

**National follow-up report of
the Madrid International Plan of Action on Ageing (MIPAA) and
the United Nations Economic Commission for Europe (UNECE)
Regional Implementation Strategy (RIS)**

REPUBLIC OF HUNGARY

Budapest, 2007

Table of Contents

Concise summary of the follow-up report of the Madrid International Plan of Action on Ageing (MIPAA) and its Regional Implementation Strategy (RIS) / Republic of Hungary	3
0. General information	7
1. Elder affairs: Activities and priorities	8
a) The current situation: Elder affairs and ageing	8
b) Legislative environment.....	12
c) Identifying areas that require detailed appraisal.....	14
2. Methodology used for the detailed appraisal of identified priorities.....	15
3. National capacities in monitoring MIPAA/RIS	15
4. Review and appraisal by specialized area	16
RIS COMMITMENT 1: TO MAINSTREAM AGEING IN ALL POLICY FIELDS.....	16
RIS COMMITMENT 2: TO ENSURE FULL INTEGRATION AND PARTICIPATION OF OLDER PERSONS IN SOCIETY	17
RIS COMMITMENT 3: TO PROMOTE EQUITABLE AND SUSTAINABLE ECONOMIC GROWTH IN RESPONSE TO POPULATION AGEING.....	23
RIS COMMITMENT 4: TO ADJUST SOCIAL PROTECTION SYSTEMS IN RESPONSE TO DEMOGRAPHIC CHANGES AND THEIR SOCIAL AND ECONOMIC CONSEQUENCES...	24
RIS COMMITMENT 5: TO ENABLE LABOUR MARKETS TO RESPOND TO THE ECONOMIC AND SOCIAL CONSEQUENCES OF POPULATION AGEING	25
RIS COMMITMENT 6: TO PROMOTE LIFE-LONG LEARNING AND ADAPT THE EDUCATIONAL SYSTEM IN ORDER TO MEET THE CHANGING ECONOMIC, SOCIAL AND DEMOGRAPHIC CONDITIONS.....	27
RIS COMMITMENT 7: TO STRIVE TO ENSURE QUALITY OF LIFE AT ALL AGES AND MAINTAIN INDEPENDENT LIVING INCLUDING HEALTH AND WELL-BEING.....	28
RIS COMMITMENT 8: TO MAINSTREAM A GENDER APPROACH IN AN AGEING SOCIETY	31
RIS COMMITMENT 9: TO SUPPORT FAMILIES THAT PROVIDE CARE FOR OLDER PERSONS AND PROMOTE INTERGENERATIONAL AND INTRA-GENERATIONAL SOLIDARITY AMONG THEIR MEMBERS.....	32
RIS COMMITMENT 10: TO PROMOTE THE IMPLEMENTATION AND FOLLOW-UP OF THE REGIONAL IMPLEMENTATION STRATEGY THROUGH REGIONAL CO-OPERATION...	33
5. Conclusions and looking towards the future	35
ATTACHMENTS AND ANNEXES	36

Concise summary of the follow-up report of the Madrid International Plan of Action on Ageing (MIPAA) and its Regional Implementation Strategy (RIS) / Republic of Hungary

Methodological background

In compiling this Report, we have relied on data and analyses from the Hungarian Central Statistical Office as well as on numerous laws, studies, proceedings, practical manuals and reports written within the framework of the “Programme for Active and Dignified Ageing”.

We specifically organized three monitoring sessions with the involvement of an external facilitator, attended by members and leaders of senior organizations, cultural and social practitioners, local government experts, entrepreneurs providing services to the elderly and members of the Council for Elder Affairs.¹ The participants focused on three topics in detail: How to achieve the social integration and participation of the elderly; Participation of seniors in leisure activities, vacationing, culture, and sports; and evaluation of the work of the Council for Elder Affairs and its affect on the quality of life of older generations between 2002 and 2007.

Recordings and a written summary of the monitoring sessions were prepared. Opinions expressed by participants were included in the report in two forms. The essential points of the appraisal, the detailed appraisal of the areas singled out, the conclusions, and the proposals, were formulated with a mind to what was stressed during the discussions at the meetings. Direct quotes have been included in the report, in boxes.

Detailed contributions to the Report were prepared by the Ministry of Health, and by specialist departments at the Social Policy State Secretariat, the Employment and Training State Secretariat, and the departments of the Equal Opportunity State Secretariat of the Ministry of Social Affairs and Labour.

Review and appraisal of the national progress achieved in meeting RIS commitments - priority directions

The first area we focused on in our report was ‘*The integration and social participation of senior citizens*’. The combination of the Madrid International Plan of Action on Ageing and measures of harmonisation of legislation in the process of our accession to the European Union resulted in a major shift in societal-level publicity and in the operation of our NGOs. Government bodies now treat elderly people as their partners, both when they appear as individuals and within organizations. To increase incentives to elderly people to contribute to society and to recognize their contributions, in 2005 the Minister of Youth, Family, Social Affairs and Equal Opportunity established an award called ‘For Older Persons’. Older people, acting either as individuals or as members of their interest groups can voice their opinions on the services they are provided with through organized channels and administrative forums. This is assisted by the Elder-Friendly Local Government Award established in 2004 by the Minister of the Interior and the Minister of Youth, Family, Social Affairs and Equal Opportunity. The elderly may now establish local governments of care-recipients in social institutions and, if their rights are violated, they have been able to turn to the staff of the independent Public Foundation for Patients’ Rights, Care Recipients’ Rights and Children’s Rights since 2004.

Act L of 2003, which established the National Civil Fund Program, created funding for the operation of civic organizations and provided for equal access to the funds. A new feature is that the civic organizations are charged with making their decisions in a manner that is free from government

¹ See attachment for detailed list

influence. Some 20 billion forints in grants were awarded to foundations and associations that submitted successful bids between 2004 and 2007.

The Act on the National Civil Fund Program is currently under review for amendment with the intention of strengthening the role of the NGO sector. Government Decree 1138/2002 (VIII.9.) Korm², which increased the role of the *Council for Elder Affairs*, gave new impetus to NGOs representing senior citizens. Operating alongside the government, the Council is a consultative, advisory, and proposing body. The Council has 20 members, 13 of who represent national advocacy groups for elderly persons and 7 are assigned to the Council as experts. Following the national example, many county and municipal governments have established their own councils of elder affairs and the Ministry of Defence as the economic sector with the largest number of retirees, has established its own sectoral council for elder affairs. The numerous opportunities for synergic cooperation mean even more to us than the simple existence of these organizations. Of course, increasing opportunities to act has created new demands, so the Ministry Youth, Family, Social Affairs and Equal Opportunity devoted 50 million forints (HUF) between 2004 and 2006 to NGOs that support the senior citizen intergenerational and intra-generational projects called “Active Ageing,” as well as 115 million forints for computer courses in 2003 and 2004. Elder organizations expect additional help for their operations on local and national levels, the social aspects of which are far more emphatic than their aspirations for a political role.

Integrated communities grouped by age operate primarily in smaller settlements and within professional and art groups. There are many programmes to promote intergenerational cooperation indirectly but offering direct incentives could result in pseudo-communities that come together solely for the money and quickly collapse. Act LXXXVIII of 2005 on voluntary activities in the public interest has helped to gain recognition for voluntary work, and retirees play a significant role as volunteers in consumer protection and crime prevention. In addition, the organizations that handle the bulk of the tasks of current communities of retirees are made up of volunteers. “Integration” of new retirees into pensioner society is a special challenge. Their activeness in public and economic life and the generation of programmes that assist seniors in living actively, as well as in setting active seniors as examples by presenting them in the media, can make a major contribution to shaping a positive social image of ageing.

Adjusting social protection systems is the second priority direction

In Hungary, social protection systems are continuously adjusted to meet social and demographic changes. This means that certain forms of benefit and support are terminated while others are expanded, and still others, more targeted, are introduced. Under Act III of 1993 on Social Administration and Social Benefits, local governments have the right to determine exactly who in their communities are eligible to receive cash benefits and in-kind benefits. Often they also determine how much these people receive, through the following vehicles: old-age annuity, regular social assistance, support for home maintenance, carer’s allowance, temporary assistance, funeral assistance, provision of public funerals, medically indigent care, and eligibility for healthcare services.

From the above, we want to focus on old-age annuity that offers assistance to persons who are over retirement age and do not have sufficient income to provide for their own subsistence. In 2006, on average 6,230 people/month were provided with this assistance.

Among services accessible to elderly people, we would emphasize the village caregiver service, unique in Europe, aimed at reducing the disadvantages of living in small settlements where there is a lack of institutions.

² The Government Decree is included in the attachment

The introduction of a 13th month's pension payment during the period under investigation will help improve pension recipients' living standards. Act CLXXIII of 2005 was intended to alleviate injustices in the amounts of pensions paid by increasing pensions set in different years in a differentiated manner, above and beyond the annual scheduled pension rises. In five years, this programme will increase pensions by over 130 billion forints, to make the various pension proportions fairer and the lives of several million elderly people more secure. In an effort to correct the disproportionate incomes of men and women, in 2006 the law called for a 3 percent increase in pensions for men if the initial amount was awarded before 1988 and a 5 percent increase in pensions for women whose pensions also date from before 1988.

The third priority direction concerns preparing the labour market to manage the economic and social consequences of an ageing population

In helping older workers to find jobs, Act CI of 2001 on adult education, which has been amended on several occasions, stipulated that there can be no age ceiling on supports available to people attending professional, language or general training courses. In fact, on a transitional basis, in 2005 and 2006, people over the age of 50 years – in certain occupations – were allowed to train for a second skill free of charge. About one billion forints a year was available to help county employment centres to train older workers and support them in subsequent jobs. Thanks to central programmes to help people over the age of 50 years to find work, 390,000 people found jobs in 2005 and 2006.

In order to promote employment, Decree 6/1996 (VII.16.) MüM of the Minister of Labour on assistance to promote employment was amended in 2003 to expand support to employers who employ people over the age of 45 years. With respect to community service jobs, the employing entity is allowed better than average conditions for this group. Since 2004, employers who hire a person over the age of 50 years who has been jobless on long term do not have to pay health tax levied on the payroll. Since January 1, 2005, there has been a favourable change in the rate of reduction in contribution-payment that an employer may claim when employing a jobless person over the age of 50 years. As of January 1, 2007, Act IV of 1991 on Job Assistance and Unemployment Benefits was amended – in keeping with Regulation (EC) No 2204/2002 – to qualify job seekers over the age of 50 years as disadvantaged employees; thus employers receive 50 percent support to the wages and payroll taxes.

The Human Resources Development Operational Programme includes a wide variety of measures. Programmes within it support disadvantaged persons including older jobless persons, people at risk of joblessness, and people living in backward regions. They receive support in seeking work and some training support. Several projects target registered permanently jobless persons over the age of 45 years for assistance.

A measure intended to increase the age at which people retire and introduced in 2004, consists of granting people a pension increase of 0.5 percent after every 30 days they remain on the job if they continue working after reaching retirement age and do not claim their pensions. Another programme, called Premium Years, is intended to promote gradual retirement. Under it, civil servants and public employees who lose their jobs because of downsizing and are close to retirement age have the opportunity to maintain their status as “employed” with reduced incomes and shorter working hours until reaching retirement age. This programme was extended to the private sector in October 2005, and as of December 31, 2006, there were 519 people in the Premium Years programme.

Review and appraisal of the national progress achieved in meeting RIS commitments – other directions

A comprehensive process including government reform, economic reform, and healthcare and education reform is underway in Hungary. Within this reform process the two population groups the Government has been paying particular attention to are elderly people and children, while also focusing on reducing differences in social and healthcare services, as well as in education and culture across regions and communities.

In the following, we focus on the measures already implemented that demonstrate compliance with the commitments undertaken as part of the Madrid International Plan of Action on Ageing.

As laid down in Government Decree 362/2004 (12. 26.) Korm, the Equal Treatment Authority monitors implementation of the requirement for equal treatment as an entity with nationwide authority. If the requirement for equal treatment is violated, the authority has the power to investigate to determine whether discrimination has occurred. If the requirement for equal treatment has been violated, the authority takes a decision to apply sanctions. Complaints about age discrimination are almost exclusively related to the world of work. Since 2004, the requirement for equal treatment in remuneration for work must be adhered to. Hungary devoted significant amounts from European Social Fund resources between 2004 and 2006 to improving the employment situation of women and promoting family-friendly workplaces.

The draft strategy for lifelong learning designed by the Hungarian Government in 2005 is intended to improve the current education system on short term, by enabling it to immediately meet labour market demands (increased participation in adult education, training and extension training for people with low education levels, training for people over the age of 55 years).

About 1,000 people over the age of 50 were able to undergo vocational training using the capitation support granted to adult education, receiving 150 million forints in support overall.

Many programmes were started up in the past five years to help train people over the age of 55 years, principally in promoting skills with information technology tools. Many local governments and major corporations joined these programmes. One pilot-project involves retirees helping to train their peers, which if successful, can live up voluntary work and other alternative forms of training among pensioners.

In the social area, Parliament adopted a law promoting multipurpose associations in sub-regions, aimed at reducing unjustified social and regional inequalities by encouraging associations conducive to economies of scale.

The Hungarian National Vacation Fund offered support for six thousand retirees to participate in therapeutic holidays in 2002, a number that gradually increased to over ninety thousand in 2006, at a cost of over three billion forints.

There are a number of legal institutions in Hungary promoting the responsibility of family members for one another. They include ones that focus on the values of intergenerational reciprocity and solidarity. As of 2002, childcare allowance available to grandparents can be granted to grandparents who receive pensions, and as of 2006, grandparents may receive the childcare allowance even if also receiving regular social assistance of a pension variety.

Unbearable family burdens will also be reduced by a 7,500 bed increase in facilities caring for patients with chronic disorders (who are, for the most part, elderly), within the framework of a hospital development programme. Carer's allowance is a financial contribution to assist an adult family member who remains at home to care for a person in the household with a chronic illness. This has been a part of the system of social supports for over 15 years, and entitlement conditions have been expanding steadily over the years.

Hospice care includes assisting family members of a terminally ill patient in caring for the patient and in offering emotional support to them and their families during the period of illness and mourning.

Conclusions

In the light of the Madrid International Plan of Action of Ageing and its Regional Implementation Strategy, the quality of life, income situation and social integration of older generations have changed on multiple levels in Hungary. Measures to safeguard rights, to expand services, and to increase income and resources have focused equally on individuals, non-governmental organizations, communities and various strata within generations alike. As a result, a turning point in elder affairs has become tangible, from two points of view. The current reform underway in the major social systems is targeting access that is more equitable for all. This reduces the risk that elderly people living alone in small settlements will be abandoned when in a difficult situation, or of receiving much worse care than a similar person living in a large city. These measures not only improve the level of care but also contribute to boosting intra-generational solidarity. At the same time, a more definitive presence of increasingly active older persons, who are present in a growing number of arenas of day-to-day life (people accessing the Internet, enjoying vacations, participating in sports, playing roles in public life) is promoting intergenerational cooperation and solidarity. These two conditions offer a sure social foundation for continued fulfilment of the Plan of Action.

0. General information

Name of country

Republic of Hungary

Name(s) of author(s) of this report:

Judit Ágnes Szabó, deputy head of department; Zsuzsanna Chirer, chief counsellor; Dr. Teréz Sütő, advisor, member of the Council for Elder Affairs

Author(s) of this report may be contacted through:

Ministry of Social Affairs and Labour, Equal Opportunity Department/Elder Affairs
Secretariat

H-1054 Budapest, Akadémia u. 3. Tel: (36-1) 475 5710 Fax: (36-1) 312-7842 E-mail:
idosugy@szmm.gov.hu

Address of Dr. Teréz Sütő: Sopron, Kertvárosi u. 14. E-mail: Suto_@axelero.hu

Name and accessibility of official elder affairs focus point:

Ministry of Social Affairs and Labour, Equal Opportunity Department/Elder Affairs
Secretariat

H-1054 Budapest, Akadémia u. 3. Tel: (36-1) 475 5710 Fax: (36-1) 312-7842 E-mail:
idosugy@szmm.gov.hu

Names, references and dates of adoption or expected dates of completion of the national strategy, the plan or action or of other similar political documents on elder affairs

List of the organizations participating directly in preparing this report, and contact information	Attachment 1
List of organizations participating in the MIPAA/RIS follow-up and contact information	Attachment 2
Hungarian Charter on Elderly People , 2001	Attachment 3
Legislation on the operation of the Council for Elder Affairs, 2002	Attachment 4
Annual work plans of the Council for Elder Affairs, 2003-2007	Attachment 5
National Action Plan on Social Inclusion (2004-2006)	Appendix 1
[3.4.2 Activation and dignity for the elderly, page 52-54]	
National Strategy Report on Social Protection and Social Inclusion (2006-2008)	Appendix 2

1. Elder affairs: Activities and priorities

a) The current situation: Elder affairs and ageing

Demographics

Hungary's population has been declining for a number of decades. In 2005, the number of residents was 10,097,500, a drop by 2.3 percent compared to ten years earlier. With slight fluctuations, the population has been going down by over 20,000 people a year. Natural population movements have played the major role in this, yielding a negative balance of 38,200 people a year. This is counterbalanced by a 17,300-person/year positive immigration balance. The number of people aged 24 years and under declined at a rate that significantly exceeds the overall population drop. This group currently makes up 28.7 percent of the overall population, 5.4 percent less than ten years ago. During this same period, the rate of people aged 49 years and over grew by 4.3 percent to 35.3 percent of the overall population

Number of population by age group and gender as of January 1, 2005, capita

	0-4	5-9	10-14	15-19	20-24	25-24	30-34	35-39	40-44
Males	245,305	258,131	306,066	323,730	350,875	431,966	382,022	342,196	303,818
Females	232,539	244,997	292,659	310,598	336,821	414,201	370,697	336,735	310,409
Total	477,844	503,128	598,725	634,328	687,696	846,167	752,719	678,931	614,227
	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-X
Males	357,226	369,907	292,881	252,197	191,270	165,068	117,864	70,574	32,019
Females	380,855	409,048	341,747	322,324	282,419	263,022	220,067	153,995	81,301
Total	738,081	778,955	634,628	574,521	473,689	428,090	337,931	224,569	113,320

Since 1949, the average age of the population has increased by 7.7 years, being 40.1 years as of 2005. A demographic projection indicates that the average age will continue to increase, reaching 41 in 2010, 44 in 2030, and 46.4 in 2050.

Population numbers in key age groups, capita

	2010	2020	2030	2040	2050
0-14 year- olds	1,489,536	1,493,430	1,387,065	1,258,570	1,210,165
15-64 year-olds	6,857,114	6,414,305	6,142,106	5,761,334	5,185,184
65+ year-olds	1,666,827	1,958,301	2,064,885	2,167,137	2,346,196
Total	10,013,477	9,866,036	9,594,056	9,187,041	8,741,545

Looking at demographic dependency rates, we have seen a steady decrease in the rate of 0-14-year-olds compared to the 15-64-year-olds, combined with a rise in that of 65+ year olds. Projections into the future indicate that the rate of the former will halt its decline and even improve somewhat, while the growth rate of the latter will remain slow for a time and then accelerate.

Demographic dependency rates

	1949	2001	2010	2030	2050
0-14/15-64 year-olds	0.368	0.243	0.214	0.227	0.231
65-X/15-64 year-olds	0.111	0.222	0.241	0.331	0.473

Within the elderly (65+) age group, the rate of people over the age of 80 years has nearly doubled during the past half century. In 2005 this age group accounted for 21.4 percent (as against 11.2 percent in 1950, 16.6 percent in 2000, and percent in 2050).

Life expectancy at selected ages, by gender, 2004

Age (years)	0	1	20	60	80
Males	68.59	68.09	49.44	16.06	6.01
Females	76.91	76.36	57.59	20.86	7.03
Total	72.78	72.26	53.55	18.72	6.68

The total fertility rate has declined by half since the 1950s. As of the mid-1990s, it still exceeded the average for the EU-15, but by today it is significantly lower. During this same period, the net reproduction coefficient also declined by nearly half.

Total fertility rate and net reproduction coefficient

	1949	1960	1970	1980	1990	2000	2004
Overall	2.54	2.02	1.97	1.92	1.84	1.33	1.28
Net	1.060	0.917	0.912	0.909	0.889	0.635	0.618

Incomes

In 2005, the equivalent available income was 984,110 forints (about 3,936 Euros). The indicator S80/S20 (the ratio of the uppermost to the lowermost income quintile) showing the inequality of income distribution has a value of 4. According to the various indicators, the poverty risk of the elderly is lower than the poverty risk for the overall population below the age of 65 years (60 years). This is triggered by the fact that pensions are a sure and reliable income, in contrast with the income fluctuation of people of economically active age who are vulnerable to the uncertainties of the labour market. There are less extreme income inequalities among older people than the nationwide average. The largest groups of retirees are in the middle (or higher) income deciles.

The largest component of the monthly incomes of people aged 65 years and older is pensions. For people in the third and fourth income quintiles, pensions make up 81 and 82 percent of monthly incomes with 15 and 16 percent respectively derived from work and 2 and 3 percent from other sources. For retirees in the second and fifth quintiles, pensions made up three-fourths of income, while 21 and 23 percent comes from work. In the group in the uppermost quintile, 5 percent of income

comes from other sources, while in the second quintile, 2 percent is from other sources. An additional 2 percent of income in this latter group comes from social benefits. Among people aged 65 years and older who are in the lowest quintile, 68 percent of income is from pensions, 23 percent from work, 7 percent from social benefits and 3 percent from other sources.³

The poverty rate, calculated at 60 percent of the median income, is 13.4 percent in Hungary. Among the elderly, the poverty rate is significantly below the population average (it is 10.1 percent for people between the ages of 50 and 64 year, and 6.5 percent for people over 65 years). As far as the various age groups are concerned, children are in the worst situation (19.5 percent for the 0-15-age-group). For the population as a whole the relative median poverty gap is 18.8 percent. Among the elderly, this rate, as measured, was also significantly below average (9.3 percent for people aged 65 years and more).

In 2006, the minimum old-age pension was increased to 25,800 forints. The value has shown a decline over the past decade compared to both the average pension level and the minimum wage. In 2006, the per capita average monthly old-age pension was 69,145, which is 63 percent of average nationwide net earnings.

