar to other OECD countries, having universal coverage and dominant public funding about 70% of expenditure. Most of the problems are very similar to other European countries, including challenges of cost-containment, perverse incentives, lack of efficiency, and quality of care.

Earlier OECD reports agreed that there is no need to implement a new or more complex financing system in Hungary. The weaknesses of the current single pipe system are outweighed by its advantages. The Hungarian legal regulations allow for supplementary insurance to offer different kind of health insurance. The system using the capped budgets reached efficient macro-level cost-control except for the pharmaceutical and medical device budgets.

Uncapped pharmaceutical and medical device budget, low salary and unbalanced structure of medical personnel, growing regional inequalities in utilization of health care, the significant impact of informal payments on efficiency and access to health care are the key areas where the government should strengthen its regulations and implement new reforms.

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