As of January 2005, the benefits received by 62 percent of pensioners were less than the average pension amount. Within that, nearly 10-13 percent received pensions that were barely over the minimum pension.

As of January 1, 2006, some 75 percent of pensioners aged 62 years and older received old-age pensions while 17.4 percent received disability pensions after having reached retirement age, 1 percent received disability pensions below retirement age and 6.5 percent received widows'/widowers' pensions. In 2004, fully 44.9 percent of social protection expenditure was devoted to pensions.

The Hungarian pension system does not offer automatic guarantees against poverty in old age. This goal is met through a social protection system that offers supplementary assistance – means tested – that is part of the pension system. An old-age annuity may be applied for if needed. It is means tested. A person is entitled to this social transfer if he or she has not earned the right to his or her own pension or if the amount of that pension is below a set level. The support may be applied for after reaching full retirement age, if the per capita income of the person and spouse together is less than 80 percent of the current minimum pension, or for a person who lives alone, if it is less than 95 percent of the minimum pension. The allowance for the elderly will increase low incomes to minimum pension level.⁴ In 2005, the gross replacement rate of the index comparing average incomes and pensions was 65.6, while the net replacement rate was 101.7. The gross rate is expected to rise after 2010, but the net replacement rate will decline in parallel.

Labour market and economic activeness

The economic activeness of the older population declined continuously through most the 1990s, but began to increase as of 1998. This is partly due to an increase in the proportion of the elderly within the overall population, but also reflects a growth in their active participation in the workforce. The proportion of economically active persons among the 55-64 age group rose from 17.65 percent of the age group in 1997 to 33.8 percent in 2005, while the proportion of economic activeness among the 25-54-year-olds, the group considered to be the most economically active, hardly changed.

The employment trends of the 1990s are similar to the ones appearing since them. Among 55-64-year-olds, the proportion who is employed doubled between 1998 and 2005. In 1998, the proportion of 55-64-year-olds employed was less than one-fourth the proportion of the 25-54-year-olds, while in 2005 it was nearly half.

Proportion of employed persons by age group, %

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
25-54	70.2	69.8	70.3	72.3	73.0	73.1	73.0	73.7	73.6	73.7

³ Data are from 2002

⁴ As of January 1, 2006, the allowance for the elderly raised the incomes of single elderly people over the age of 75 to 130 percent of the minimum old age pension, assuming that their monthly income did not reach this level without the allowance

55-64	17.7	17.7	17.3	19.4	22.2	23.5	25.6	28.9	31.1	33.0
-------	----	----	------	------	------	------	------	------	------	------	------	------

Among the older persons, the number and rate of the economically inactive dropped from nearly 83 percent to 64 percent, while the inactive rate of the 25-54-year-olds barely changed, from 22 percent to 21.

The unemployment rate among 55-64-year-olds is not significant. It has been about 1 percent for a number of years, while among the 25-54-year-olds it has dropped from nearly 7 percent to about 5 since the early 1990s, notwithstanding a bit of fluctuation.

The real average age at which people tended to leave the labour market was 57.6 years in 2001, 61.6 years in 2003, and 59.8 years in 2005.

Among the 55-64-year-olds, 52,057 people attended some form of training in 2003, of which 539 attended some sort of school. The people in training programmes made up 4.5 percent of their age group and 15.1 percent of the economically active portion of this age group.

Social protection and financial sustainability

The ratio of median income from pensions received by retirees aged 65-74 years in their own right to the median incomes of working people aged 50-59 years (excluding social benefits of a non-pension nature) is 71. For males the figure was 69, for females it was 81. In 2004, the minimum pension amounted to 40 percent of the average old-age pension. The guaranteed minimum pension requires payment of at least 20 years of contributions.

The S80/S20 indicator of inequalities in income distribution (it is the ratio of the uppermost and lowermost income quintiles) yields a value of 4. Among older age groups, the value of the indicator is lower, and the value declines as inequalities and age grow (over the age of 60 years it is 2.9 and over 70 years it is 2.7). Looking at the age of the head of household, the non-income-based deprivation index is mildly U-shaped, but the rate increases in value above the age of 70 years. Here the deprivation risk is 1.58 times the average. Inequality indices for males are higher in all age groups.

Among the elderly, income inequalities are typically lower than the nationwide average. The largest groups of retirees are in the middle (or slightly higher) income deciles. In January 2005, benefits provided to 62 percent of pensioners were lower than the average pension. Within that, about 10-13 percent of them had pensions that were only slightly over the minimum level.

The pension system in Hungary rests on two pillars – making it a mixed system. Three-quarters is made up of a pay-as-you-go social insurance system and the remaining quarter is a mandatory fully funded system with individual accounts. In other words, the first pillar consists of funds flowing into and out of the state treasury while the second consists of private insurance payments. An investigation of contributions and pensions received made retrospectively discovered that the largest net payers into the system throughout their careers were people born between 1940 and 1955, while the net loss for younger age groups showed a constant decline. To guarantee the stability of the pension system, the government mandated that people just entering the workforce join private pension insurance funds. In connection with intergenerational solidarity, we need to mention that providing supplementary entitlements within the framework of the pay-as-you-go system principally affected inactive females and offered subsistence to low-income widowed females.

In 2005, pension expenditure amounted to 10.7 percent of GDP. Forecasts indicate that by 2050 this type of expenditure will grow by 60 percent. This increase will be due to dependence rate in 79.4 percent, unemployment rate in 10.3 percent, the take-up ratio in 33.4 percent, and the benefit rate with 16.3 percent. According to forecasts, a higher employment rate in general and a higher employment rate among older workers could have a noteworthy effect on pension spending in Hungary. (In the order mentioned, the value of the rates is -0.7 and -1.1). According to preliminary calculations, the assets in all pension schemes as a share of GDP will grow steadily to 2050 and the value should come

to 73.7 percent. Age-related expenditure (pensions, healthcare spending, costs of long-term care) will decline as a proportion of GDP by 2050.

The System Dependency Ratio of the pension regime is 73. Forecasts indicate that the significant deficit will be evened out after 2040, and by 2050, the number of contributors should exceed the number of pensioners.

About 30 percent of the life cycle of males and females is spent at school. However, males spend 52 percent of their lives working while females spend only 43 percent, which means that males spend 18 percent of their lives in retirement while females spend 26 percent.

As far as gender is concerned, the Hungarian pension system guarantees complete equality to both genders (retirement age for both males and females is 62 years). These equal conditions evolved gradually (males became entitled to widowers' pensions and to childcare benefits). Currently, females are entitled to certain preferences, depending on the year in which they were born.

b) Legislative environment

In recent years, legislative practices related to elderly persons are threefold⁵:

Promoting transparency, gaining a public eye and boosting the participation of NGOs and within this of older persons in civic society

In order to establish greater government transparency and assure easier and faster access by citizens to data of interest to the public, the Parliament of the Republic of Hungary adopted *Act XC of 2005 on the Freedom of Information by Electronic Means*, which mandated that the central administration maintain its own website. Other administrative bodies were allowed to decide whether to maintain websites jointly with other bodies or put their data on websites operated by their supervisory and/or coordinative body.

The passage of *Act L of 2003 on the National Civil Fund Program* was of special importance to the development process of the Hungarian NGO sector. A new feature was to free them from government influence and to allow NGO decision-making. Organizations submitting bids for assistance can be certain that their bids will be judged by the members of the bodies they themselves elected. Thus, the NGOs essentially make their own decisions on the distribution of the funding available to them.

In the period between 2004 and 2007, about 20 billion forints in grants has been distributed to foundations and associations that submitted successful bids. An amendment to the Act on the National Civil Fund Program currently being drafted will further enhance the role of the non-governmental sphere.

Government Decree 1138/2002 (VIII.9.)⁶ governs the operations of the *Council for Elder Affairs*. The Council is a consultative, advisory and proposal-making body that operates alongside the Government. The Council has 20 members, 13 of who represent national advocacy groups for elderly persons and 7 of who are assigned to the Council as experts.

Improving living standards for the elderly by changing and adjusting rules on the provision of pension benefits

Primary changes in the pension system between 2002 and 2006:

Pensions are the defining element of income security for elderly persons, amounting to nearly 80 percent of senior citizen incomes. In the period under review, the government's goal was to improve the purchasing power of pensions and to increase support to pensioners in the most difficult situations.

⁵ There is a significant body of legislation focused on reinforcing the position of elder workers who are still of economically active age, however, they are not categorized within the narrow sphere of 'elder affairs'.

⁶ The government decree is included in the attachment

In an effort to meet this goal, a 13th month of pension payments was gradually introduced, one week a year, starting in 2003. By 2006, this new benefit amounted to an 8.4 percent pension increase for 2.7 million pensioners.

To assist people living under the most difficult circumstances, widow's/widower's pensions to be paid in addition to earned pensions, and pensions for surviving spouses who did not have pensions of their own were increased. The two measures improved the situations of about 800,000 surviving spouses. Projected to all pensioners, it meant an increase of about 2.5 percent in the average amount of pension benefits.

Extraordinary pension increase was re-introduced in 2002 in an effort to grant support to the persons with the lowest pensions. In 2006, one-time supports to pensioners were granted.

The measures listed, and regular annual pension increases, have boosted the purchasing power of pensions by about 24 percent since 2002, calculating with the special consumer price index for pensioners. For the first time since the change in the political system, the rise in the purchasing power of pensions slightly exceeded the increase in the purchasing power of the net average earnings of the economically active portion of the population.

Act CLXXIII of 2005 called for a differentiated increase in the pensions of persons who retired prior to the change in the political system, an increase intended to compensate for the depreciation in the pensions of the affected persons between 2006 and 2010, affecting nearly one million people.

Regulations to expand, and improve equity in access to public services, particularly healthcare and social benefits

Within the various rules on *healthcare benefits*, we would like to emphasize regulations related to palliative care and to measures on procurement of *medical devices and therapeutic aids* that help elderly persons to prolong retention of their independent lifestyles.

The Ministry of Health treats *hospice care* as an important health policy issue. The conceptual framework of developing hospice care was finalized in 2004. Government Decree 43/1999 (III.3.) on regulations of financing health care services from the National Health Insurance Fund was amended to cover hospice care at home among the activities financed.

Decree 19/2003. (IV. 29.) ESzCsM of the Minister of Health, Social and Family Affairs on medical devices and prostheses which may be prescribed and rented with social insurance reimbursement, on the amount and rate of reimbursement as well as on the professional requirements of prescription, distribution, renting and repair took effect on May 1, 2003. With the entry into force of this decree, many new implements were included into social insurance coverage, which resulted in an improvement in care for chronically ill elderly patients. Within the framework of healthcare reform, Act XCVIII of 2006 on safe and economic supply of medicinal products and medical devices, and laying down the general rules of the distribution of medicinal products took effect in December 2006. Its goal was to evolve a new reimbursement system in the area of medical devices, taking into account growing average age due to improved clinical outcomes for certain diseases, increased demands for rehabilitation, the appearance of more modern devices.

The new law can help to improve quality of life and achieve more effective rehabilitation, making it possible for elderly patients to remain or become independent, and easing the burden on the family and on people in the immediate environment caring for the person. Promotion of home care with proper equipment can keep the person out of a hospital or can reduce hospital stays.

Decree 5/2004. (XI. 9.) EüM of the Minister of Health on balneotherapy for the purposes of medical rehabilitation that may be utilized with social insurance reimbursement is also designed to promote independent living for older persons.

Improving *social benefits* for the elderly insofar as basic social services are concerned, has been focused primarily on offering assistance in the home to allow older people to remain in their homes

and retain their independence in a safe way. Starting in 2004, a system of home care with an alarm system was given priority when it was introduced as a care form for which government capitation funds were provided. Special attention was devoted to providing care for elderly persons with dementia, either in their own homes or within institutions, by designing separate dementia sections of homes for the elderly with priority financing.

To assist elderly persons in financially disadvantageous conditions with their living expenses, Act III of 1993 on Social Administration and Social Benefits was amended to introduce home maintenance support, the amounts of which are granted by local governments and are used to reduce the amount of utility bills, such as rent, water fees, heating costs, etc. The amount of this support ranged from 2,500 forints/month to 6,000 forints, decided on the merits of each case.

c) Identifying areas that require detailed appraisal

In 2001, the Council for Elder Affairs concluded that an unprecedented ageing of the world's population had become common in the 20th century and was continuing into the 21st. It therefore debated and adopted a Hungarian Charter on Elderly People in Hungary in conformity with UN guidelines, including the provisions in UN General Assembly resolution No. 46/91 of March 18, 1992 and in the appendix to resolution No. 47/5 of October 16, as well as with relevant European documents on the subject.

There has been a (national) Council for Elder Affairs operating in Hungary since 1997 – much earlier than in many other European countries – and the Council was well ahead of many other countries – as well as the Madrid International Plan of Action on Ageing – in establishing an extraordinarily progressive long term Charter for Elder Affairs that was holistic in outlook. Based on guidelines from national and international documents, a workshop with the participation of all relevant line ministries was initiated in 2003 to design a detailed programme of action. The programme for an active old age, the features of an elder-friendly physical and social environment, and the drafts of elder-friendly measures were all designed during this period and they are the strong points of elder affairs in Hungary.

These were also the years when there was an unprecedented impetus to legislate the issue as Hungary prepared to access to the European Union (on May 1, 2004). The regulation of the NGOs, of interest representation and advocacy, of legal protection, and of partnerships played an outstanding role in the legislative process. The civic world gained access to rights, resources, and a sphere of motion that would have been inconceivable earlier, and this of course also affected the organizations of older persons.

Sadly, this legislative “high tide” did not make it possible for the Charter for Elder Affairs, written earlier, to serve as a codified document in defining the actions of elder affairs. Despite that, it was obvious that Hungary had made the most progress in “The Integration and Participation of Older Persons,” which is why we chose this comprehensive area as one of our focal points.

Another focus point we chose was the section on adjusting social protection systems, for these systems are under constant renewal and are required to adjust to steadily changing needs. We have also given high priority to addressing the measures taken by the Government in order to enable labour markets to respond to the economic and social consequences of population ageing.

2. Methodology used for the detailed appraisal of identified priorities

In compiling this Report, we have relied on data and analyses from the Hungarian Central Statistical Office as well as on numerous laws, studies, proceedings, practical manuals and reports written within the framework of the “Programme for Active and Dignified Ageing”. In the past four years, the United Nation Plan of Action on Ageing, adopted in 2002, was debated at numerous conferences, pensioners’ forums and extension training courses. A conference to sum up the subject was organized in October 2006 by the Budapest Equal Opportunity Coordination Bureau, on the theme of “The Role of Older Persons in the 21st Century: Changed Social Expectations?” In February 2007, three monitoring group sessions were held with specially invited facilitators, and were attended by members and leaders of senior organizations, cultural and social practitioners, local government experts, entrepreneurs providing services to the elderly as well as members of the Council for Elder Affairs.⁷ The topics monitored were connected to the areas we focused on, and were as follows:

- Achievement of the social integration and participation of elderly persons - 1. (subjects covered: interest advocacy, interest representation, participation in processes preparing professional policy decisions, recognizing the socio-economic contributions of elder citizens, volunteer work, incentives to the different generations to cooperate).
- Achievement of the social integration and participation of elderly persons - 2. (with particular emphasis on leisure time, vacations, culture, sports, and other leisure activity)
- Evaluation of the work of the Council for Elder Affairs and of its influence on the quality of life of the older generations, 2002-2007.

Recordings and a written summary of the monitoring sessions were prepared. Opinions expressed by participants were included in the report in two forms. The essential points of the appraisal, the detailed appraisal of the areas singled out, the conclusions, and the proposals, were formulated with a mind to what was stressed during the discussions at the meetings. Direct quotes have been included in the report, in boxes.

Detailed contributions to the Report were prepared by the Ministry of Health, and by specialist departments at the Social Policy State Secretariat, the Employment and Training State Secretariat, and the Equal Opportunity State Secretariat of the Ministry of Social Affairs and Labour.

The effort was coordinated, and the report was prepared by the Secretariat for Elder Affairs within the Equal Opportunity Department of the Ministry of Social Affairs and Labour.

3. National capacities in monitoring MIPAA/RIS

In Hungary, the Council for Elder Affairs operating within the ministry responsible for social affairs traditionally works together with the responsible specialized divisions of the line ministries in initiating and coordinating the programmes and projects that implement the commitments agreed under MIPAA/RIS. This secretariat has evolved close cooperation with the non-governmental umbrella organizations for elder persons, thus their feedback is direct. In 2003, the ministry evolved a long-term cooperation programme with the Hungarian Central Statistical Office to collect targeted data. The data is on the composition of the elderly population, the health status of older people, the

⁷ See attachment for a detailed list of attendees.

circumstances under which they retire, their incomes, consumption, typical housing situations, social benefits they receive, way of life, use of time, involvement in crime, and political participation – information published every two years. These volumes are distributed not only to politicians specialized in the field, to professional experts, to researchers and to elder organizations, but also to university and college libraries and to all professionals – focusing on both theoretical and practical issues – who are interested in them.

Applied social gerontology training is offered in several universities and colleges and studies may be conducted in the frames of specialist extension training or training available as a module in medical school. In addition, information on elder affairs, linked to social benefit provisions, is considered a natural part of social worker training.

Every two years the Hungarian Central Statistical Office organizes a conference on ageing, which also reviews the results of the latest research on ageing and provides the information in a separate volume to all participants. A staff member of the Hungarian Central Statistical Office who works on the elder projects attends all meetings of the Council for Elder Affairs, which means there is direct interaction between subjective and scientific positions, and new research projects are initiated as the result of new impetuses. Each year the Council for Elder Affairs organizes a comprehensive scientific conference covering one or another major area, or a series of workshops with the same intention.

As of 2005, a growing number of county-level “Opportunity-Houses” also hold regular forums, workshops, training sessions or conferences to study the quality of life and social participation of the older generations.

There has been no independent and impartial monitoring mechanism with separate resources to monitor progress in the implementation of MIPAA/RIS.

4. Review and appraisal by specialized area

RIS COMMITMENT 1: TO MAINSTREAM AGEING IN ALL POLICY FIELDS

Mainstreaming

As a Member State of the European Union, Hungary has an open legislative system. The concepts, strategies, and drafts are accessible on the websites of the various ministries and on other Internet forums. Non-governmental organizations, members of the private sector and interest groups all participate in shaping opinions. Councils of various strata and sectors, as well as forums and interest reconciliation councils channel and represent the opinions and clusters of opinion. The prime minister, the ministers, and professionals in the political world all appear in person at local forums where over half of the participants are older citizens, and retiree organizations themselves organize a large number of these targeted forums. NGOs are involved not only in preparing decisions, but thanks to government outsourcing, they also participate in implementation: for instance, NGOs provide about 30 percent of services in the social services arena.

In addition to the Council for Elder Affairs we have already mentioned (where 85 percent of the members are over the age of 60 years), we have randomly investigated the other councils considered partners to the Ministry of Social Affairs and Labour to see the rate of participants over the age of 60 years. We found that the representation of this age group corresponds to their share within the population (20 percent).

Older persons are not this well represented in politics: In 2002, exactly 36.6 percent of Members of Parliament of the parties in Parliament were over the age of 50 years. However only 7.8 percent were over the age of 60 years and 1.8 percent were over 70 years.

Initiatives and some results in halting discrimination by age

In December 2004, the Government of the Republic of Hungary adopted a decree setting up the *Equal Treatment Authority* and laying down its detailed procedural rules. The Equal Treatment Authority monitors how the requirement for equal treatment is adhered to, operating as a body with nationwide authority. When the requirement for equal treatment is violated, the authority responds to the request of the person whose rights are violated or ex officio in cases specified by law. It will conduct an administrative procedure to determine whether discrimination occurred. If it is found during the procedure that the requirement for equal treatment was violated, the authority will take a decision to apply the sanctions set by law. Complaints related to age discrimination have almost exclusively been work-related. Some complaints concern not being able to get a job because of age while others cite termination of their employment because of age. It is fair to conclude as a fact that age discrimination does not primarily affect people who are over the age of 50 years, the age set in various sociological surveys, but hurts people over the age of 40 years who seek jobs, particularly women, regardless of their education levels.

In the period between January 1 and September 30, 2006, proceedings were initiated for discrimination by age in 14 cases, and the authority found that there had truly been age discrimination in one of these.

Holistic approach

There has been a shift towards a holistic approach in Hungary in recent years under the impact of European and other international experience, programmes and actions initiated by line ministries and supported by the influence of the media; however, coordinated and consistent application of a holistic approach is not foreseen to appear before the end of the decade. Government players, public opinion, and the elderly persons themselves need a change in outlook in order to achieve that elderly people are considered active citizens, too.

RIS COMMITMENT 2: TO ENSURE FULL INTEGRATION AND PARTICIPATION OF OLDER PERSONS IN SOCIETY

Enhancing and encouraging the social contribution of older persons

In connection with a proposal submitted to it, the Council for Elder Affairs suggested in 2005 that a new award be established. The award “For the Elderly” may be granted to a maximum of 20 persons a year in recognition of their efforts to promote the dignity, financial, physical, and emotional health and well-being of elder persons, and to support activeness in old age. It is presented on the International Day of Older Persons, in Parliament, by the Minister of Youth, Family, Social Affairs and Equal Opportunity. Most of the award winners are members of retiree organizations, volunteers of clubs, and a fewer number are social and healthcare professionals and pension affairs experts.

Opportunities for elderly persons to shape opinions on the services they receive

The *Elder-Friendly Local Government Award* was established in 2004 by the Minister of the Interior and the Minister of Youth, Family, Social Affairs and Equal Opportunity. The intention of the

ministers in granting this award is to recognize past achievement and to call attention to the fact that local governments acting on local level can do the most to promote elder-friendly policies. All local governments (settlement, county, Budapest district, and Budapest municipal level alike) may apply for the Elder-Friendly Local Government Award if, above and beyond their basic tasks, they have taken exemplary initiatives to support the older population:

- if they actively promote improvements in the quality of life of older citizens through the operations of local organizations, or if they contribute to organizing leisure programmes,
- if they evolve exemplary cooperation with persons or organizations operating in the area of elder affairs,
- if they extensively include elderly citizens and senior citizen organizations in local public life and in shaping it.

Each year local governments submit some 120 applications. The chairperson of the jury is the president of the largest organization of pensioners. Each year the ministers present the award amidst a ceremony held as part of a conference connected to the UN International Day of Older Persons, which is held in Parliament. Three awards were presented at the first year's ceremony, and six plus special awards⁸ were granted from the second year onwards.

Users of services in specialized social institutions providing personal care and users of services in institutions offering daytime care *may establish their own "governments" of care-recipients* to represent them and to organize community life. These governments operate with differing levels effectiveness from the completely formal to well-operating and active governments with subcommittees able to handle different matters.

The Public Foundation for Patient's Rights, Care Recipient's Rights, and Children's Rights also helps elder persons in advocating for their rights. It was established in January 2004 by a parliamentary decree initiated by the Government. The Public Foundation organized a nationwide network concerned with the protection of rights. It helps older persons to learn about their rights, offering information on rights with patients' rights representatives operating in healthcare institutions and care recipient rights' advocates operating in social institutions to help the elderly. Their job is to provide information and to verbalize complaints. They initiate measures with the heads of the institutions, the bodies maintaining them and the various authorities to terminate violations of rights. Care recipient rights' advocates hold office hours in live-in facilities and participate regularly in residents' meetings and in interest advocacy forums.

How does your country enhance the social, economic, political and cultural participation of older persons? The following is a review of the crystallized appraisals coming from the sessions of the monitoring group.⁹

Tasks and challenges of civic organizations for retirees

Old people do not want to become a burden on the social provision system. They are demanding new ways of life. Today's middle-aged population will be different from the current old folks, for whom a new perspective needs to be found. Family ties are falling apart. With people having fewer children, we are seeing a growing number of old folk whose children and grandchildren cannot help them in their old age. There are some – especially the newly retired, who do not go to retiree clubs because they do not see themselves as "retired." For them new fields of motion need to be created.

⁸ The Budapest Municipal Government and the National Association of Settlement Local Governments joined the initiative by offering prizes of their own.

⁹ See attachment for detailed list of attendees

Organizational life

A certain financial background is necessary if work with elderly persons is to be satisfactory. That financial background must be secured! Those organizations that currently operate on a voluntary basis, given a satisfactory financial background, would be able to implement professional programmes that today are limited by financial difficulties. One basis for obtaining the resources is successful participation in bidding for competitive grants offered domestically and by the European Union. However, many of these organizations are unable to put down the necessary co-funding.

Volunteering

People who volunteer in self-organized groups are using their brains and keeping themselves fit. From the economic point of view, an active person will delay accessing expensive healthcare services. In addition, activeness provides a viable and dignified old age. Old people who volunteer play an important role in society. Older people can develop themselves in many organizations if these organizations are intensive and are ready to integrate them.

Training, counselling

Retirees and old people in general have demands of their own: they want to participate in language courses, go on organized vacations and excursions, attend computer courses (a great example of this is the “Click on it, Grandma!” Programme), and attend folk arts circles. We need services in which experienced retirees help the new ones, so that once they leave the labour market they become aware of the opportunities available to them. The focus should not be on what they do not know but on their areas of competence. Not only should we build on past competences but on new ones, too.

Vacations, recreation

A study by tourism agency Magyar Turizmus Rt [Hungarian Tourism Co.], done in 2004, found that the Hungarian population spent 29 billion forints for domestic travel, and 16 percent of those travellers were older persons. A study of international travel found that 6.5 percent were paid by older people for package tours. This is a significant amount.

The success of holiday checks offered by private companies, NGOs, and local governments shows that these entities are playing a growing role in supporting vacations for retirees. They offer assistance in preparing bids, in the organized transfer of the bids, and in a growing number of cases, they offer to pay the co-payment required to be eligible for the funding.

Public life

Participatory democracy is necessary in elder affairs. In elder affairs, the emphasis has to be on interest advocacy because interest representation is impossible without advocacy. A network of organizations can be an important player in the interest advocacy structure. Interest advocacy is possible in various local venues.

Participation in local social life is unsatisfactory and the organizations do not take that participation seriously, so self-organization is vital. This means we need to evolve regional, sub-regional, and settlement-level interest advocacy and shape new systems of relations.

*Local Governments*¹⁰

In recent years, cooperation with local governments has improved. A growing number of local governments and sub-regional associations have established cooperation agreements with organizations of retirees and these agreements cover cultural, healthcare, and social issues. At the

¹⁰ There are over 3,100 settlement governments in Hungary, so it is understandable that there are examples of both good and bad operations

same time, over the course of cooperating with the local governments, a measure of dependence can evolve (for instance, if the local government offers the organization space free of charge).

Connection to society

We need to recognize that elderly people are consumers within society and the economy. Society knows nothing of retiree society, so it is worth seeking more forums through the media, and maintaining contacts with media representatives. We have to introduce the retiree age group to society.

Looking outward

There are regions within the European Union, so we need to prepare to operate as regions. We need to build trans-border ties and reinforce contacts.

Promoting political participation of elderly persons

Non-governmental organizations for retirees in Hungary have about 10 larger or smaller umbrella organizations. The chairpersons of these organizations – together with other invited members – make up the Council for Elder Affairs. Eleven years ago the Hungarian Government established the Council for Elder Affairs to operate alongside the Government as a consultative and advisory body makes recommendations.¹¹ The Council chair is the Prime Minister, and the vice-chair is the Minister of Social Affairs and Labour. Many smaller organizations have not joined any umbrella organizations and there are also a large number of retiree communities that operate quite effectively but have not formalized themselves (these latter are primarily in smaller villages). In other words, the structure of civic organizations for pensioners forms a hierarchy, but is not centralized. The heads of the largest umbrella organizations often appear in the national media to voice their opinions, but retiree-society has no “single spokesperson.” It is worth mentioning that in the last parliamentary elections two members of the Council for Elder Affairs were elected to parliament.¹² The Pensioners’ Board of the National Confederation of Hungarian Trade Unions has a significant number of members nationwide and in the various sectors of the economy.

It should be possible to describe the operation of the Council for Elder Affairs by pointing out that it does not plan to boost the political role of the representatives of the older generation, for the Council for Elder Affairs expressly operates in a neutral manner as far as party politics are concerned. As a point of interest, we would like to mention that while about 10 percent of the Members of Parliament are female, in the Council for Elder Affairs, the proportion is 35 percent.

We have described the government resolution on the operation of the Council for Elder Affairs¹³ and the tasks of the Council elsewhere, in an earlier section of this report, and we have included the working plans for the past four years of Council operation in the attachment.

We will now offer excerpts from the appraisal by the Council members.

¹¹ The role of the Council for Elder Affairs declined significantly for about eleven years after it was founded, but it has been growing in strength since 2002.

¹² They are now working in Parliament, while the Prime Minister invited two other persons from a similar professional background, to take their places in the Council for Elder Affairs.

¹³ When speaking of the Council for Elder Affairs we refer to the National Council for Elder Affairs. The Defence Ministry has established its own council for elder affairs and many settlements and counties have also set up their own councils for elder affairs.

Tasks:

The tasks have to be built upon three pillars:

- Reinforcing social security. (This has to be reinforced in the employment area)
- Good health for older persons. (We have very serious problems in this area. By increasing the number of older persons in a satisfactory state of health, we could reduce the burden on the healthcare system)
- Change in outlook (We need to change the social attitude towards older persons)

The Council can be a tool providing a flow of information among elder organizations.

Based on the review of the five-year plans of operation of the Council for Elder Affairs between 2003 and 2007, the Council included tasks and actions from the following five areas on its agenda.

- “Mobilization” matters
E.g.: Participation in professional conferences; UN International Day of Older Persons, senior sports, Elder-Friendly Local Government Awards, exchanges of experience, etc.
- Issues related to pensions and the size of pensions
E.g. Old-age pensions, 13th pension month, pensions established for reasons of fairness, etc.
- Legal Affairs
E.g.: National Action Plan on Social Inclusion (2004-2006), social legislation
- Interest representation (opportunities for, and quality of life of people of retirement age
E.g.: Hungarian National Vacation Fund – vacations, free medication for the indigent, the right to a healthy old age, employment forms for people of retirement age
- Social participation (recognition of persons of retirement age, training and inclusion in the operation of day-to-day society)
E.g. Regional and Sectorial Councils for Elder Affairs, training, training as senior counsellors

Social responsibility:

The Council for Elder Affairs is able to think in terms of all levels, not just elder affairs. It is politically neutral. Its substantive work has been growing steadily and many Council proposals have been included in legislation.

The problem of pensions cannot be resolved as far as demographic data is concerned. For this reason, the Council must support measures to encourage people to have children, for this is vital. The Council represents one social stratum – elderly people. It would be worth cooperating with representatives of the other social strata, such as organizing joint vacation programmes. That way we could get to understand one another’s proposals and problems. For instance, when cooperating with young people we could eliminate the mistaken belief that we want to take jobs away from the economically active group.

There does not seem to be sufficient awareness of the fact that in ten years’ time 30-35 percent of the population will be retired. This will have a huge effect on the whole of the nation and the economy. We need to shape a national elder policy. The Council should set itself the goal of designing strategic principles for elder affairs.

Results:

On the whole, we might say that *the biggest steps forward have been in legislative proposals*. It is very good that we have arrived at a level in which we have the chance to look over ideas and concepts on various issues and choose among possible solutions. This is very important because we are doing more than offering an opinion on something, an opinion that can be accepted or rejected. The best example of this was the introduction of the 13th month pension.

The Elder-Friendly Local Government Award has been a success. If information on it were more public, it might even become an international success. The reason for its success is that the older people are included in its implementation. Local governments are capable of mobilizing non-governmental society.

The publication on the Elder-Friendly Local Government Award is used primarily by local governments that have not yet won the title. With it to help them, they might be able to submit successful bids the next time the award is offered.

The Award for the Elderly has become a symbol of recognition.

The spread of the Elder-Friendly Hotel is in the interests of both the hotels and elderly persons. This configuration could lead to a major economic success.

The Elder-Friendly Home requires a small investment to improve the safety and comfort levels of the homes that elderly persons live in. This is good because we do not have a sufficient number of homes especially designed for older persons to give everyone a place and because it requires a very small investment.

The idea of the *Pensioners' Island* came from the Island Festival organized annually for young persons. It was decided to hold a separate festival for retirees. The idea was supported by the city of Budapest and the sixth one will be held this year.

We do have *senior sports* but the idea is not particularly widespread. Elderly persons attend the programmes together with their families, where everyone can find a suitable sport to participate in. The Council also supports participation in international contests. A number of us were in Brussels at an international senior sports contest supported by the Council. Hungarian athletes have done quite well on multiple occasions.

Difficulties, problems:

There are elder laws in 12 Member States but none in Hungary.

There has been little feedback after we offered our opinions on the proposals. We need to expand our right to make proposals and offer opinions, and the Council should also have veto rights and decision-making rights. In addition, we need to have better personnel, objective, and financial operating conditions. The media has been showing a growing interest in us more recently. However, the articles constantly appearing in the press are ones printed in agreement with the government. Differences of opinion are not published and we need to change this because that is a legitimate aspect of public life.

Proposals

In elder affairs, we need the government, the market, and the non-governmental sphere to cooperate. It would be useful to reinforce international relations and exchanges of experience.

How the Council disseminates its initiatives to the regional and settlement organizations is decisive, since interest advocacy and interest protection not only exist on nationwide level but also on regional and settlement levels. We need to improve our regional and sub-regional operations. We need to call the attention of the media to our work by issuing a press release after every meeting of the Council, reporting on the decisions we took and the opinions we voice.

There are not enough newspapers for retirees – we need to get the number increased.

All organizations have some sort of health maintenance activity but we need to give greater emphasis to various sports activities. If someone participates in sports, that person has a far greater chance of staying healthy. The result would be having to spend less money on healthcare services. It is far better to finance health maintenance. We need sports facilities that are open to elder persons. Today, fitness salons are not happy to receive elder persons and we need to change that.

Promoting voluntary activity and the development of age integrated communities

Before the law on public service volunteer work took effect on November 1, 2005, there was no Hungarian legislation that clearly stipulated the legal situation of a volunteer, and some regulations made it difficult to allow organizations to use volunteers at all. Once the law was adopted, it clarified the status of helpers, by clearly defining the status of the volunteer. A large number of retirees work as volunteers in traditional social services areas as well as in consumer protection and crime prevention.

Older and younger people are encouraged to cooperate in the work of NGOs such as the “Home Start” Foundation, the Hungarian Red Cross, the National Association of Railway Worker Pensioners Clubs and many rural development communities, principally operating in smaller settlements. Since 2005, the Ministry of Social Affairs and Labour has devoted 50 million forints to support bids for grants that involve implementing multigenerational joint projects. We have particularly emphasized supports for projects focusing on elderly persons in live-in facilities, by publishing a “best practices” volume.

Promoting a positive image of ageing

Hungary has been celebrating UN International Day of Older Persons with government participation since 1997. Each year since 2002 there has been a “central celebration” attended by the Prime Minister, which guarantees media attention. In addition, year after year a growing number of county and economic sector celebrations are held with high-ranking participants, which are reported on by the regional and local media. Thus, in October and November, there is a veritable campaign of information in news magazines, which print articles and other information on the elderly, and a steadily growing proportion of them focus on positive aspects of ageing.

The decisions and achievements with the greatest media coverage and echo have been:

- The pension correction law
- International Day of Older Persons
- Presentation of the Elder-Friendly Local Government awards

Our experience shows that presentation of the way older people live in a differentiated and diverse manner is one effective tool, but that the best way to generate intergenerational dialogue is through local projects. Our own publications (“Feeling Good as Seniors!,” and the “Best Practices” chapter of the book “Elder-Friendly Local Government,” as well as the collection of games called “Games Give Us Impetus”) always presents opportunities for communication based on the knowledge, experience and freedom of older persons.

RIS COMMITMENT 3: TO PROMOTE EQUITABLE AND SUSTAINABLE ECONOMIC GROWTH IN RESPONSE TO POPULATION AGEING

Hungary is a country on a medium level of development. It is industrial with an advanced agriculture, is sensitive to the international economy and nearly two-thirds of its GDP is produced by the service sector. Industry, which relies primarily on the processing industry, produces about one quarter of the gross domestic product. The GDP has been growing at a more or less stable rate, exceeding the average of the EU-15 by about 1.5-2 percentage points.

By 2000, it became possible to reduce the public finance deficit to 3 percent of GDP, set as a Maastricht criterion. Afterwards, however, the deficit grew substantially, and by 2002, it had reached an exceptionally high 9.2 percent. In 2003 and 2004, the deficit declined but the rate at which it declined was slower than planned.

In the first half of its term of office, which runs from 2006 to 2010, the current Government is determined to restore public finance equilibrium, since fulfilment of its programme of social justice and modernization are putting the economy at risk with an unacceptably high budget deficit. For this reason, after the new government took office (2006), it acted immediately to restore public finance equilibrium so that it will be able to meet the Maastricht criteria by the middle of its term of office. To do this, on short term the government has significantly cut expenditure while it needs to increase its revenues substantially. Therefore, a comprehensive reform is underway in Hungary, which includes reform in government administration, in the economy, in healthcare, and in education. Within the reform process, the Government is particularly focusing on protecting children and on old people, as well as on eliminating regional differences and differences in settlements. (This affects disadvantaged regions and older people living in smaller settlements in a positive way.) It is also focusing on social and healthcare benefits, and on education and culture.

RIS COMMITMENT 4: TO ADJUST SOCIAL PROTECTION SYSTEMS IN RESPONSE TO DEMOGRAPHIC CHANGES AND THEIR SOCIAL AND ECONOMIC CONSEQUENCES

The social protection systems in Hungary are continuously adjusted to social and demographic changes. This means giving up certain forms of support, while expanding others and introducing still others (for instance, certain financially vulnerable families began receiving subsidies towards the price of gas in 2007 and certain vulnerable families began receiving subsidies towards the cost of district heating in 2007; other services include debt management and managing mortgages families have undertaken but cannot pay).

Under Act III of 1993 on Social Administration and Social Benefits, local governments can provide the following *cash benefits and in-kind benefits* to citizens in financial need: old-age annuity, regular social assistance, home maintenance support, carer's allowance, temporary assistance, funeral assistance, public payment of funeral, medically indigent care, granting of eligibility for healthcare services.

Of the above, we would like to emphasize the *old-age annuity*, which may be granted to a person who is over retirement age and does not have an income sufficient for subsistence. A person who is over the age of 62 or the retirement age valid for him or her may apply for this assistance. The caveat is that the person's per capita income, calculating that he or she is living together with a spouse or partner, may not exceed 80 percent of the minimum old-age pension (this amount, beginning on February 15, 2007, is 21,704 forints per person). If the person lives alone, his or her income may not exceed 95 percent of the minimum pension (in 2007 this is 25,774 forints or, if the person is over the age of 75, the amount may not exceed 130 percent of the minimum pension (35,269 forints in 2007). If the person has some income, the allowance will boost it to the above level.

The old-age annuity increases incomes to the above level. The measure is intended primarily to assist elderly women living in small settlements. In 2006, an average of 6,230 persons received this assistance on a monthly basis. About one-third of them received the enhanced allowance.

Elderly persons may access the following *social services*:

NAME OF SERVICE	Index numbers of entities maintaining service provider (No of service recipients and services)		
	January 2006		
	Local Gov't	NGO	Faith-based/church
Meals on wheels	90,000 persons	2,900 persons	1,500 persons
Home assistance	41,030 persons	530 persons	270 persons
Home assistance when signalled	6,000 persons	4,000 persons	50 persons
Village or homestead caregiver services	922 services	2 services	1 services
Support services	80 services	230 services	40 services
Community services	44 services	27 services	3 services
Day-care for the elderly, for psychiatric patients and substances abusers, and for the homeless	35,000 persons	6,600 persons	1,900 persons
Day-care for persons with disabilities	1,900 persons	1,130 persons	120 persons
Residential care for persons with dementia, disabilities, psychiatric disorders, or substance abuse problems	26,167 persons	3,250 persons	1,400 persons
Long-term and transitional live-in care for elderly persons	24,500 persons	5,000 persons	8,500 persons
Enhanced level live-in care	4,000 persons	7,100 persons	2,900 persons

Persons with disabilities and vulnerable elderly people who are at risk are assisted in maintaining their living standards by:

- Support to persons with disabilities introduced in 2003,
- Transport subsidies for persons with locomotive disabilities,
- The National Disability Programme, which has a section requiring that public buildings be made accessible to all,
- Funding available annually to bidders ready to employ persons with altered working abilities, with the money coming from the Rehabilitation Fund,
- One-time support of a maximum of 150,000 forints to remodel a home and make it accessible to a person with disabilities,
- Sign language interpreting services provided for persons with hearing disorders in managing public affairs (available since 2003).

There is a National Council on Disability Affairs and a „Chance for Disabled People” Public Foundation to help persons with disabilities retain their independence and dignity, and to provide them with a growing number of relevant services.

With the *healthcare reform* underway, 7,500 acute hospital beds will be terminated as of April 1, 2007 and will become chronic beds instead, while long-term nursing care will become available in geriatric wards.

The Hungarian pension system has been a mixed-funded one since January 1, 1998. This means that alongside the government’s statutory social insurance scheme, it meets pensioners’ needs through a private pension scheme, too.

People beginning their careers are required to join private pension funds. Members of the private pension funds will have to pay contributions towards pensions and membership dues to cover their eventual care. Voluntary pension funds are required to limit their services to pension services which must be financed by regular membership payments undertaken voluntarily and accounted individually.

The operation and advancement of the statutory social insurance system is the government’s job. The most important features of the pension system operated by the government are a pay-as-you-go type funding, as well as components of mixed funding.

The government of the Republic of Hungary has started up a five-year programme running from 2006 to 2010 to alleviate injustices in the amount of pensions paid to retirees, by increasing pensions originally awarded before 1998 in a differentiated manner above and beyond the regular pension increases specified by law. In five years, the programme will make pension distribution fairer by increasing their value by some 130 billion forints, to make the lives of several million older persons more secure. Act CLXXIII of 2005 is intended to resolve an injustice under which people who had had the same income and the same creditable period/length of service received different pensions simply because their pensions were established according to differing rules.

The retirement age for both males and females is 62 years, because of reforms of recent years. We need to emphasize that in order to correct income disproportions between males and females, in 2006 the pensions of males who retired before 1988 were increased by 3 percent across the board, while those of females were raised by 5 percent.

RIS COMMITMENT 5: TO ENABLE LABOUR MARKETS TO RESPOND TO THE ECONOMIC AND SOCIAL CONSEQUENCES OF POPULATION AGEING

Employability

Act CI of 2001 on Adult Education, which was amended several times, has terminated the age ceiling on supports available to persons learning skills, studying languages and/or attending general education classes. In fact, transitionally, in 2005 and 2006, people over the age of 50 years could learn a second skill free of charge – in certain occupations – and receive capitation support in adult education, normally limited to the first skill.

County employment centres have been helping older job-seekers to find work through education and training amounting to about one billion forints a year.

Central programmes were launched in 2005 and 2006 to promote the employment of people over 50 years, which helped 390,000 people to find jobs.

Improve the employability of older workers

Decree 6/1996 (VII. 16.) MüM of the Minister of Labour offered an opportunity to expand support to persons over the age of 45 years seeking jobs, and, if employed for community service, it allowed more favourable than average support conditions. (This means that subsidies to employers towards the person's wages can be granted for a long period of time, and can be higher when the person was previously unemployed.) Since 2004, an employer who employs a person over the age of 50 years who had been jobless on long term does not have to pay a lump sum in healthcare contributions normally due on each hire.

As of January 1, 2005, the contributions payable by employers who employ hitherto jobless persons over the age of 50 years have been changed in that a positive lower cap was put on the government subsidy covering this contribution. Now, if the employment centre ascertains that the subsidy is due the employer, it may not be less than 50 percent of the total amount of the share that may be taken over by the government from the employee's and employer's part of the health and pension insurance contributions to be made from the wage plus the health tax to be paid by the. Act IV of 1991 on promoting employment and benefits for the jobless was amended as of January 1, 2007 – to correspond to Regulation 2204/2002 EC – qualifying a person over the age of 50 years who seeks a job as a disadvantaged employee, so that the employer can receive a subsidy of 50 percent of the employee's wages and contributions.

Act CLXXX of 2005 on the measures to be taken to increase employment and to enhance flexible forms of employment in the public sector, supports to micro, small, and medium-sized businesses and non-profits in expanding jobs became available from January 1 to December 31, 2006. Employers who employed a person registered as having been seeking a job for at least three months and to keep that person on staff for at least two years were exempted from paying any employer contribution and payroll taxes on that person for an entire year. About 11,000 businesses joined the programme, permanently employing nearly 15,000 people who had been registered as job-seekers for at least three months previously. A variety of programmes and diverse measures have been introduced by the Human Resources Development Operational Programme to assist persons in disadvantaged situations including older jobless persons, persons at risk of losing their jobs, and residents of backward regions, by offering supports to help them train and find jobs. These supports have been augmented to include subsistence funding while the person undergoes job-training, reimbursement of travel costs – local and inter-city – to travel to a training site, and coverage of meal and accommodation costs. Several of their projects targeted persons over the age of 45 years who were jobless on long term.

The measure introduced in 2004, which states that a person who continues working after reaching retirement age without applying for their pension to be established is entitled to a 0.5 percent increase in his or her pension every 30 days spent on the job is intended *to delay the age at which people retire*.

Promotion of gradual retirement is the goal of the Premium Years Programme. Based on Act CXXII of 2004 the Government announced the Premium Years Programme as part of its streamlining of public administration. This programme offers public employees and civil servants who are close to

retirement age and would lose their jobs because of downsizing the chance to continue working a reduced number of hours with a cut in income until they become eligible for retirement. Participants in the programme may continue working for a maximum of five years with closed-ended contracts, and may work a maximum of 12 hours/week for their former employer, not necessarily in their old job. This programme was expanded to the private sector in October 2005. As of December 31, 2006, on nationwide scale 519 people signed up for the Premium Years Programme.

RIS COMMITMENT 6: TO PROMOTE LIFE-LONG LEARNING AND ADAPT THE EDUCATIONAL SYSTEM IN ORDER TO MEET THE CHANGING ECONOMIC, SOCIAL AND DEMOGRAPHIC CONDITIONS

Facilitate and encourage life-long learning

In 2005, the Hungarian Government designed a lifelong learning strategy. On the one hand, its intention on short term was to enable the current education system to immediately meet the needs of the labour market (increasing participation in adult education, offering special training for persons with low education levels, together with extension training and standard training for persons over the age of 55 years). On the other, its intention on long term was to promote the evolvement of a new culture of study resting on competence-based training on society-wide level. A culture of study based on lifelong learning has an eye on the multiple goals of the education sector, which are promoting personal development, the enhancement of the general knowledge base, are implementing economic, social and cultural goals, and considering that when an individual is in different life phases, the order of priority of the above goals varies.

Hungary's strategy is to offer developmental measures in many key areas within the education and training system:

- The improvement of basic skills (reading, writing and mathematical competencies) and the development of key competencies (including other languages, computer literacy, civics, business savvy, etc.);
- The development of lifelong career orientation and career guidance systems;
- The expansion of study opportunities and recognition of completed education – the design of equivalency systems (including on-the-job learning, alternative forms of education, distance learning);
- The advancement of skills training, higher education, and adult education, adjusted to labour market and individual demands;
- The expansion of access to learning for all age and social groups, with particular respect to persons in disadvantaged situations from the point of view of education and to persons who are at risk of losing or not finding jobs.

Training

Considering that – according to a survey conducted by the Hungarian Central Statistical Office in 2003 – the participation of the age group in question in adult education is very low – 10 percent of students are age 50-54 years and 2.7 percent are age 55 and older – one portion of the state subsidy programmes is intended to increase the participation of this age group. This portion took effect in 2002.

About 1,000 people over the age of 50 learned new trades within the framework of capitation support for adult education, receiving about 150 million forints in support funding. Employer contributions to

skills training, funds they retain to train their own staff instead of paying into a central education fund, also affects this age group, but we do not have detailed accounts. Reliable estimates say it also amounts to 150 million forints a year in supports.

Participation of the oldest groups in education

To promote the training of persons over the age of 55 years, in 2003 the National Institute for Adult Education, which included seven nationwide civic organizations supporting elders and other organizations in the project, initiated information technology training for older persons, teaching use of computers and the Internet. Funding available for the course amounted to 100 million forints and 2,500 people received training. Monitoring found that the programme had been a success.

The goal of the EzustNet – SilverNet – contest organized by the Ministry of Social Affairs in 2005 was to support older persons living in smaller settlements in learning how to handle computers and the Internet, and to independently access electronic information by visiting public access points, while encouraging their fellows to do the same. The programme offered support to people over the age of 60 years living in settlements with fewer than 5,000 residents to attend 30-hour computer operator and Internet user courses. The available funding amounted to 14,370,000 forints and nearly 500 people attended these courses. Urban and Budapest district governments regularly organize computer courses and basic foreign language courses for their retired citizens, and as of 2006, an Internet service provider financed computer courses being held in 11 cities. In 2007, another 1,000 persons can be trained in other cities.

On initiative of the Ministry of Social Affairs and Labour in September 2006, university instructors designed a retired peer-assistance training curriculum and study materials and in the first quarter of 2007, training of 50 people in a pilot study of that programme got underway.

RIS COMMITMENT 7: TO STRIVE TO ENSURE QUALITY OF LIFE AT ALL AGES AND MAINTAIN INDEPENDENT LIVING INCLUDING HEALTH AND WELL-BEING

Integrating the issue of ageing into sectoral politics

In 2003, the Ministry of Health, Social and Family Affairs initiated a series of workshop talks to which it invited staff from all other ministries. At these meetings, members of the Council for Elder Affairs and invited guests reviewed proposals for each sector of the economy within the Madrid International Plan of Action on Ageing and identified opportunities for the different ministries. The closest cooperation was among the culture, labour, and health ministries.¹⁴

The Council for Elder Affairs – included with its many other callings – considers it a primary goal to integrate ageing issues into the policies of each separate ministry. This is reflected in the subjects on the agenda of the Council for Elder Affairs, too. (See attachment.)

Targeted measures to reduce unequal access to healthcare and social services, including improving access for persons living in rural and isolated areas

In 2006-2007 a comprehensive healthcare reform got underway in Hungary. A review of the reform goes beyond the framework of this report, but we would like to include the hospital development component, since it has direct bearing on equalizing healthcare services and reducing uneven access.

¹⁴ In 2004 Social Affairs was separated from the Ministry of Health, Social and Family Affairs to become Ministry of Youth, Family, Social Affairs and Equal Opportunity, and since 2006 the Ministry has been operating as the Ministry of Social Affairs and Labour

One basic principle of hospital development states: “No matter where people live, they are entitled to equal access to the care they need and to receive it in a comparatively short period of time.” Within the framework of hospital development, there is an internal restructuring of hospital care underway. Beds available to persons with chronic disorders will increase by 7,500 (most of the people who need these beds are elderly), while the number of acute beds available to persons with locomotive disorders, tumours, and mental disorders will increase, amidst an overall 11 percent decline in the number of beds. This requires a major regional restructuring to eliminate inequalities from one county to another. In the social area, to *boost incentives for sub-regions to form service associations*, while recognizing the principle of freedom to associate, in 2004, parliament passed a law allowing the governments of settlements to form multi-purpose associations with other settlement governments on sub-regional level. With adoption of that law, it became possible to offer direct supports from the central budget to sub-regional associations, which offers direct advantages to citizens:

- they become able to offer quality services that become available to everyone alike
- unjustified social and regional inequalities will diminish

The 2004 budget was the first time that parliament offered funding to stimulate cooperation on sub-regional level. That funding amounted to 7.7 billion forints. In 2005, the Government earmarked another nine billion forints to support the sub-regional associations already in operation.

Public service task undertaken	Number of associations undertaking tasks and applying for subsidies	Total support for given public service task (Million Forints)
Social institutional task	17	342.6
Family assistance	44	499.5
Home assistance	33	165.8
Home assistance on signal	31	75.7
Communal services	13	40.5
Support services	21	116.5
Day-care	17	108.4
Internal control task	85	624.4
Mobile library task	22	200.0

As of 2006, entitlements for support for multi-purpose sub-regional associations have been included among the government supports offered on a capitation basis, resulting in funding amounts easier to predict. As far as we know, the *village caregiver service* is unique in Europe. The goal is to reduce the disadvantages resulting from the absence of institutions in small settlements, tiny villages, and outlying regions. The village caregiver’s activity is not limited to social care in the narrow sense of the term for it includes helping people to access the cultural life of the settlement, assisting residents to access healthcare facilities, transport of pre-school and school aged children, etc. These services may be introduced to all settlements with populations of fewer than 600 people, while homestead caregiver services are offered to outlying areas where there are a minimum of 70 residents.

Each year, the Ministry of Social Affairs and Labour has supported successful bidders for these services as follows:

Year	Amount available (million forints)
1996	200
1997	280
1998	180
1999	230
2000	230

2001	230
2002	311
2003	481
2004	126
2005	492
Total:	2693

Decree 20/1996 (VII. 26) NM of the Minister of Welfare on Home Care provides for *skilled nursing care* in the home of the patient. When ordered by the physician treating the patient it is free of charge. The nurse is authorized to make daily visits not exceeding three hours. The purpose of skilled nursing at home is to care for a patient in a home environment, offering personalized, humane, and skilled nursing care. This form of care can reduce the frequency of hospital visits, which are uncomfortable and more expensive.

The goal of care for terminally ill patients is to offer physical and emotional assistance and support to a terminally ill patient, helping to improve quality of life, alleviate suffering and rendering support to enable the person to retain his or her dignity to the end. A terminal patient is entitled to pain alleviation, to treatment of physical symptoms and to reduction of emotional suffering. The person is also entitled to be in the company of family and friends.

When possible, care for a terminal patient should be in the patient's home, in the company of family. To this end, the health insurance fund supports home hospice care. The physician treating the patient may order home hospice care for a maximum of 50 days, but following a second medical examination – and a newer written order – the 50 days of care can be repeated twice more.

Improving the skills of elderly persons with regard to self-care, health education, disease prevention and disability

As people grow older, increased attention must go to *accident prevention (principally falls that often results in hip fractures)*. A safety programme affiliated with the European Network for Safety among Elderly (EUNESE) was initiated in 2004. The domestic pilot project is focused on the safety of elderly persons who live alone and on senior citizens whose homes are in live-in facilities. The *Elder Friendly Home Programme* was initiated in 2003, on the initiative of the Council for Elder Affairs. The immediate aim of the programme is to present examples of how the homes of persons over the age of 75 who find it difficult to move about can be made safer for them. This enables them to retain their autonomy and contributes to maintaining their human dignity. A working group designed a series of measures adjusted to different types of homes and demands in 2006, presenting solutions applied to 50 homes between 2003 and 2005 to make life safer for 50 people over the age of 75 years who live alone. In four years, the Ministry of Health, Social and Family Affairs, later Ministry of Youth, Family, Social Affairs and Equal Opportunity spent 20 million forints on this programme. As of March 2007, the home remodelling solutions are available over the Internet.

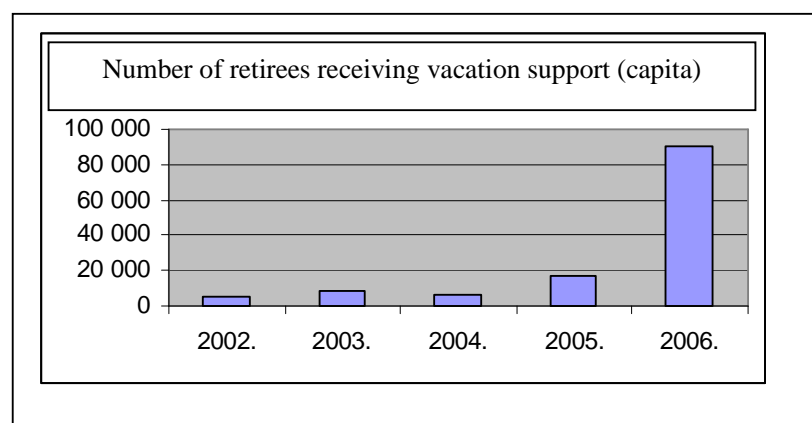
The EUNESE Programme already mentioned and the “Elder Friendly Home” Programme initiated by the Ministry of Social Affairs and Labour were connected in 2007. The concluding event in the programme will mark the start of a *nationwide campaign*. Programme specialists of the 2 programmes in every county in the country will discuss how elderly people can avoid falling and what prevention opportunities look like, including how to evolve a safe home environment. Other elements of the nationwide campaign include a road show attended by the media, posters in healthcare facilities and communities, brochures and other leaflets, and information accessible on longer term from a number of Internet websites.

The National Public Health Programme has been established in accordance with Parliamentary Resolution 46/2003 (IV. 16.) OGY. The goal is to promote a healthy way of life, and one subsection of the programme is on improving the health status of elderly persons. The primary goal of this programme subsection is to improve quality of life for a steadily growing older population. In 2003, the Ministry of Health, Social and Family Affairs used five million forints to support the upgrading of primary care to better resolve the specific problems of elderly persons. One tool was to organize a conference called “Lifestyle, joyful life 2003,” while another was to publish an extension training publication on the way of life of older persons, the care they need, and how they can be rehabilitated. Local governments, the Hungarian Red Cross, civic organizations for older persons and other NGOs focusing on healthy lifestyles hold multiple “Health Days” each year combined with screenings, where there are presentations, where tools are demonstrated, and where healthy foods are offered for tasting, to expand information on healthy lifestyles. Several walking movements have been recognized; they are organized by pensioners’ NGOs.

Support for therapeutic vacations and recreation for senior citizens

The Hungarian National Vacation Foundation is an NGO established in 1992 by the Government of the Republic of Hungary, and six trade union confederations as a public service entity. The main goal set by the founders was to provide subsidized vacations for workers, cooperative members and their families, retirees and for other persons who do not have separate incomes. It meets this task with financial support for physical and intellectual regeneration through vacations and recreation. The foundation accepts bids for vacations and grants them to persons unable to afford them on their own – in other words to persons in the lowest income categories – including pensioners. Decisions are made on the basis of objective criteria and are capitation-based.

Vacation vouchers won in competitive bidding processes can be used by retirees for a variety of purposes involving health maintenance (therapeutic spas), to treat illnesses (the vouchers will cover the costs of treatment), and for vacations, recreation, and leisure activities (leisure and cultural programmes, long-distance travel, etc.) Supports to retirees to take vacations have been growing dynamically. In 2002, the Hungarian National Vacation Foundation supported about six thousand retirees in taking therapeutic holidays, while in 2006 – with gradually increased funding – it supported over ninety thousand, at a cost of over three billion forints.



RIS COMMITMENT 8: TO MAINSTREAM A GENDER APPROACH IN AN AGEING SOCIETY

When the Republic of Hungary became member of the European Union, laws related to women's issues and equal opportunity were harmonized to conform to the EU. Outstanding among the many laws in this regard was Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunities.

The Ministry of Social Affairs and Labour *has a particular focus on collecting data separately by gender and age*, and working in cooperation with the Hungarian Central Statistical Office it issues an annual statistical pocketbook called Males and Females in Hungary.

Employment measures:

Support to female employment is a top Government priority. According to regulations, as of 2004, equal wages must be offered to males and females for equal work.

From 2004 to 2006, Hungary received funding from European Social Fund for domestic programmes such as the Human Resources Development Operational Programme and the EU's EQUAL Programme. It used the money to improve the employment situation of women, to encourage women to go into business, to disseminate family friendly jobs, and to start experimental programmes to reduce vertical segregation and dividing employment by gender.

Each year since 2000, the award *Family-Friendly Workplace* has been distributed to facilities that introduce measures to reconcile job and family obligations. It is granted to businesses and institutions that do an outstanding job in introducing family-friendly measures. Hungarian women with children under the age of five years take the fewest number of jobs in the EU-25 for only 32.1 percent are working. A defining role in this is played by a childcare support system which is not generous in the amount of money it distributes but is extensive in duration. People who take advantage of the system are officially declared economically inactive. The problem is that the three years that may be spent at home with a single child loosens a woman's ties to the labour market and weakens her chances of returning.¹⁵

Most supports available for children are available to the father as well as the mother, if the family should so choose. In addition, both males and females may undertake to care for elderly family members and receive carer's allowance – if they meet all other eligibility criteria.

RIS COMMITMENT 9: TO SUPPORT FAMILIES THAT PROVIDE CARE FOR OLDER PERSONS AND PROMOTE INTERGENERATIONAL AND INTRA-GENERATIONAL SOLIDARITY AMONG THEIR MEMBERS

There are a number of legal institutions in Hungary supporting family members in taking responsibility for one another, keeping in mind the reciprocity and solidarity¹⁶ values of generations.

Child care allowance is available to grandparents, and since 2002 grandparents receiving old age pensions may also receive this benefit. Since 2006, it has been available to grandparents who are recipients of regular social assistance granted as a quasi-pension. Child care allowance is available until a child reaches the age of three years. A grandparent may receive this benefit when caring for a child over the age of one if the parents submit a written statement, agreeing that the money be turned over to the grandparent. The monthly amount of child care allowance is equal to the minimum old age pension, and the time the recipient spends receiving it qualifies as creditable time for pension

¹⁵ Child care benefits available to grandparents will be discussed in the next section

¹⁶ Hospice care discussed earlier includes assisting family members of a terminally ill patient in caring for the patient, as well as offering emotional support to family members during the illness and the subsequent period of mourning.

purposes. In 2006, an average of 167,000 people received this benefit, of which 3,000-4,000 were grandparents.

The *carer's allowance* is granted to an adult family member who takes care of a chronically ill person within the household. This benefit has been a part of the social support system for over 15 years, and eligibility conditions have been expanded repeatedly over the years. The principle on which the supports operate is social solidarity, and it grants moral and financial support to a person meeting a family obligation.

Stipulations on the carer's allowance are in Act III of 1993 on Social Administration and Social Benefits. The carer's allowance may be set (out of fairness) by a local government for a person who nurses and cares for another person over the age of 18 years, who is chronically ill. The care may be provided by many different family members as specified by law, but not by a neighbour – which creates difficulties for a person with no family.

Benefits are available only up to a specific family income level, the amount of which is set by settlement governments in ordinances. In these cases, the primary care physician must certify that the person is chronically ill and that he or she needs continuous and long-term care.

	No. of persons receiving carer's allowances (capita)				Annual expenditure from budget (Billion forints)				Monthly amount of support in 2006
	1992	1995	2000	2005	1992	1995	2000	2005	
Carer's allowance granted for purposes of fairness ¹⁷	10,872	14,456	18,390	20,810	0.5	1.2	2.7	5.1	20,640 Ft (80% of the minimum old-age pension)

The period of time in which a person receives a carer's allowance qualifies as time spent on the job for retirement purposes, and the person is required to pay a contribution to the central pension fund and/or to a private pension fund.

RIS COMMITMENT 10: TO PROMOTE THE IMPLEMENTATION AND FOLLOW-UP OF THE REGIONAL IMPLEMENTATION STRATEGY THROUGH REGIONAL CO-OPERATION

Regional cooperation with the UNECE members

- Dr. Karl Blecha current president of the Austrian Council for Elder Affairs was invited to attend the central celebration of International Day of Older Persons in 2003 and during consultations he met with members of the Hungarian Council for Elder Affairs
- Representatives of AGE – The European Older People's Platform and of Help the Aged attended the May 2004 meeting of the Council for Elder Affairs and in their addresses they discussed their own activity.

¹⁷ There is also another type of carer's allowance in Hungary for people caring for a person with a disability. Discussion of that fee goes beyond the limits of this Report.

- In 2005, the Ministry of Youth, Family, Social Affairs and Equal Opportunity prepared a study called Elder Policy Practices in the European Union on Community and Member State level. It is available as a written document and in electronic form on the Ministry's website.
- In September 2005, the Council for Elder Affairs paid a three-day visit to Brussels where it reinforced its contacts and initiated new ones. As part of the study trip, there were meetings with representatives of the EU, with the European Interest Group, with the European Commissioner for Employment and Social Affairs Jan Jarab, and with the staff of AGE.
- In 2006, a staff member from the Council for Elder Affairs secretariat attended the lifelong learning conference and study festival in Munich.
- In 2006, a National Conference on Pension Affairs was organized in Parliament, addressed by Member of European Parliament Magda Kovács Kósa, who spoke on "Labour Reserves of the Third Age Group"
- In March 2007, delegations from AGE and Help the Aged will participate in and address the Council for Elder Affairs session and a conference on equal opportunity. Other speakers at the conference will be Members of European Parliament Katalin Lévai and Magda Kovács Kósa.

NGO participation in the process

- In 2005 the Council invited representatives of retiree organizations from neighbouring countries to Hungary to participate in a Welcoming of the Elderly at the Arts Palace, as well as to the presentation of the Elder-Friendly Local Government Awards and Conference. Guests came from Austria, Slovakia, Romania, Croatia, Serbia and Montenegro, Ukraine, and Slovenia.
- The Ministry of Youth, Family, Social Affairs and Equal Opportunity offered assistance in preparing a conference organized by the Retiree Clubs and Elderly "Add Life to the Years" National Association organized in 2006 together with the European Federation of Older Persons (EURAG), and called "Active Old Age."
- In 2007, the Budapest Association of Retirees, with help from the Ministry of Social Affairs, is organizing a conference on equal opportunity for elderly persons which will be attended by delegations from AGE and Help the Aged.
- One of the largest elder organizations has actively joined international senior sports life. For a number of years the Ministry of Health, Social and Family Affairs, later Ministry of Youth, Family, Social Affairs and Equal Opportunity has offered assistance to the organization in conducting its activity. In 2003, a 16-member delegation attended the First International Senior Games in Gent, Belgium. In 2005, with the agreement of the Ministry a delegation of Hungarian athletes attended the Second International Senior Games in Palermo. In 2006, the Council for Elder Affairs issued a decision supporting the holding of the Senior Games in Hungary. They will be held this September, in Győr. The Government has contributed 6 million forints toward the costs of the event.

Future opportunities

We propose that the UNECE initiate a campaign year of "Active Ageing" in Europe. It would be suitable for an international exchange of experience as well as for calling the attention of the national media to the project and thus influencing the attitudes of public opinion.

5. Conclusions and looking towards the future

In the past five years, Hungary has moved forward significantly in obtaining public forums for elderly persons, in advocacy for elder rights, in organizing NGOs, in promoting social participation, in social protections and in providing a fair income in an effort to be just. It took a number of measures, outstanding even when gauged by the whole of Europe, in a number of clearly circumspect areas including reinforcement of the Council for Elder Affairs, the elder-friendly movement, introducing the village caregiver and supporting vacations for elderly persons. Sadly, these outstanding measures and many other important and progressive measures – although they actually make up a system – do not appear as a system in society's eyes because there is no codified programme of action or specifically elder legislation.

The biggest challenge will be the rise in single-person households and the provision of social ties and care to single old persons. The Government is readying itself to respond to the challenges in healthcare and social affairs with comprehensive reforms, the details of which can be the subject of another Report. Similar powerful and all-encompassing steps need to be taken by local societies and particularly by communities of retirees to increase their strength, since as middle-aged generations become more mobile, the elder persons will have to rely increasingly on their communities of friends and neighbours.

It is already clear in light of experience with new retirees that the retirees of the decades to come will have different interests and be better educated and more prosperous than the current generation of persons over the age of 70 years. As a result, the social role of the older generations will change. Therefore, “silver economy” programmes, which offer services and products to elder persons, will have to pick up.

Today's elderly people over the age of 70 years have spent the majority of their lives in an economic, public life and cultural environment focused on egalitarianism, so any possible age discrimination is still difficult to catch, because of current economic and cultural differences. People of middle age and older tend to see fewer symmetric situations, while the retirees of the next few decades will pick them up quickly. Therefore, currently neglected discrimination research in Hungary will receive a bigger role.

In coming decades, it may be necessary to establish a scientific and methodology centre on ageing to promote partnerships between the NGOs and government sectors, to design programmes and information exchanges in the interests of strengthening local communities, and to support and coordinate research and conduct advances in methodology.

ATTACHMENTS AND ANNEXES

List of the organizations participating directly in preparing this report, and contact information

Name of Organization	Contacts
Elder Secretariat, Ministry of Social Affairs and Labour	1054 Budapest, Akadémia u. 3. idosugy@szmm.gov.hu
Budapest Organization of Konszenzus Foundation Budapest	1025 Budapest, Zöldlomb u. 24/A. gesko@konszenzus.org
National Federation of Bajtárs Associations	1087 Budapest, Kerepesi út 29/b. sipos.beosz@freemail.hu
Dr. Nándor Hun Association for Pensioners with Compromised Health	1077 Budapest, Wesselényi u. 17. hunnandor40@freemail.hu
National Federation of Hungarian Pensioners Associations	1081 Budapest, Köztársaság tér 26. nyosz@citynet.hu
Public Service Foundation of the Community of Hungarian Retirees	1051 Budapest, Arany J. u. 7. mnyk@pr.hu
Pensioners' Board of the National Confederation of Hungarian Trade Unions	1068 Budapest, Városligeti fasor 46-48. nyugdujasszovetseg@mszosz.hu
National Society of Agricultural Retirees	1054 Budapest, Akadémia u. 1. menye@mosz.tvnet.hu
National Federation of Retiree Clubs and Senior "Adding Life to Years" Association	1126 Budapest, Böszörményi út 20-22. nyugszov@hu.inter.net
Budapest Retiree's Association	1054 Budapest, Akadémia u. 1. postmaster@nyubusz.axelero.net
National Representation of Retirees	1107 Budapest, Mázsza tér 2-6. nyok@nyok.hu
National Civic Association of Retirees	1126 Budapest, Böszörményi út 20-22. postmaster@onype.t-online.hu
Pensioners' Board of the Teachers' Union	1068 Budapest, Városligeti fasor 10. szabo.zoli@citromail.hu
National Association of Railway Worker Pensioners' Clubs	1087 Budapest, Kerepesi út 14.
National Railway Workers' Union Pensioners' Organization	1062 Budapest, Podmaniczky u. 28. pallos@invitel.hu

List of organizations participating in the MIPAA/RIS follow-up and contact information**Government Institutions**

Elder Affairs Secretariat of the Ministry of Social Affairs and Labour	1054 Budapest, Akadémia u. 3. idosugy@szmm.gov.hu
National Public Health and Medical Officers' Service	1097 Budapest, Gyáli út 2-6 falusf@oth.antsz.hu
Division of Social Dialogue and NGO relations, Ministry of Social Affairs and Labour	1054 Budapest, Akadémia u. 3. istvan.nemoda@szmm.gov.hu
Hungarian Central Statistical Office	1024 Bp. Keleti Károly u. 5/7. informacioszolgalat@ksh.hu
Budapest Equal Opportunity Coordination Bureau	1077 Budapest, Wesselényi u. 17. bpeselyekhaza@erzsebetvaros.hu

Local Government Bodies

Budapest Municipal Government, Home for Senior Citizens	1173 Budapest Pesti út 117. pestiotthon@axelero.hu
Budaörs Municipal Government, Bureau of Social Affairs and Health	2040 Budaörs Szabadság út 134. kovesdi.gabriella@budaors.hu

NGOs

National Federation of Bajtárs (Companion) Associations	1087 Budapest, Kerepesi út 29/b. sipos.beosz@freemail.hu
Dr. Nándor Hun Association for Pensioners with Compromised Health	1077 Budapest, Wesselényi u. 17. hunnandor40@freemail.hu
National Federation of Hungarian Pensioners' Associations	1081 Budapest, Köztársaság tér 26. nyosz@citynet.hu
Public Service Foundation of the Community of Hungarian Retirees	1051 Budapest, Arany J. u. 7. mnyk@pr.hu
Pensioners' Board of the National Confederation of Hungarian Trade Unions	1068 Budapest, Városligeti fasor 46-48. nyugdujasszovetseg@mszosz.hu
National Society of Agricultural Pensioners	1054 Budapest, Akadémia u. 1. menye@mosz.tvnet.hu
National Federation of Pensioners' Clubs and Senior "Adding Life to Years" Association	1126 Budapest, Böszörményi út 20-22. nyugszov@hu.inter.net

Budapest Pensioners' Association	1054 Budapest, Akadémia u. 1. postmaster@nyubusz.axelero.net
National Representation of Retirees	1107 Budapest, Mázsza tér 2-6. nyok@nyok.hu
National Civic Association of Retirees	1126 Budapest, Böszörményi út 20-22. postmaster@onype.t-online.hu
Pensioners' Board of the Teachers' Union	1068 Budapest, Városligeti fasor 10. szabo.zoli@citromail.hu
National Association of Railway Worker Pensioners' Clubs	1087 Budapest, Kerepesi út 14.
National Railway Workers' Union Pensioners' Organization	1062 Budapest, Podmaniczky u. 28. pallos@invitel.hu
Alba Regia Pensioners' Association	8000 Székesfehérvár Városház tér 2.
Délután (Afternoon) Foundation	1093 Budapest, Közraktár u. 22. delutanalapitvany@t-online.hu
Hajdú-Bihar County Pensioners's' Association	4032 Debrecen, Jerikó u. 17-19.
Professional Association for Equal Chances and Equal Opportunity	8000 Székesfehérvár, Almássy telep 4. 1/46. marton.z@t-online.hu
Hungarian National Vacation Foundation	1146 Budapest, Hermina út 63. info@mnu.hu

Academic and research community

University of Debrecen, Medical and Health Science Center (Sándor Imre, MD)	4024 Debrecen Sumen u. 28. drimresandor@gmail.com
István Széchenyi University – Győr (Ildikó Somorjai)	9026 Győr, Egyetem tér 1. b.impet@chello.hu
Eötvös Loránd University – Budapest (Dr. Katalin Talyigás)	1026 Budapest Nagyajtai u. 1/b. bullain@mail.datanet.hu
Eötvös Lóránd University Institute of Sociology (Sándor Mátyási)	1117 Budapest, Pázmány Péter sétány 1/a.
Studio Metropolitana Urban Research Centre Public Society (Zsuzsanna Kravalik)	1075 Budapest, Madách Imre tér 1-3. kravalik@studiometropolitana.hu

Religious Bodies

Lutheran Church (Dr. Katalin Breuer)	1055 Budapest Markó u. 1/a breuer@t-online.hu
Hungarian Maltese Charity Service	1125 Budapest Szarvas Gábor u. 58-60. mmszok@malta.hu

Independent Experts

Dr. Teréz Sütő	9400 Sopron Kertvárosi u. 14. Suto_@axelero.hu
Mrs. Árpád Tóth	8083 Csákvár Május 1. út 3.

Private Sector

Budapest Bank Foundation Bureau	1138 Budapest Váci út 188. maria1.nagy@ge.com
Magyar Telekom	1541 Budapest
Senior 2003 Ltd.	9028 Győr Soproni u. 53. jgyorgyi@szenior.hu
Hotel Association of Hungary	1123 Budapest Jagelló út 23. hah@axelero.hu
Magyar Turizmus ZRt (Hungarian Tourism Co.)	1012 Budapest Vérmező út 4. mtrtit@itthon.hu

Cultural Institutes

Hungarian Institute for Culture	1157 Budapest Páskom park 17. peterfi@kkapcsolat.hu
Budapest Cultural Centre	1119 Budapest, Etele út 55. nagy@bmknet.hu

Specialist Media

Hungarian Public Radio (Eta Martos)	1800 Budapest Bródy S. u. 5-7. pataki.agnes@radio.hu
SeniorOK	1089 Budapest Korányi S. u. 4. II./21. seniorok@seniorok.hu

Hungarian Charter on Elderly People (September 2001)

Measures of the Hungarian Charter on Elderly People

Participation in social activities

- Elderly people are full-fledged citizens of the country. Their contribution in the intellectual, cultural, social and economic fields and their activities in helping their families are social assets. It must be promoted that they give their experiences and knowledge to younger generations. Any discrimination, prejudice and separation concerning elderly people are detrimental to society.
- As members of society with equal status, elderly people should be given a chance to participate in the drafting of legal acts through their representatives, especially in cases which essentially affect their situation. Questions related to elderly people and the requirements resulting from their special situation should be integrated into major national economic, social and health programmes.
- Cooperation forms and institutions have to be established where a permanent cooperation between young and old generations can be achieved with respect to the economic and cultural activities of society as well as to the deepening of intergenerational solidarity, the preservation of its values and its development.
- Organisation and development of movements engaged in the matters of elderly people, the organisation of elderly people and the establishment of associations and clubs at the service of each other and the society have to be supported.
It is a natural phenomenon that elderly people form interest organisations and participate in international organisations with similar objectives.
- The issue of ageing creates a wide range of knowledge leading to the establishment of a new branch of science. Organised education in this field should begin in early childhood applying up-to-date communication techniques.
- Hungarian media should pay more attention to the social problems of ageing and issues of economy, pensions, social benefits and health. The representatives of this age group should be involved in the managing bodies of public media in accordance with their social weight and importance.
- Together with civil organisations, governments should ensure proper celebration of the International Day of Elderly Persons.

Material conditions of the life of the elderly

- Elderly people are entitled to all benefits necessary for dignified living. They are entitled to a pension earned by their work and their contributions that ensures decent living conditions for them and also to a just pension system that guarantees this.

- Elderly persons who do not have a decent income and therefore need support have to be cared for by extensive social measures. This should enable them to maintain their lifestyles, meet their needs and access specific health benefits.
- The government must guarantee a right to elderly people to have basic social benefits at their place of residence.
- Appropriate provisions and incentives need to be put in place and applied for the gradual retirement of elderly people who are still capable of working, in agreement with those interested. Negative discrimination based on age should be eliminated in employment. Employment and pay should depend on ability to work and on performance and not on age.
- The actual employment policy should ensure a favourable opportunity to the elderly for participation in training programmes, thus promoting that they remain active players in society for a longer time.

Health care, social benefits and care

- Elderly people often get in a dependent and vulnerable situation. They should be properly protected in an organised way and have access to advice services for the prevention and the elimination of accumulated dangers they face (criminal activity, transport, negative discrimination).
- The operational functioning of the health and social sector as well as the provision of benefits and care need to take account of the specific needs of elderly people, including the prevention and treatment of diseases which occur more frequently in old age, the rehabilitation and continuous care of elderly people and access to necessary medicines.
- Healthcare benefits should be based on a statutory insurance system operating on the solidarity principle, in the framework of which both basic benefits and other health and social services necessary for a decent life should be made available. Supplementary insurances might provide further coverage.
- Demographic changes, as well as morbidity and mortality data justify an institutional reform of the social and health care services to elderly people. To this end, an appropriate action programme needs to be designed.
- The action programme must ensure the development of up-to-date ageing research and training. It seems necessary to form an expert interdepartmental coordination committee, dealing with ageing, social and health issues.

Protecting the rights of elderly people

- Protection of the rights of the elderly must be ensured by state, social and municipal bodies and authorities during their procedures and activities.
- The Government shall establish, above and beyond the Council for Elder Affairs, an Elder Rights' Commissioner, under the supervision of the Minister of Social and Family Affairs; furthermore, it shall see to it that in the county/Budapest offices of public administration, elder rights' advocates are employed under the coordination of the Elder Rights' Commissioner.

**Government Decree 1138/2002 (VIII. 9.) Korm
on the operation of the Council for Elder Affairs and issues related to its operation**

1. The Government, in consideration of its responsibility for improving the living conditions of the elderly as well as in order to express the interests of the elderly more successfully within government activities, hereby establishes a Council for Elder Affairs (hereinafter: Council). Operating alongside the government, the Council shall serve as a consultative, advisory, proposing, and in a specific sphere of tasks, coordinating body.

2. The Council's tasks shall be as follows:

a) to develop position statements on legislation directly affecting the living conditions of the elderly and other government decisions in the preparatory phase, to make proposals on planned measures, and to initiate consultations on implementation experience;

b) to protect the interests of the elderly, to relay the proposals and opinions of the non-governmental organizations charged with meeting the typical needs of this age group to the Government;

c) to participate in Government measures taken to prepare for the International Day of Older Persons and in related programmes;

d) to compile annual reports on the activity of the Council for Elder Affairs.

3. The Council's

a) president shall be the Prime Minister, for whom the Council vice-president shall substitute if the Prime Minister is unable to attend,

b) vice-president shall be the Minister of Youth, Family, Social Affairs and Equal Opportunities,

c) members shall be invited by the Prime Minister in part on the proposals of organizations advocating for the interests of the elderly, and in part from among professionals in medicine, demography, and social policy, religious denominations, local governments, and non-governmental organizations.

4. One delegate each from the Ministry of Health, the Ministry of Youth, Family, Social Affairs and Equal Opportunities, the Ministry of Finance, the National Health Insurance Fund, the National Pension Insurance Directorate, and the Hungarian Central Statistical Office shall attend the meetings of the Council upon standing invitation as non-voting participants.

5. The Council vice-president shall appoint the secretary of the Council. Funding for the operation and programmes of the Council shall be provided by the section of the central budget covering funding for the Ministry of Youth, Family, Social Affairs and Equal Opportunities.

6. The Council shall adopt its rules of procedures and plan of work.

7. The Government hereby calls on the non-governmental organizations and foundations whose activity affects the living conditions of the elderly to support the activity and programmes of the Council.

8. The Government hereby calls upon the ministers and the leaders of other bodies with nationwide authority to allow the Council to exercise its right to be consulted and to advise in the course of drafting conceptual arrangements that fundamentally and directly affect the living conditions of the elderly.

9. The Council's operations shall not affect the tasks or authorities of the ministers and bodies with nationwide authority as specified by law.

10. This decree shall enter into force on the day of its promulgation and at this time Government Decree 1116/1996 (XII.6.) Korm on the establishment and tasks of a Council for Elder Affairs, as well as Subsection 10, Paragraph *a*) of Government Decree 1130/1998 (X.6.) on the review of certain government decisions related to the reshaping of the Prime Minister's Office and on further tasks shall be repealed.

11. It must be ensured that the Council for Elder Affairs in its new composition of members be convened within 30 days of the entry into force of this decree.

Council for Elder Affairs - Plan of Work for the Year 2003

February

1. The effects of the accession to the European Union on the elderly
2. Evaluation of the 2002 activity of the re-established Council for Elder Affairs
3. Activity of the organizations advocating for the elderly in 2002
4. Adoption of the Council for Elder Affairs Plan of Work for 2003
5. Proposal of the Ministry of Health, Social and Family Affairs for using the budgetary appropriations earmarked for the 2003 Council for Elder Affairs programmes and the order for submitting and deciding on requests for support
6. Miscellaneous

April

1. Experimental models in geriatrics
 - a. Experimental model at the Central Hospital of the Hungarian Railways (MÁV Hospital)
 - b. Introducing the 'ISZER model' (Integrált Szociális és Egészségügyi Rendszer - Integrated Social and Healthcare System)
 - c. Plan for evolving geriatric care at 'Szent Rókus' Hospital
2. Grandparents for Grandchildren, Grandchildren for Grandparents, a priority programme of the Council for Elder Affairs
3. Current information
 - Briefing on the system of charges to be paid to social institutions
 - Briefing on preparing the law covering the National Civil Fund Programme
 - Briefing on the establishment of the Council for Elder Affairs and cooperation among the ministries on this issue
 - Briefing on setting up the Internet website ezustkor.hu [Age of Silver]

June

1. Briefing on the design of the Programme for Active and Dignified Ageing and discussions on the sections that have already been elaborated
2. Reports of the interdepartmental committee and the working groups preparing the programme (benefits for retirees, clarification of pension-related concepts)
3. Presentation of a test-version of a Portal for Elder Affairs
4. Proposal to amend the rules of procedures
 - a. Raising extra agenda points at the meeting
 - b. How Council Members can represent the Council for Elder Affairs
 - c. Delegates of regional Councils for Elder Affairs may participate in the meeting with consultative (non-voting) rights
5. Planned transformation of the system of covering medication costs for the indigent
6. Briefing on the processing of requests to increase pensions for reasons of fairness and a Pensioners' National Representation (NYOK) survey
7. Miscellaneous
 - Preparations for Pensioners' Island programmes

September

1. Presentation of credentials and introductions of new Council members (representatives of non-national organizations),
2. Preparations for the UN International Day of Older Persons
3. Evaluation of Pensioners' Island
4. Miscellaneous

October

1. Discussion of pension measures and draft legislative amendments planned for 2004
2. Relationship between retirees and former employers
3. Briefing by Ministry of Employment and Labour on the employment situation of the ageing population
4. Evaluation of the expanded draft of the Government National Action Programme for Elder Affairs (KINCS)
5. Miscellaneous

November

1. Debate on the draft implementing decrees for the legislative changes taking effect in 2004
2. Briefing on how funding to support the Council for Elder Affairs programmes was used in 2003
3. Proposal on considerations and methods of using funding available for support in 2004
4. Briefing on processing of requests for fairness-based pension increases
5. Experience in implement the "Walk for Health" programme
6. Evaluating Council for Elder Affairs operations in 2003. Proposals for the content of the Plan of Work for the first half of 2004
7. Miscellaneous

Written briefings:

- Hungarian language version of the Madrid International Plan of Action on Ageing (MIPAA)
- Quarterly briefing on the processing of requests for fairness-based pensions (Dr. Gábor Barát, Director-General, Central Administration of National Pension Insurance.)
- Professional summaries on pensions and on the pension system
- Summary on the most frequently asked questions by residents
- Professional and statistical briefing by the Hungarian Central Statistical Office

Council for Elder Affairs - Plan of Work for the year 2004

January

- Evaluation of activity conducted by the Council for Elder Affairs in 2003 (proposal on admission of possible new members)
- Council for Elder Affairs Plan of Work for 2004
- Proposal by Dr. Pál Aszódi on amending the government decree resolving the status of people imprisoned between 1945 and 1963 and in connection with the revolution and freedom fight of 1956
- Miscellaneous: the system of subsidized holidays in 2004

February

- Briefing on experiences gained from the experimental model started up in 2003
 - 3 geriatric models
 - Elder Friendly Home Programme
- Opportunities for supporting transportation for pensioners
- Review of government proposal for implementation of Parliamentary Resolution 78/2003 OGY “on improving the living conditions of pensioners in the process of accession to the European Union”
- Briefing on preparations for the “Elder-Friendly Local Government” awards

March

Ongoing initiatives as well as arrangements by the Ministry of Health, Social and Family Affairs that are in the pipeline or planned for the immediate future and which have an impact on the elderly

- Briefing on the conceptual draft of the basic solidarity act (SZOLID)
- Briefing on the health reform concept
- Advancing the geriatric care network
- Experience with the Johan Béla National Programme for the Decade of Health and with the Public Health programme and future trends in this regard
- National Health Insurance Fund (OEP) changes in services for the elderly
- Briefing on preparations for a Joint Memorandum on Social Inclusion and on a plan of action

April

Elderly people as citizen of the European Union

- International Relations of Council for Elder Affairs member organizations and members, presentation of a few “good practices”
- Elder affairs in the EU – the importance of an active old age
- Consumer protection in the EU

May

Equal opportunity, employment

- Equal opportunity for elderly persons, too
- The law on legal assistance - “People’s Defender”
- Employment of pensioners: introducing new forms of employment, incentives on the labour market (part time work, telecommuting)
- Pensioners as volunteers

June

- Government National Action Programme for Elder Affairs
- The significance of teaching geriatrics as a specialty in undergraduate medical education
- Briefing on the meeting of the working group preparing the UN International Day of Older Persons

July

Meeting to be convened as needed or on written proposal of Council for Elder Affairs members

August

Meeting to be convened as needed or on written proposal of Council for Elder Affairs members

September

Education

- Opportunities for education and training for senior citizens
- Information technology for the older generations
- Elder affairs in higher education
- Briefing on the senior sports programmes of the National Association of Clubs for Railway Worker Retirees

October

October 1 UN International Day of Older Persons

October 5 On-site meeting in Sopron

end-of-October meeting:

- Opinions presented on pension measures planned for 2005 and on planned amendments to other laws
- Questions related to other issues of the draft 2005 budget that affect pensioners (inflation, VAT, utility fees, etc.)

November

- Briefing on processing of requests for fairness-based pension increases
- National Health Insurance Fund (OEP) experiences for 2004
- Briefing on the operation of the National Civil Fund Programme
- Experience of the 2004 subsidized holiday programme, and proposals for next year

December

- Council plans for 2005
- Operation of the Public Foundation for Patients' Rights, Care Recipients' Rights and Children's Rights
- Government plans to improve the living conditions of nearly 1.2 million pensioners in need, using central budget funds
- Current issues of concern to pensioners and elderly persons

Council for Elder Affairs - Plan of Work for the year 2005

January

- Briefing on the government's plans for 2005
- Briefing on amendments to the Social Act affecting elderly persons
- Proposal on expanding the "Elder-Friendly Local Government" award for 2005, proposal to establish minister's award
- Proposal for the Council for Elder Affairs Plan of Work for 2005

February

- New phase in the Public Health Programme
- Concept of transforming method of providing free medication to the indigent population
- The phasing of Council for Elder Affairs consultations for 2005 and the establishment of working groups

March

- The situation of agricultural retirees, conditions for early retirement for farmers
- Presentation of the programme "For a Village that's Better to Live In"
- Presentation of the social system for the elderly, with particular focus on the land programme, the operation of the village caregiver and the homestead caregiver network

April

On-site meeting (Nyíregyháza)

- Relationship between Council for Elder Affairs and University of Debrecen (gerontology research and education programmes at University of Debrecen)
- 15 years in the service of social policy and of social worker training (the 15-year history of the Healthcare Faculty and the General Social Worker Faculty at the college in Nyíregyháza)
- Nyíregyháza, winner of the Elder-Friendly Local Government Award for 2004 (discussion of achievements to date and future plans)
- Role and significance of the Retirees' Organizations of Szabolcs-Szatmár-Bereg County in the social integration of elderly people and in maintaining relations with neighbouring countries

May

On-site meeting (Óbuda-Békásmegyer [Budapest] Local Government and the Hungarian Maltese Charity Service (MMSZ))

- Current situation of basic social and day care services in the capital
- Presentation of Óbuda-Békásmegyer social services
- Presentation of social services of the Hungarian Maltese Charity Service
- Cooperation among social institution networks

The meeting will be linked with opportunities to visit institutions

June

- Briefing on the draft for the National Strategy Report on Pension to be prepared in the framework of open coordination of the EU
- Sustainable value of pensions and factors that influence it
- Briefing on processing of requests for fairness-based pension increases
- Report on the activity of the National Institute of Medical Expertise which provides professional opinions on entitlement to receive disability pensions
- Briefing on social systems affecting senior citizens

September

- Provisions of medical devices and other therapy factors
- Pensioners in the EU (will invite a Member of Parliament who represents Hungarian retirees)
- National Development Plan and Europe Plan
- Retirees' organizations and their ties with organizations in neighbouring countries

October

On-site meeting, Sopron

- Latest results of gerontology research
- Briefing on tasks completed in the National Crime Prevention Committee
- Crime Prevention situation – with particular respect to the elderly
- Presentation of the Patients' Rights Foundation, review of work by advocates of the rights of care recipients

This meeting is connected to a three-day conference entitled "Abuse and its victims; legal, healthcare and social protections"

November

- Briefing on pension increases anticipated in 2006
- Consumer protection as interest advocacy
- "Five Years after the UN International Year of Older Persons"
- Evolving cultural, education and employment opportunities for pensioners
- Results of the survey on "Everyday discrimination against the elderly"

December

- Report on the activity of the National Health Insurance Fund (OEP)
- Summary of the 2005 experience of the Council for Elder Affairs
- Plans for 2006

Programmes

- Series of workshops to analyze the experience of the "Elder-Friendly Local Government" contests, dissemination of information on the award among a wider public

- Series of programmes: National Meeting of Retired Poetry Reciters marking the 100th birthday of poet Attila József
- Invitation to Brussels in September by Members of European Parliament Magda Kovács Kósa and Katalin Lévai, September
- Conference and presentation of “Elder-Friendly Local Government” award
- Gala programme for “UN International Day of Older Persons”
- Geriatric conference

Subjects of consultations and working groups

- Consultation on subsidized holidays for pensioners (January)
- Preparing National Civil Fund Programme competitions and reports (February)
- Methodological and consultative cooperation with the Hungarian Central Statistical Office on the pensioners’ consumer price index (February)
- Preparing for the UN International Day of Older Persons (June-July)
- Evolving the considerations and aspects to focus on in reports by pensioners’ organizations – Working group (proposal by György Jankovits)

Council for Elder Affairs - Plan of Work of the Year 2006

Regular agenda topics:

- Reports by members assigned to represent the Council for Elder Affairs on their work as representatives

January

- Report on the activity of the Council for Elder Affairs in 2005
- Proposal for Council for Elder Affairs Plan of Work for 2006
- Briefing on the National Holiday Foundation and opportunities for organized group holidays
- Briefing on the activity of the DéiUtán (AfterNoon) Foundation

February

- Necessary and possible ways of improving the situation of pensioners from farming cooperatives receiving annuities instead of pensions
- Current issues related to medicinal products, medical devices, therapeutic spas and free medicines for the indigent
- Briefing on plans to train social workers in healthcare
- Briefing on safety measures taken to protect the elderly

March

- Briefing by pensioner organizations on their activity in 2005 (if needed)
- Presentation of civic organization networks assisting the elderly
- Operation of the National Civil Fund, experience of elections and competitive bids for grants/assistance

April

- New element of the pension system, the 4th pillar
- Review of widow's/widowers' pensions
- Opportunities to offer special benefits to persons aged 80, 90, 95, and 100.
- The practice of providing legal assistance, with particular respect to the elderly

May-June

- Reports by members assigned to represent the Council for Elder Affairs on their work as representatives
- Briefing on the activity of the National Institute of Medical Expertise
- Role of the National Health Insurance Fund (OEP) in accident care
- Briefing on the processing of requests to increase pensions for reasons of fairness and on the experience following introduction of one-off exceptional assistance

September

- Review of social science research projects affecting the elderly
- Experience with bids for the title of Elder-Friendly Local Government 2006
- Topicality of passing a law on the elderly
- Briefing on annuity contract arrangements and on the experience of persons utilising them

October

Social benefits for the elderly

- Trends in the theoretical and practical implementation of a fair social provisions system and concrete longer term tasks
- Briefing on homes for the elderly run by the central government, religious denominations and private entities from the point of view of changing rules
- Forms of home care using alarm systems and possible development trends

November

The health status of elderly persons

- Briefing on the process of admission to homes maintained by the Budapest Municipal Government, and presentation of the activity of the Admission Preparation Group
- Chances to remain healthy while growing old in Hungary - Results of a public health survey
- Briefing on the outcomes of activity of the parts of the Public Health Programme that affect senior citizens
- Briefing on pension increases expected in 2007

December

- Briefing by the Director-General of the Central Administration of National Pension Insurance (ONYF) on the Administration's activity through the past year and on topical issues, including a study of the regular annual pension increases
- Briefing by the Director-General of the National Health Insurance Fund (OEP) on the Fund's activity through the past year and on topical issues
- Summary of Council for Elder Affairs experience in 2006
- Plans for 2007

Programmes

- Scientific conference on elder affairs organized by the Hungarian Central Statistical Office (May)
- Conference and presentation of "Elder-Friendly Local Government" award (September-October)
- Gala programme to celebrate UN International Day of Older Persons
- Training programmes for civic organizations representing pensioners (information on elder affairs, techniques for grant applications, and rule for preparing reports) and for winning and losing bidders who applied for Ezüstprog-05 (SilverProg-05) funding (February-March)

Consultations, exchanges of experience

- Conference on pension strategic issues (February)
- Preparations for UN International Day of Older Persons (June-July)
- Visit to "Kincses Sziget" [Treasure Island] senior citizens' home in Noszvaj (NE Hungary) to exchange experience
- Virtual or real visit: The Internet website of Budapest Municipal Government Home for Senior Citizens on Pesti Avenue celebrates its 5th anniversary

Council for Elder Affairs - Plan of Work for the Year 2007

1. Planned meetings of the Council for Elder Affairs and their agendas

FEBRUARY	<ol style="list-style-type: none"> 1. Briefing on trends in the welfare-supported holidays for senior citizens and on available grants for 2007 2. Report of the Council for Elder Affairs on its 2006 activity 3. The Council for Elder Affairs work plan for 2007 4. The need to amend Act I of 2003 on the National Civil Fund Programme, and how to amend it 5. 2007 – European Year of Equal Opportunities
MARCH	<ol style="list-style-type: none"> 1. The Central Administration of National Pension Insurance (ONYF) will present a briefing on its activity in 2006 and on its management of issues based on fairness 2. Opportunities to advance the system of assistance to persons providing informal nursing care to family members in the home¹⁸ 3. Trends in cultural modernization – the role of culture in the lives of elderly persons: opportunities for joining cultural grass-roots organizations 4. Briefing in which representatives of the European Older People's Platform (AGE) will be present, on preparations for a conference scheduled in March
MARCH	<p>Session with the contribution of AGE officers (The European Older People's Platform)</p> <ol style="list-style-type: none"> 1. Outlook on the senior policy of the various European Union institutions 2. Affects of certain components of the Elder-Friendly Movement (local governments, hotels, fee for older persons) on domestic elder policy and areas in which development is possible 3. Briefing on preparations for the 2007 Elder-Friendly Local Government competition and conference 4. Implementing elder policy in regions and sub-regions, and the experience of elder-council operations
APRIL	<ol style="list-style-type: none"> 1. Preparations for UN International Day of Older Persons 2. Briefing on the 2007 budget of the Republic of Hungary with regard to measures directly affecting senior citizens 3. Reviewing the Operative Programmes of the National Development Plan – the elderly as a target group 4. Alternative arrangements in elder care
MAY	<p>JOINT SESSION WITH THE COUNCIL FOR DEFENCE RETIREES</p> <ol style="list-style-type: none"> 1. Briefing on social benefits to defence organization retirees and on the activity of the Council for Defence Retirees 2. Elderly-related employment policy 3. Employment and social assistance to persons with altered working

¹⁸ Postponed

	abilities in the light of changing regulations 4. Issues related to the concepts of perspective pension reform
JUNE	1. Meeting of generations – Meeting with the heads of nationwide youth organizations 2. What can civic organizations do to help the elderly to a more liveable life and to conditions of human dignity? 3. Briefing on the four-year-old programme Grandparents for Grandchildren and Grandchildren for Grandparents 4. TOPICAL ISSUE
JULY-AUGUST	Summer recess
SEPTEMBER	Joint meeting with the Social Council and the National Health Council 1. Effects of the Healthcare Reform on elder care and general experience with it 2. How access to healthcare services has changed for rural residents 3. TOPICAL ISSUE
OCTOBER	1. Guidelines in promoting relations between government and civic bodies 2. Review of the decisions and measures taken by the Council for Elder Affairs in the first half year 3. Briefing by the pension reform working group 4. TOPICAL ISSUE
NOVEMBER	1. Briefing by the National Crime Prevention Committee 2. Review of study opportunities for seniors 3. Listening to report by representatives of eldest senior citizens 4. TOPICAL ISSUE
DECEMBER	1. Elaboration of conditions for elder policy on regional and sub-regional levels 2. Summary of Council for Elder Affairs work in 2007 3. Establishing major targets for 2008 operations

4. Consultations, programmes

- Consultation on training in Senior counselling which is to begin in March (January)
- Group meetings to evaluate the national follow-up report of the UN European Economic Commission (UNECE) Regional Implementation Strategy (RIS) (February)
- Conference with the participation of an AGE delegation (March)
- Programmes of the Elder Professional Workshop within the framework of the “UN Action Plan for Older Persons is Five Years Old”
- Participation in the Seventh National Forum of Retired Soldiers and Defence Retirees (June)
- UN International Day of Older Persons (connected to October 1)
- Elder-Friendly Local Government Conference and presentation of award (connected to October 1)
- Participation by delegated members in the work of committees and working groups (ongoing)

Hungarian National Action Plan on Social Inclusion (2004-2006)

Page 52-54

3.4.2. Activation and dignity for the elderly

Similarly to European trends, the general ageing of population is increasingly typical in Hungary, too. This is an increasing challenge as far as maintaining living conditions and quality of life are concerned. The strata of elderly are differentiated. There are groups of youthful, energetic persons as well as a growing number of fragile elderly who need significantly more nursing and care capacity than are available at present. Meanwhile responses to the challenges of age, the issues of “active ageing” are being increasingly spotlighted in Hungary, too. At the same time, from the point of view of the living conditions of retirees, increasing the rate of economic activity is a key, which means that early retirement needs to be effectively reduced.

In past years numerous measures were taken to assist retirees to *improve their financial situations*:

In 2003 and 2004, widows pension, provided in addition to their own pension, were raised from 20% to 30%, which affected about 580,000 widows. As of 2003, the concept of a 13th month pension is gradually being introduced. The full 13th month will be paid in 2006 for the first time, until then the pension will be increased by one week each year. In 2004 the extra amount is being paid in two instalments, one in May and one in December. In 2003, the real value of pensions was increased by 8% (partly as a result of the introduction of the first week of the 13th month). A further increase in real value is expected in 2004.

The target is to assist elderly people to actively and extensively participate in society, to achieve an active and dignified life as senior citizens. In order to do this we must establish an elderly-friendly physical and social environment and expanded access to public services, insure the reinforcement of participation in local community and shaping the social attitudes towards senior citizens and facilitate inter-generational solidarity

The *Government National Action Programme for the Elderly* (KINCS) will coordinate measures affecting elderly persons in various policy fields. The programme is targeted at improving information (research and conferences) and activating elderly people (training, programmes), as well as improving their healthcare and welfare (geriatric wards, professional nursing home, expanding caregiving).

The extensive travel concessions offered to senior citizens in Hungary - compared to elsewhere in Europe - serves to *support a senior-friendly physical and social environment and an active old age*.

- Road and rail transport is free of charge within the country for persons over the age of 65,
- Pensioners who are not yet 65 may purchase monthly tickets for local transport at a preferential rate as well as 16 long distance tickets at a 50% reduced rate or 8 tickets at a 90% reduced rate, plus another two tickets at a 90% reduced rate annually,
- Women over the age of 55 and men over the age of 60 are eligible to 20% reduced rate on rail transport.

A model programme called “Senior-friendly housing” was begun in 2003. In 2004, taking advantage of the experience of redesigning some 40-50 apartments to make them senior-friendly, a series of technical and architectural standards are being established. They will assist fragile elderly (principally

persons over the age of 75) who live alone and have reduced functional capabilities to remain in their own homes amidst secure conditions and to stay active.

The establishment of an award called “Senior-friendly Local Self-Government” is being established to *promote participation in local communities*. The programme will seek out “best practice,” and disseminate them. Local self-governments are key players in creating a physical environment appropriate for elderly people, for promoting participation in cultural life, for including the elderly in local public life, and for assuring public services. As of 2004, three local self-governments a year, which are deemed the most outstanding in this area, will be awarded and together with the other most successful bidders, will meet at conferences and publish good practice aimed at improving quality of life for seniors in a yearbook.

To shape societal attitudes towards the elderly, the following programmes are being established between 2004 and 2006:

- A series of research projects called “Living conditions for seniors” on the elderly population, its health status, living conditions and activity,
- Celebration of World Senior Day and month, turning it into a social event,
- Dialoguing by media campaigns, publications, conferences to popularise active ageing,
- A senior sports meeting is being organised yearly from 2004. It will be a nationwide sports event involving elderly persons.

Supporting inter-generational projects aimed at furthering tradition, culture and recreational activities are intended to *build solidarity between generations*.

Expanding access to public services

A project within the framework of the *National Public Health Programme* aims to disseminate innovative methods in the area of geriatric outpatients and daytime healthcare. Within this framework, integrated social and healthcare services adjusted to the demands and needs of senior citizens and accessible from their homes will be modelled.

In the period between 2004 and 2006

- the financing of geriatric wards has to be ensured with their own geriatric code system,
- acute hospital beds have to be transformed to be able to provide long-term nursing care
- the hospice system has to be evolved and disseminated within both an institutional and a home-based care framework
- the system of skilled home-based nursing has to be advanced.

The development of *social services* for elderly people - particularly as regards basic services - include home care support services which allow this group to remain in their homes and continue to live safely and independently. The goal is for this care to be accessible in all settlements throughout the country. Currently, 55% of local self-governments offer these services.

A supplementary form of home care support is the ‘signalling’ system. It is offered by 247 local self-governments and is accessible throughout the country except for Heves and Nógrád counties. As of 2004, the development of the signalling system will receive priority. The government has introduced capitation grant for this form of social care services as of 2004.

The developmental goals between 2004 and 2006:

- strengthening cooperation between home care support, primary healthcare services and the home-based nursing service to improve the effectiveness of home care in every settlements,
- home care support with signalling system is to be made accessible in 500 settlements,
- developing both home-based and institutional care facilities for elderly people with dementia, in terms of institutional care specially financed dementia care centres to be set up in 800 nursing homes by 2006,

- provisions of Internet access (with 2,100 computers) to be set up in day-care, transition institutions, and elderly homes to improve their chances of accessing information.

The Hungarian Information Society Strategy (MITS) sets a high priority on *promoting equal access to information technologies*, which includes promoting computer and Internet access for senior citizens and training programmes. The target is to increase the number of computer and Internet users among the over-60 population by 15% by 2006.

Assuring multi-channel access to information (traditional, electronic, and telephone) supports the dignity and autonomy of elderly people. As of 2004, a service called DR. INFO, which operates over the telephone and the Internet, will be made available. It offers general information on health issues in an easily accessible manner and plans are to advance the system following a targeted survey. KINCS plans to introduce other telephone services by 2006, which elderly people can access.

As mentioned in the Report, the Hungarian elderly-policy has not got one unified and codificated document. The most recent and comprehensive strategy is stated in the National Strategy Report on Social Protection and Social Inclusion (2006-2008), in chapter 3. (National Strategy Report for Pensions 2006-2008) and chapter 4 (The healthcare system and long term care).

National Strategy Report on Social Protection and Social Inclusion (2006-2008)

3. National Strategy Report for Pensions 2006-2008

Introduction

The purpose of the transformation of the pension system is to adapt the pension system to the constantly changing conditions. In the short term, the focus is on the measures improving the efficiency of the system and the balancing the shifts in proportions, while in the long term the requirement is to align the operation of the pension system with demographic processes, while maintaining the appropriate level of pensions, the sustainability and adaptability of the system.

The Government is committed to carry on the pension reforms started in 1997, the relevant politicalstrategic decisions will be made before the end of 2006. However, even before that the Government put on the agenda the implementation of some important measures, aimed to reduce the deficit and ensure the more efficient operation of the system. In order to implement the short-term measures as soon as possible, the required legal basis will be established before the end of this year.

3.1. Measures related to the objectives defined regarding the pension system

Since 2005 no large-scale measures have been taken regarding the pension system, however, some changes should be detailed here:

Objective (g) 3.1.1. How do the new measures enable, for example, that everybody should draw an income from pension, or that the living standards should continue to be appropriate in the retirement years.

Having been accepted in 2005, the pension close-up program initiated the raise of the benefits paid as *widow's pension, to widows having no pension by their own right*, in two phases, in January 2006 and 2007, owing to which these widow's pensions was increased from the former rate of 50% to 60%, resulting in better social security for persons living in single households. This measure mainly affects women who did not earn a pension on their own rights, for them this measure results in the improvement of income guarantees, which applies to some 180 thousand persons.

Having been paid from January 1, 2006 the *increased old age allowance* has been introduced for *single persons over 75 years of age*, which highly contributes to the improvement of the social safety of older generations. It is known that among these people the risk of poverty significantly exceeds the indicators of both the average population and the elderly: the increased allowance constitutes 130% of the amount of minimum pension, and the eligibility threshold also rose to 130% of minimum old age pension (in 2006 this meant 33,540 HUF per month). Around one-third of the recipients of allowance are eligible for the increased amount (as of March 2006 the total number of qualifying persons was 6,152, of whom 1,822 people received increased allowance).

It is an important step in the direction of a guaranteed pension in the future, that from 1 January 2007 the *obligation of maintaining a pension insurance has been extended to farmers*. (The community of

farmers, estimated at about 30 000, could so far only obtain eligibility for pension insurance on a voluntary basis, subject to agreement). As a result of the change, the community of those who are not covered by the obligatory pension insurance system despite their gainful activity, could be narrowed significantly.

Objective (h) 3.1.2. How do the new measures serve the assurance of sustainability, for example, by a longer working life, by improving the balance between contributions and benefits, or by providing guarantee for the safety of state or private funds.

In 2006 we should highlight the impact of two measures:

In the reform of 1997, as the continuing effect of the announced raise of age limit, from 2004 to 2005, *the employment rate of older employees (those between 55 to 64 years of age)* continued to increase – by about 2 percentage points to 33% – although in international comparison this value can still be considered low.

On the side of employment policy, the benefit of paying 50% less in contribution on older employees encourages this process. Having been launched in 2005 by the Public Employment Service, the central labour market program aimed at promoting *employment of people over the age of 50*, in which so far 27,000 of the 43,000 notified clients have found the employment, will last until January 2007.

It is another measure promoting the sustainability of the pension system, that from 1 January 2007 pension will be qualified as a non-taxable benefit. Accordingly, if someone realizes income in addition to his pension, then the amount of the pension will be counted in the tax base, but the tax on the pension will be deducted from the calculated tax (at present pensions are totally non-taxable and not counted in the tax base, either).

Those plans that were accepted by the Government in August 2006 as part of the Convergence Programme, are also aimed to improve the financing opportunities of the pension system. The tightening of the system of conditions and measures of benefits for persons under retirement age, the transformation of the system of disability pension involving the aspect of rehabilitation, the adjustment of the starting level of pensions and the suspension of benefits for people under retirement age if they pursue any gainful activity belong to this category. The Parliament will adopt the specific change of rules during 2006.

Objective (i) 3.1.3. How do the new measures address the social and structural changes? How do the new measures improve the transparency of the system and the provision of information to the citizens?

The only way to gain acceptance of the population for the necessary changes in the pension system is to keep the public well-informed about the effects of the demographic changes on the pension system. *This requires efforts to extend active working years, the consistent application of the lifelong approach, both in the pension reforms and in the development of personal life strategies.* It is necessary to increase transparency of operation and to provide genuine information about the measure of expected pensions. This should be supported by an effective IT system at the Government. It is an essential element of the pension-related IT developments, expected to be incorporated in the 'New Hungary' Development Plan, that the pension insurance records should be made digital, furthermore, as a result, the development of customer relations and IT background compliant with the requirements of the information society, as well as connection to the data exchange networks of pension insurance institutes of EU member states (*epension*) will also be included.

It is an essential condition for the "making work pay" philosophy that *pension awareness* should be created. It is important that the individuals should possess information already before retirement age about what pension they can expect with the given conditions – meaning contribution, time spent

as insured – and if we can manage to create an awareness of these factors in their active age, they will still have time to make the appropriate decisions before it is too late (accumulate savings, conclude insurance), in order to ensure an appropriate level of pensions for themselves. Although the institutional framework of self-care was established in the 1990s, a survey taken recently indicated that the Hungarian population is very far from being properly aware of this field. Laying the foundations for a shift in the approach and increased awareness of self-care is probably also the way to avoid mass poverty among the elderly, therefore this task requires the active role of the Government in the future.

3.2. Areas under special scrutiny

3.2.1 Development of minimum income for the elderly (including the relationship between pensions and other benefits provided to retired persons)

The Hungarian social protection system is based on the principal that the determining element of income security for the elderly is and will remain the pension, and the way to uphold the value of the pensions is to maintain the financial stability of the pension system, to adapt the system to the needs of the economy and employment, and ongoing adaptation to the changes of the labour market. In order to meet these requirements in the future, the employment and social protection policies must encourage as many people as possible to obtain and lay the foundations of income security for their old age while they are active, and by way of employment, and through the systems of social protections related to employment.

The guarantees for the standard of living provided to the elderly are mainly ensured by pensions as well as the guarantee elements supplementing pensions, assured by laws (see Exhibit 1 and the report for 2005 for a more detailed presentation). In order to reconcile contributions and services, the reform measures of the 1990s made it obvious that pension is an acquired right meaning assistance "bought" by obligation of payments, and where the level of the benefit is more proportionately related to contributions. The principle of *self-care* remains an important principle in the accomplishment of income security for old age, it is necessary to promote this attitude in practice and create as much awareness as possible of the related preferences. Those who did not acquire the right to minimum pension or only acquired a right to a low level of coverage while paying the contributions, the old age allowance, a system operating as social transfer, provides basic support, which is supplemented by a system of targeted in-cash and in-kind social benefits provided as regulated by law.

Owing to the almost full coverage of the population by retirement benefits and the system of supplementary support reflecting on the specific needs of the elderly, it is ensured that by now the relative poverty of the elderly has shown more favourable figures than those of active people. The gradual buildup of income security for the elderly, in harmony with the performance of the economy, is a task that is on the agenda continuously, for that purpose three specific measures were taken in 2006:

- Implementation of increased old-age allowance, for persons over 75 years of age, from 1 January 2006.
- Under the pension adjustment program, in January 2006 and 2007 the widow's pension for those having no pension on their own right will be increased in two stages, from the former level of 50% to 60%, which will improve the social safety of persons living in single households, mainly women.
- The obligation of pension insurance, to be extended to the community of farmers from 2007, will mean increased income guarantee for the elderly in this community.

However, in the longer term it is a cause for major concerns that owing to the transformation of employment profiles in the 1990s, as a result of high level of inactivity and permanent unemployment, an increasingly high proportion of the population have been affected by broken career and shorter employment, which will result in shorter terms of pension contribution and consequently lower pensions. Another factor that contributes to an increasing portion of low pensions is that around 30% of the insured are now paying contributions on minimum wages (if this tendency does not

change, this will mean minimum pensions, or pensions barely exceeding the minimum levels in almost the same ratio). While the conditions of eligibility for pension are being tightened according to the reform, these two factors *increase the serious risk of mass poverty of the elderly in the years following 2010*.

3.2.2. Increasing the relationship between contribution and benefits (enabling the life career approach to pensions, furthermore, also including topics of terms not covered by contribution and equal opportunity for both sexes)

It can be said that one of the main objectives of the measures and reforms of the 1990s was to reinforce the relationship between contribution and pension benefits. Measures that worked in this direction include profile clearing, transformation of pension into a stand-alone branch of insurance, the gradual conversion of the income used as a basis for pension calculation into lifelong earnings, the gradual tightening of the conditions of advanced old-age retirement.

1. Seen from the lifecycle approach, over the recent decades there have been favourable changes in the Hungarian pension system in several directions:
 - One of these was the measure announced at the beginning of the 1990s, which takes into account in the calculation of pension the earnings of a period that is extended from year to year; thus people in their thirties and forties today will retire with a pension calculated in consideration of their *life earnings*.
 - The *acceptance and supportive treatment of non-typical careers* in the pension system serves this purpose, which means, on the one hand, the acceptance of child care and nursing activities mainly affecting women as periods entitling to pension (for more details see the report of 2005, strategic summary), on the other hand, the 100 Steps program of the Government assigned further preferential elements to part-time jobs and other non-typical forms of employment from the side of the pension system (book of day labourers, contribution coupon - see the National Reform Programme for more details).
 - Thirdly, the voluntary mutual benefit fund system launched in 1994 was such a step, which preferred voluntary pension savings by tax benefits, thereby encouraging *self-care*. In 2006 another form of savings with preference to old-age self-care was introduced (special investment funds, i.e. the "4th pillar" of pension).
2. It is one of the important requirements of the reinforcement of the relationship between contributions and benefits that the system should be able to fulfil the expectation that identical insurance performance should be rewarded by identical benefits. There are two action items on the agenda that are designed to accomplish this objective by balancing the disparities between pensions payable to persons having retired in different years.
 - As the combined result of high inflation and other factors determining the calculation of pensions, in the 1990s the initial pension levels showed significant variations, which had major effects on several cohorts in the 1990s. Significant differences occurred in the pension benefits of persons having retired with identical insurance history and subject to similar conditions, according to the year of retirement. Act CLXXIII of 2005 provides for the compensation to cohorts of retired people adversely affected and specifies the schedule of the compensation. In 2007 those persons are receiving differentiated pension raise who are pensioners by their own right and whose pensions were defined before 1988, there are about 600,000 people affected, the measure of the raise is 7% on average (this cohort is the oldest, even the latest cohort is well over 70 years on average, but many are beyond the age of 80-85). From 2008 on, those who retired by their own right between 1991-1996 will receive a raise of about 6% (up to 10%, depending on the length of time spent in employment).

- On the other hand, also as the combined result of structural causes (raise of the upper limit of contribution payment, dynamic increase of net wages, etc.) the level of the initial pensions has started to grow significantly since 2002. This is implied by the level of the theoretical net replacement rate as of 2005 (83%, as opposed to the average level of 60-65%¹⁹), which causes a shift of proportions in the initial pensions among the individual cohorts of pensioners. The development of short-term measures is in progress, for the purpose of balancing the level of pensions to be started in the future.
3. Another step serving the reinforcement of the relationship between contributions and benefits is the review and gradual phasing out of the differences in the time of service, age limits and method of wage inclusion that still exist but are no longer justified in certain occupational groups (army, armed forces and disaster recovery agencies, artists, etc.). The objective is to have the general conditions of pensions apply, gradually and in a differentiated manner, in consideration of appropriate preparation time in every occupation.

3.2.3. The relationship between flexibility of retirement age and longer life spent in employment

Typically, the flexibility of retirement age applies in Hungary in such a manner that eligible persons retire before official retirement age. Longer years spent in employment were rewarded by a retirement bonus in encouraging continued work after retirement, which will increase the amount of pension by 0.5 percent on each additional month spent in employment, i.e. by 6% annually. However, this encouraging effect hardly applies, which is also indicated by the fact that while in 2004 only a fraction of pensioners took advantage of this, 94% of all pensioners retired earlier than the official retirement age, and only 6% of them retired when reaching the official retirement age.

Parallel with the adverse labour market processes of the 1990s and with the raise of the age limit, early retirement became an increasingly wide practice. In addition, besides advanced early retirement, other benefits are available (early pension due to hazardous working conditions, preference years available for child raising), which enabled early retirement to become a general practice. Although the pension reform of 1997 transformed the system significantly²⁰, the age centre of retirement also went up by about three years, however, even that was not able to reverse the former trend, either.

In Hungary, the favourable regulation of the employment of pensioners also contributed to the spread of early retirement, since it created an interest for the individual to retire as early as possible. This situation further increases the deficit of the Pension Fund, at the same time, it weakens the sustainability of the system, both in the long and in the short term. Therefore it has become inevitable to adjust the system in such a manner as to impede this process. The primary aim of the short-term pension measures is to *increase the age centre of retirement*, by establishing the related elements of interest and eliminating the implicit incentives for early retirement. Since the reasons are also versatile, the implementation of this objective includes a set of diverse measures to be implemented in the near future:

¹⁹ The two data are not directly comparable, here we only give an illustrative comparison: since the theoretical replacement rate is prepared for a hypothetical typical case, it compares the personal income of the last year before retirement and the personal income of the first year after retirement in a hypothetical case considered as typical, the other is an aggregate figure comparing the effective average of old-age retirement pensions to the effective average wages.

²⁰ Under the pension reform, with the gradual introduction of the raise in retirement age, the age center of retirement automatically increases, i.e. in the period between 1997-2008, as the time progresses retirement age will also grow (at present the lowest retirement age is 60 for men and 57 for women), from 2009 the retirement age for advanced pension will be 59 years uniformly. Flexible retirement age is available if a longer term was spent in insurance (in 2006 this was 38 years; after 2006 it will be 40 years). If the insurance term is shorter than that, only a reduced pension will become available, and the reduction becomes more significant with the increase of missing years.

- The conditions of retirement to old-age pension before reaching the official retirement age change in such a manner that the affected people will be liable for the related burdens. For that purpose, the conditions of early retirement and the pension increment available through continued work beyond retirement age will be regulated in a uniform system, based on the bonus-malus principal. The regulation treats the financial burdens of flexible retirement according to the rules of insurance mathematics, which makes the burdens of early retirement and the advantages of later retirement clear to the affected people. The retirement age of advanced retirement will be raised by further one year beyond the two years already announced from 2012, to 60 years, with men it would remain at 60 years.
- The regulation makes it clear that early retirement is of preference, and any earning activity is only allowed if the payment of pension is suspended. The new regulation intends to implement in Hungary the practice applied widely in Europe, that old-age pension is not available unless the person has stopped working. As a specific measure, from 1 August 2006 it has been made possible to suspend pension benefits already granted by the recipient's own right. A pensioner earning an income may decide to request the suspension of his or her pension only for a time, typically for the time of gainful activity. Suspension will last as long as the pensioner does not request the resumption of his or her pension. At present this is only significant if the pensioner cannot be employed by the employer because the person intended to be employed beyond retirement age is receiving both pension and wages at the same time. However, according to plans the regulation will make this restriction obligatory for early retirement.
- According to the new rules, from 2007 further eligibility for early retirement will only be allowed in ways that will not charge the pension fund. By the development of transitional rules, the Government is working on establishment of a new system that will make employers and employees interested in prevention and the preservation of health.
- The system of dues applying to wage earned by pensioners will be identical to the rules applying to wage earned by active workers, the payment of individual pension dues will entitle the worker to additional services.
- It is important to highlight that the dismissal of elderly employees will not result in additional special early retirement options, rather in special employment schemes (Premium Years Program), which takes into account the labour potential of elderly employees and offers a solution to keep this community partially on the labour market.

The transformation of the *system of disability benefits* from the aspect of rehabilitation is designed not to encourage the accomplishment and preservation of an existing benefit option, rather to support return to the labour market by the successful rehabilitation of the remaining working capacity. For that purpose, a new complex rehabilitation system will be built up, which will integrate aspects of health care, employment and welfare.

The transformation of the system of disability pension for the purpose of rehabilitation includes the following: development of a new classification system, based on those skills and capabilities that have been preserved and can be enhanced; personalized service-support system and new rehabilitation assistance provided for the term of the program as an incentive; development of a temporary allowance designed for persons who lost part of their working capacity and are disabled in class III, which, when supplemented by appropriate rehabilitation, will create a strong incentive to stay in the labour market and for re-assimilation, the change of the rules of grant and control in such a manner that will exclude the currently existing abuses, and with the current disability pensioners and the new target groups, development of more efficient methods of control for revision.

3.2.4. The key issues of the enhancement of private pensions (efficient legislative framework, equal opportunities for access, security, information, temporary costs, contribution of private pensions to financial sustainability)

In July 2006 those legislative rules were adopted that will contribute to the more efficient operation of the compulsory pillar II and the voluntary supplementary pillar III of the pension system. The most important element of these measures to be implemented from 1 January 2007 are the following:

- in the case of both pillar II and pillar III institutions, the costs deductible for operating purposes and available to cover asset management expenses will be restricted. This will contribute to the reduction of the cost levels of funds, thereby increasing the level of benefits;
- in the future reports and payment of membership fees will become centralized (the employers will have to report and pay the compulsory membership fees of private pension funds not to the individual private pension funds, rather to the state tax authority), which will significantly contribute to cutting down the administrative burdens of both the funds and the employers.
- in the private pension fund system, optional portfolio plans will be introduced as an option from 2007, and as an obligatory scheme from 2009 (with voluntary pension funds this option has existed from 2001). The system of optional portfolios will create the opportunity of long-term optimizing of savings for fund members, without jeopardizing the safety of the savings.

3.2.5. Development of regular monitoring and adjusting mechanisms

The monitoring and assessment of the measures is primarily the function of the responsible ministries and institutes. Regarding pension measures, several analyses have been and are prepared for this purpose, both at the Central Administration of National Pension Insurance and at the competent ministries, in order to present the impacts of the individual measures. In the Strategy Report on Pensions of 2005, we included more detailed references to regularly submitted reports and analyses, regular statistical data collections, which are ultimately designed to serve this purpose. After the review of the existing system and indicators together with the stakeholders, the process of supplementing them is in progress, in order to enable us to assess the processes relevant for the Hungarian situation with more sophistication in the future. By the finalization of monitoring before the end of this year, we will be able to perform the assessment of the implementation of the report in 2007-2008 according to aspects of assessment developed together.

4. The healthcare system and long term care

Introduction

Health is of inestimable value to each and every one of us. Maintaining health, offering effective and adequate prevention and health promotion, while providing high level care to people who become ill are the prime conditions for guaranteeing a general satisfactory state of health. Only a healthy society has the ability to make a continuous contribution to economic growth and to increasing employment, because only it is able to retain its working ability, with its members holding various positions throughout different stages of their lives. It is, of course, essential that the strongest possible support for workforce participation be combined with coordinated and effective institutionalized systems to care for people who require nursing and other forms of care (care facilities near the home as well as in institutions).

Since 1990, every Hungarian government has been aware of this challenge and has been deeply committed to improving the health status of Hungarians, which is quite poor by international comparison. This involves structural transformation and satisfactory coordination of the healthcare systems combined with a high level of care and services, cost-effectiveness and the establishment and

operation of a longterm care system. Although significant measures to this end have been taken on an ongoing basis over the past 16 years and there have been positive results (such as an improvement in male life expectancy at birth), the unresolved issues we still have to contend with add increasing urgency to the need for a comprehensive and radical transformation in the system. We firmly believe that no further postponements are possible.

4.1. Summary of the healthcare and long-term care systems

Hungarian health services must respond to the same challenges we see throughout the developed world such as an ageing society and the need to keep up with changes in medical technology. We also have specific problems to resolve, that are rooted in the inertia, rigidity and market-hostility of the healthcare system evolved over past decades, and which, as a consequence of many historical, social, economic, and cultural factors, are related to the exceptionally poor health status of the Hungarian people.

In August 2005, the government initiated a comprehensive programme called “100 Steps,” of which 21 steps were focused immediately on healthcare, initiating short and long-term measures in the following areas:

- Improving emergency care
- The National Infant and Child Health Programme
- The National Cancer Control Programme
- Improving family practitioner services and specialized outpatient care
- Reducing existing inequalities in access to healthcare
- Providing the funding needed to cover healthcare • Strengthening the principle of insurance
- Pharmaceutical market

The measures of the 21-Step programme took effect in the latter half of 2005 and as of January 1, 2006.

The new administration that took office on June 9, 2006 has been continuing the various components of the programme that got underway last year. It has moved forward within the framework of Phase I. of a sweeping sectoral healthcare reform adopted on August 31, 2006, together with a series of other reform measures. The most important goal of the government is to implement the short and long-term measures to create the conditions for growth based on long-term equilibrium so that economic performance and living conditions improve steadily and at an accelerating rate, cutting the gap between Hungary and the most advanced nations of the European Union. The fundamental condition for sustainable growth is that a larger proportion of the working age population actually works. The low employment rate means that a smaller proportion of the population bears the brunt of the tax and contribution burden which finances public services and benefits. This limits public finance inflow and increases expenditure (particularly for social insurance and in general for social welfare purposes). Considering demographic processes, the expected ageing of the population will increase public finance outflow still further and there will be fewer tax and contribution payers available to cover these costs. Economic policy is aware of these contingencies and must act now to take the reform measures that will enable us to continue to finance pensions, and healthcare and nursing expenditure in future decades through sustainable systems.

The goal of healthcare reform is to bring about a much more service-oriented system than the current one, one that is corruption-free and adjusted to European Union norms, offering higher quality and more costeffective preventive-curative care to all who access it.

A fundamental condition for transforming the system into an efficient one is to establish the true principle and practice of insurance. Since the structure of the current healthcare system is not in conformity with the tasks we face, the entire structure has to be transformed. The healthcare system is overburdened even with current – oversized – capacities, since none of the players (doctors, patients, healthcare institutions) have any interest in reducing a demand that exceeds true needs. This calls for a series of measures to cut excessive demand with respect to both services and drug consumption. Reinforcement of the supervisory system is a prerequisite to implementation of the reforms listed earlier. Reform goals include improving the standard of services, cutting inequalities in access, and keeping state expenditure on a sustainable level.

Putting more emphasis on the principle of insurance is intended to alter attitudes as well, shifting what is currently viewed as an unlimited public responsibility and public financing burden, and making it clear that the individual is also responsible for his or her own health, by introducing an individual contribution to healthcare on a regulated basis. Having insurance or another registered condition providing entitlement, and paying the contributions will become the prerequisite to accessing services. Failing this, only basic services will be available. In addition to establishing the insurance principle, it also will be necessary to limit demand for healthcare services that is not justified by state of health and to increase the operation efficiency of the network of healthcare institutions.

The manner of doing this includes:

- Introduction of a fee (a co-payment) payable by user when seeing a doctor and when accessing diagnostic tests.
- The general need for a referral from a lower level of care in order to access the next (higher) level.
- Elimination of unused or irrationally operated excessive acute inpatient capacities, transferring them into chronic, outpatient (day or ambulatory care) or into nursing or rehabilitation capacities.
- These service providers should be made to compete for social insurance funds. Under the new system the National Health Insurance Fund Administration will buy no more services than it actually needs.
- Establishing legal (and financing) frameworks under which the service providers (typically, the hospitals) operate will change, allowing transparent accounting and profit and loss statements, the profit orientation of the owner (operator) and an employment scheme that allows more flexible wages for workers.
- Seeing to the coordination of primary health care (family practitioner) services on sub-regional level.
- Altering the drug reimbursement scheme, changing prescription habits, transforming the pricing, reimbursement, and co-payment systems.
- Heightening the monitoring systems, expanding invoicing and improving the IT system.

Extensive use of quality control systems also contribute to improving the standards of healthcare services. To do this:

- Treatment and financing protocols (patient pathways) will be insisted upon to rationalize the provision of and use of services.
- A health insurance supervisory body to monitor operations and also to provide consumer protection will be established.

There are several strategic areas of health policy within the Hungarian healthcare reform process for which European level activity can produce significant added value:

a) Defining insurance packages

The Hungarian practice, going back for multiple decades, has been based on free access to healthcare offered as a right to all citizens. When this promise was first made, it was a major social achievement, and in the era when immunisation and antibiotics first appeared, the results were

significant (such as 100 percent immunisation coverage) and the irrational nature of the long-term promise was not apparent. In past decades however – the contradiction between an ageing population, changing morbidity patterns and a palette of medical technology expanding at a fantastically rapid rate (and growing proportionately more expensive) and the country's finite economic capacity with its relatively limited resources became untenable.

One clear indication of this is that the infrastructures supporting the various medical specializations and geographic areas have varied widely in level and volume. Another is the survival of the deeply rooted custom of paying gratuities. This latter clearly reflects the fact that most members of the public/patients do not believe the promise that satisfactory and adequate services will be provided free of charge.

A situation in which people access the most expensive treatment modalities by offering significant gratuities while sidestepping the payment of taxes and contributions, while many people who regularly pay contributions are denied that level of treatment because of its limited nature, does not meet the minimum social justice criterion. The first measure in resolving the professional, economic, and social problems of healthcare will have to include a definition of

- benefits that qualify as basic and will continue to be made available to everyone without examining eligibility,
- benefits that may be accessed if a patient is insured and
- benefits that require payment.

b) Evidence-based professional protocols

Professional guidelines and diagnostic and treatment protocols are recommendations designed to offer systematic care of health problems through methodologies designed using scientific methods and resting on the best scientific evidence available. Their goal is to assist the doctor offering treatment, the patient, and health policy decision-makers in choosing the highest standard and most effective treatment for a given disease.

Adherence to diagnostic and therapeutic guidelines and protocols based on scientific evidence is a general professional requirement that we expect adherence to, for without them it would not be possible to objectively determine negligence, errors or omissions, and unjustifiable differences between treatments.

When guidelines or protocols are issued, the result is that quality of care becomes tangible and disparities across regions or institutions decline.

In Hungary, we try to establish treatment and financing protocols that are sufficient and, expedient and offer financing for the significant portion of care that is adequate but not excessive for all diagnostic and treatment procedures, interventions and other types of care provision, in which the entire system is transparent and public.

c) Patient safety

The European Commission's High Level Group on Health Services and Medical Care has focused special attention on patient safety. In this process – in which organization and processing of national tasks is the responsibility of the given country – Hungary has taken a role in designing a system of collecting data on events that put patient safety at risk. A professional supervisory system, a system of patients' rights advocates, the establishment of a patients' rights foundation, and Act CLIV of 1997 on Health all reinforce patient rights and quite successfully. Nevertheless, to assure the success of the above, European level initiative, it is necessary to establish a "Patient Safety Working Group" in Hungary, the members of which are professionals in healthcare, quality control, economics, patients'

rights advocacy and management.

Two tasks, which differ in subject, must be implemented during the course of this program:

- *data on all incidents occurring or “almost occurring” in domestic practice that put patient safety at risk are to be set into a map which pinpoints the courses of treatment/care where errors are most often made,*
- *a culture of patient-safety must be established.*

d) Quality management

The Ministry of Health has officially published its quality requirements, standards of care for specialist inpatient care, specialist outpatient care, primary care, and health visitor's services. The goal in issuing these standards was to guarantee high quality healthcare on all levels.

In addition to successful and efficient patient care, we have separately formulated expectations on the healthcare provider regarding patient rights, patients' right to information, and patient education. Publication of standards of care makes it possible to compare and qualify healthcare providers performing identical professional activity using objective standards. The standards were designed by practicing healthcare professionals. When formulating the requirements the main considerations were patient care needs, safety, and human and cultural expectations.

The published standards are accessible and have been disseminated and made known to all healthcare providers. A quality system to be designed on the basis of the standards is also being planned by the healthcare administration. A given provider may make its own decision on whether to shape the rules, procedures, and quality indices needed to receive voluntary certification into its healthcare activity.

4.2. The healthcare system

4.2.1 - Brief description of the healthcare system

The health status of the Hungarian public is quite poor by international comparison and is well below what would be possible on the given level of socio-economic development. There are numerous historical, social, economic, and cultural factors behind the exceptionally poor health status of the Hungarian public, the easiest of which to take hold of is lifestyle. Dietary habits in Hungary are unhealthy and a significant portion of the adult population is overweight. On average, physical exercise is negligible, while a comparatively high proportion of the people smoke tobacco. Alcoholism is also high and drug abuse is growing. Significant portions of the people are unable to cope with day-to-day problems brought on by life, and mental health problems are growing extensively.

The mortality and morbidity indices of the Hungarian public, particularly in the economically active age groups, are very unfavourable, with particularly high rates of cardiovascular diseases and tumours. By international comparison, Hungary has particularly high rates of mortality due to suicide and hepatic diseases. In recent decades, the mortality rate due to cardiovascular diseases declined while that due to tumours grew.

There are other determinants of health, such as education and income level, which contribute to differences in health status. Among some social groups, the lack of health consciousness and the presence of behaviours damaging to health (smoking, alcohol and drug consumption, inactive lifestyle) are typical. These groups are typically made up of disadvantaged segments of society (Roma, residents of small settlements, the poor, and people with disabilities). The result is that the health and employment indices of these groups are significantly worse than average, partly because of their own health behaviour, partly because of inequalities in access to healthcare, and partly because of other

socio-economic factors. This is then projected by statistics showing that some regions have better while some have worse economic performances, based on the type of settlements they encompass.

The Hungarian healthcare system is divided into primary health care, specialist outpatient care and specialist inpatient care. As far as size is concerned, it has a sufficient number of doctors to be acceptable by international comparison and a comparatively low level of allied healthcare workers and ancillary staff. It also has a comparatively large number of acute hospital beds and a very small number of chronic inpatient, rehabilitation and nursing facilities and capacities. There are numerous factors within the system affecting patient and care provider alike, fostering incentives to access care more frequently and on a higher level than is professionally and economically rational. The most advanced medical technology of the advanced countries operates in an old, obsolete and deteriorated infrastructure. In addition, internal structural disproportions are typical in outpatient and inpatient care, home and institutional care, with much too high a proportion of patients ending up in the highest levels of the care system. Most of the institutions is publicly owned (central and local governments) and movement is very slow in shifting from a budget-sponsored form of institution towards a corporate form of operation. Overlaps between the healthcare and social welfare systems and shortcomings in both are barriers to economically efficient operation.

The Ministry of Health holds primary responsibility for supervision of the healthcare network. It meets the task through a network of separate institutions, directly monitoring only a few. These include the top national institutes for each area of specialization, the public health network, and the blood supply. Below that, current responsibility for the healthcare system has been decentralized to local government level. A restructuring in responsibility for care is expected to take place as debates on reforms now underway are concluded.

The social insurance system is based on a uniform national risk pool. Healthcare is financed by contributions paid by employers and employees and by the central budget. At this time, due to demographic changes, about one-third of residents contribute to financing a healthcare system that covers the entire population. Current co-payments by the public, already required for certain healthcare services (medicines, medical devices, spas, sanatoria), make up a significant portion of private health expenditure, while they spend another significant portion on paying gratitude money. Current health policy aspirations would like to extend co-payments to include a small payment for every visit to a doctor, which it anticipates will cut demand and gratuity payments.

The disproportions cited are the reason the Hungarian healthcare system requires urgent structural transformation including basic changes in the financing system. Recently adopted decisions on health reform are targeting a comprehensive structural transformation offering preferences to acute curative care while putting a great deal more emphasis on chronic and rehabilitation efforts and on preventive care. The need to change the structure of healthcare and to reduce regional differences require the development of care modalities near to places of residence (this includes improving on various forms of specialist outpatient care) as well as integrated regional care networks complete with infrastructure.

4.2.2 - Priority policies related to Common objective (j)

[Accessible, high-quality and sustainable healthcare and long-term care by ensuring:]

(j) access for all to adequate health and long-term care and that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed;

Plans call for implementing a multiple of mutually complementary measures in Hungary starting in 2006 to support the sustainability of public finances. The areas involved include public

administration, healthcare, pensions, higher education, and employment.

One of the most important measures of the healthcare reforms adopted on August 31, 2006, one that is part of the Convergence Programme, is to reduce Health Insurance Fund expenditure. However, during the course of implementation, an effort must be made to reduce regional inequalities while improving the level of care across-the-board. As part of this effort, implementation of the measures relevant to access that enable resources to be used more efficiently and to eliminate any possible waste include:

- *Introducing a co-payment that the patient is required to make when seeing a doctor (for primary health care, specialized outpatient care and related diagnostic tests, as well as for acute inpatient care), while the healthcare service providers will be required to provide invoices.*

The goal of the measure is to evolve a more rational pattern of health services utilisation and to reduce gratuities by requiring a relatively low co-payment in the form of a visit fee that is paid legally. To maintain fairness, persons in need will be exempted as will children under the age of six. The copayment should reduce the number of unnecessary visits to the doctor and make patients more costconscious. It is expected that the measure will reduce the financing costs of care by family practitioners and dentists. The savings can then be devoted to development objectives of improving cost-efficiency that are set in the programme of transforming specialist outpatient care.

- *Professional and financing protocols will be used on a general scale to rationalize the provision and receipt of services.*

The goal of medical diagnostic and therapeutic protocols is to help doctors, patients, and policy decision-makers in selecting the highest level and most effective care modalities. Once the protocols are in place, the quality of care will become measurable, which will reduce disparities between regions and institutions. The reform is intended to set financing protocols that are adequate, expedient, and do not provide more funding than necessary for the diagnostic and treatment procedures and interventions as well as most other measures of healthcare.

- *Access to a higher level of healthcare will typically require a referral from a lower level.*

The effect we expect of this measure is to achieve a corruption-free healthcare delivery system that is more of a service-principle, conforms to EU norms and offers a higher general level of care and more efficient services, that is based on actual need and provides cost-effective preventive-curative care to persons who access it.

- *Coordinating primary health care on sub-regional level*

The purpose of this programme is to establish integrated sub-regional service centres – principally in regions where access to care is limited, particularly in disadvantaged regions. These centres are to operate within the framework of complex care offering a broad range of preventive and curative care both on primary health care level (family practitioner, health visitor, school doctor, etc.) and on specialist outpatient care level (specialist outpatient clinics, physical therapy, home rehabilitation, specialized nursing, etc.) In addition to assuring access and quality, the programme includes a sustainability component in that development funds are to be concentrated in the regional centre. This means that it will be possible to offer state-of-the-art services to a wider range of patients, resolving shortcomings in healthcare supply while using limited funds more efficiently.

- *Revisiting the rules governing pharmaceutical supply*

The goal here is to evolve an appropriate system of incentives to reduce regional inequalities in access that meet needs and demands, which includes making it possible for certain over-the-counter drugs to be distributed in places other than pharmacies.

- *Transforming the framework under which services (typically hospitals) operate*, making transparent accounting and profit and loss statements mandatory, establishing a profit orientation on the part of the owner (operator), and an employment scheme that allows greater flexibility in determining wages.

The goal of these measures is to achieve greater flexibility in the forms of ownership and ways of operation of the healthcare service providers. The transformation will include offering incentives to maintain ownership and operation that is mixed in nature. This means that publicly financed healthcare facilities should be operating as business corporations by the end of the government's term of office. Corporatisation does not mean a change in ownership or privatization. Instead, it means organizing the management of a public task in a private law form. The advantages are a more flexible and transparent financial order, increased opportunities for credit, a regulated inclusion of private capital, being subject to value added tax payment, and exemption from the restrictions governing public employees. In combination, these measures improve access and long-term financial sustainability.

- *Authorisations of the National Health Insurance Fund Administration regarding quality-based selectivity in purchasing services*

In contrast with earlier practice, the National Health Insurance Fund Administration will not be mandated to purchase services from every service provider in the country that has an operating license. Instead, it will have the opportunity to be selective, based on quality, in concluding its contracts, which will clearly improve patient chances for accessing high quality healthcare services.

- *Establishment of Health Insurance Supervisory Authority*

An important element in the transformation of the health insurance system is the establishment of an Authority that guarantees the public nature of operations, one that monitors, and when necessary, may impose sanctions. The goal of the Authority is to see to it that people who utilise healthcare services get the best possible services for the contributions they pay, and that they have full and complete information that allows them to choose among those services. The Authority will achieve its goal by evaluating and qualifying the work of the service providers and continuously briefing the public on its findings. This will improve access, quality and sustainability all at the same time.

- We will continue to implement various nationwide medical and public health programmes intended to prevent diseases, to improve the general state of health, and to develop health (National Public Health Programme, National Cancer Control Programme, National Programme for the Prevention and Treatment of Cardiovascular Diseases, and the National Infant and Child Health Programme).

As we have already shown, the health status of the Hungarian population is extremely poor in international comparison, and significantly below the level that the country's general level of socioeconomic development would make possible. Although we know that there are

numerous historical, social, economic, and cultural factors behind the exceptionally poor health status of Hungarians, the government is operating a series of nationwide programmes aimed at prevention, health status improvement and health development, in order to achieve a massive change in health damaging lifestyles that we can come to grips with most directly. Successful implementation of these programmes requires a new outlook and new practices on the part of government, residents, and health professionals. Using state-of-the-art medical technologies and providing high standard healthcare services the short-term results attained with the transformation of the system are the groundwork for long-term improvement in quality of life for every age group. The infrastructural investments completed to support the structural transformation of the healthcare system, acting of themselves, only influence the operation and efficiency of the system and are not particularly suitable for altering service utilisation patterns, evolving health conscious behaviours, and establishing satisfactory lifestyle examples and skills. For this reason, the infrastructural investments must be accompanied by professional training programmes and campaigns focused on high-risk groups. Implementation of the nationwide programmes will improve access, quality, and sustainability at the same time.

4.2.3 - Priority policies related to Common objective (k)

[Accessible, high-quality and sustainable healthcare and long-term care by ensuring:]

(k) quality in health and long-term care and by adapting care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients;

When implementing healthcare reform measures, endeavours must be made to reduce regional inequalities while generally improving the level of care. Correspondingly, the measures that are relevant from the point of view of quality are to be implemented with the aim of achieving a more efficient use of resources.

- *A rationalization in access to and the provision of services shall become widespread through use of treatment and financing protocols*

Professional peers from the given speciality must participate in measuring the usefulness, acceptability and effectiveness of a treatment protocol. To do this, we have shaped a system of specialist supervisors who use a methodology based on clinical audits.

- *Excessive acute inpatient capacities will be transformed into chronic, rehab, same-day treatment, nursing care, and outpatient capacities, or will be eliminated*

The professional structure of the care delivery system (the ratio of acute, chronic, and nursing care capacities) and the relationship between the skill-mix and morbidity and mortality patterns are distorted, poor in regional distribution, and result in unfair disparities in access to care. The infrastructure of the care system and the manner in which it operates influences the length of an illness (and therefore, the duration of an absence from the labour market), as well as the amount of funding needed for maintenance and operation of the care system. The following factors – related to the quality of care – encourage shifting acute inpatient capacities towards outpatient care: It is impossible to maintain the most expensive equipment and the most thorough training of staff, the medical equipment and infrastructure that requires the highest level of professional experience to operate, and the human resources in every small hospital, for where doctors rarely encounter a specific disease, they clearly do not have the reliable professional experience to guarantee patient safety. Therefore, the system has to be re-shaped so that treatment for emergency and «common» diseases becomes accessible in as many places as possible – preferably within the

framework of outpatient care – while more serious and costly interventions are limited to the places where all necessary conditions are available. This method is more economically efficient and fairer, for that way everyone gets the highest possible standard of healthcare.

There are many hospitals in Hungary – whose profiles are either exactly the same or contain many similar elements – that operate in very close proximity to one another, and are responsible for regions that almost completely overlap. That structure is unsustainable for the operators of the institutions as well as for the payers of the healthcare system. The operators (such as the local governments) currently operate hospitals that are neighbours – in other words, they are so close that that patients can access either the one or the other without any significant extra difficulty – and which offer identical or similar services. In addition, the most costly of the services offered by the hospitals are acute inpatient services, the costs of which are reimbursed by the National Health Insurance Fund in the framework of monthly payments. Every single hospital seeks to provide the most of the high-reimbursement services because they increase its inflow. Another argument in favour of changing the structure is that unless this situation is changed, within ten years acute inpatient care alone will cost more than the total amount available to the health insurance system for all preventive-curative services.

These changes will not only improve quality but will also help meet the goal of long-term financial sustainability.

- *Authorisations of the National Health Insurance Fund Administration regarding the selection of services purchased for quality*

In contrast with earlier practice, the National Health Insurance Fund Administration will not be mandated to purchase services from every service provider in the country that has an operating license. Instead, it will have the opportunity to be selective, based on quality, in concluding its contracts, which will clearly improve patient chances for accessing high quality healthcare services.

- *Improving emergency care*

We shall continue building an evenly distributed high standard network of emergency medical service that eliminates regional obstacles to access.

4.2.4 - Priority policies related to Common objective (I)

[Accessible, high-quality and sustainable healthcare and long-term care by ensuring:

(I) that adequate and high quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active life styles and good human resources for the care sector.

During the implementation of the reform process special efforts have to be made in order that the objectives would be reached without a deterioration of the quality of services. According to this, measures aim at the more efficient use of resources:

- *Reinforcement of the social insurance nature of healthcare* (this means setting the insurance principle as the prerequisite for accessing services, meaning payment of insurance contributions or another registered condition entitling the person to access healthcare) and up-do-

date payment of contributions. Failing the above, people only will be entitled to basic services – rescue and emergency medical care, mother and child protection, and public health and epidemiology services.

Introduction of the principal of insurance to replace today's apparently unlimited public responsibility and public financing will make it clear that the individual bears responsibility for the promotion and maintenance of his own health while the contribution of the individual to financing the costs of healthcare also becomes regulated. The condition for accessing the services is insurance or some other registered form of entitlement, and payment of the contributions that are due. Failing this, only basic services will be accessible. A system of individual health savings accounts intended to establish a connection between employment and social insurance is currently on the design board.

- *Service providers will be able to compete for social insurance financing for the National Health Insurance Fund Administration will only purchase the amount of services it needs and it will not be required to conclude contracts with all providers.*

This measure will support sustainability in the following way: The National Health Insurance Fund Administration will not be forced to purchase services from suppliers that operate inefficiently or in a wasteful manner.

4.3 Long-term care

In Hungary at present, the provision of long-term care is not set into a uniform system. Both the healthcare and the social service systems offer long-term care to persons in need of them.

The lack of a concrete definition of long-term care is a serious problem since the services involved cannot necessarily be separated from services that serve other purposes.

In the social welfare system long-term care is among social services. Social services can essentially be divided into two categories: basic social services and specialized social services. Long-term care is one of the former, offered as part of home care, while within specialised services, long-term care is offered in live-in institutions.

At the same time, it is exceedingly urgent to combine the nursing tasks currently operating separately in the healthcare and the social welfare systems, and therefore overlapping, into a uniform system. The overlaps have to be filtered out and the funding used for this purpose has to be used in a more rational, reliable, transparent way.

A long-term care package to which all persons are entitled has to be defined. The exact content of longterm services to which a person who pays social insurance contributions is entitled must be specified, to which people who are socially indigent may receive and the benefits to which it is necessary to legally involve private funding.

We also must begin to institutionalize a system that is able to satisfy differentiated demands (retirementcare savings, long-term care insurance, voluntary health insurance). The provision of nursing care and patient-minding activities that are currently offered in the semi-legal zone must be transformed into legal, professionally supervised activity. It will be necessary to state that a provider that offers basic services also may offer supplementary ones, as a way of guaranteeing system operations.

4.3.1 - Brief description of the systems for long-term care

At present responsibility for care and organization of that care is in the hands of the local governments and paid for by normative financing from the central budget. For the most part, it only manages to cover one portion of the costs of these services. For this reason the local governments operating with a shortage of funds often have no incentive to seek out people who need these services and to organize them for them. The result is that there are significant differences between the amount of services from one region to the next as well as the quality of those services. In addition to this, the current financing system is also more favourable for the development of the more expensive specialised services than for cheaper home-based primary care services.

The current system of care does not consider the criterion of need, so it has given subsidies to people who were financially able to access market-based services.

4.3.2 - Ensuring access

The current system of social services does not cover the entire country in an adequate manner and this is particularly true of services provided in the home. The network of services is incomplete with significant and lasting differences between various regions and counties. The first step is to put an end to geographic inequalities in access. To do this, we are introducing capacity regulation in the near future. In addition to eliminating inequalities, on long term this method will make it possible to verify the distribution of central resources and the order of territorial developments.

The essence of capacity regulation is that the social and welfare needs of a given area be the primary consideration when establishing services. The system is intended to offer uniformly efficient services on the basis of the regional/territorial service planning and development concepts, in such a way that it resolves existing problems with available resources. The goal is to have economically efficient services of adequate quality available throughout the country.

At the same time, introducing the system will require the territorial development of basic services since the number of settlements without them is quite significant. At present about 63 percent of local governments provide home care, which means that provisions for the home-care for socially indigent people are not satisfactory.

One portion of the development can take place through programs for closing the social welfare gap in micro-regions that are intended to even out territorial differences. These programmes offer support to service development in disadvantaged micro-regions, on the basis of the micro-regional development plans.

The regulation to be established will yield a significant saving in longer-term expenditure, since basic services will require the operator to put in significantly fewer resources than were the services provided in residential facilities, which means that financial sustainability is far more probable.

We plan to achieve territorial equality gradually, but will make a consistent effort to build up all social services. We also plan to coordinate all effective legislation to assure that the system is operative. The process will take a long period of time, and in 2007 we will only be able to take the initial steps. Full scale capacity regulation covering all operators and service providers with the sector can be achieved by 2010.

The statistical background to capacity regulation will come from a registry of social institutions and from a nationwide system of reporting and accommodation monitoring we plan to set up in the near

future.

4.3.3 - Good quality services

Our fundamental goal is to offer an appropriate service quality to persons who require them. At present service quality differs sharply – residential facilities offering nursing and care include ones which are 400- 500-bed obsolete and generally overcrowded facilities, co-existing with modern homes offering quality care to residents.

Our goal is to design and disseminate professional rules that reflect reality and which allow us to measure professional activity, thus enabling us to compare operations on the one hand, while on the other, we intend to emphasise the principle of need.

We will use quality standards and protocols currently on the designing board to achieve a continuous improvement in care quality. When doing this, we also will establish the output rules of active services, together with a documentation system. The emphasis will be on service output, meaning on improving user satisfaction.

The goal of the programme is to have service providers spotlight user interests and needs, to establish uniform framework conditions and to offer the activity on the basis of professional minimum standards.

Introducing uniform professional regulations will not only reduce the current significant differences in the quality, content, and accessibility of services. It will offer an opportunity to measure the standards on which tasks are met, the results, and to use the feedback of the various players, in particular, the users of the services.

The elaboration of the standards and protocols is taking place in working groups, whose members either were invited or who won their places through competitive applications. The project is set for completion in 2007. The professional participants will, in the meantime, prepare the regulatory materials which will be included in the valid legal document as guidelines.

Institutions for persons with disabilities are currently undergoing change. This involves breaking down the large capacity facilities into smaller ones, and upgrading and modernising them, as well as transferring inhabitants to residential home-type facilities. The goal is to cut the number of persons per facility (with a maximum of 8-12 people in residential homes for persons with disabilities) to guarantee a higher level of care, in which services can adjust better to the individual needs of residents.

4.3.4 - Ensuring financial sustainability

The financial sustainability of services must become a particularly important consideration in future plans. The phenomenon of demographic ageing is very apparent in Hungary and this is increasing the financial load on the central budget. We will have to calculate with expanding current capacities as the number of people requiring long-term care capacities continues to rise. The waiting list of people requesting these services is already significant – and in the future, we will have to improve services to promote and support the expansion of the accessibility of basic services. Our goal is to reinforce services that the user can access in or near the home, emphasising this form as opposed to residential services, which are much more of a financial burden.

When accessing services, an attempt must be made to give priority to persons with the greatest need. A social policy based on the principle of need only can be evolved if we recognize that although loss

of a job and deterioration in health, or old age or a family crisis can put anyone into a temporarily difficult life situation, it is possible to get beyond a difficult life situation by mobilizing one's own resources. The role of social policy is to implement an effective correction: to offer compensation for the damage suffered, but at the same time to offer incentives to resolve the situation that has evolved.

We distinguish among needs from two points of view – there is physical or mental health-based need and/or need based on an income situation. With respect to the latter consideration it is important to define a social minimum or, to put it another way, a minimum income level below which services are provided free of charge.

In order to precisely regulate the criteria for determining need, extensive professional agreement is necessary.

Among the problems still to be resolved is establishing the connections between basic services and specialized services – to prevent access to institutional services without having a history of needing other services. At present, the various services are not in building-block formation and the result is increased demand on specialized services.

A differentiated system of subsidies has to be evolved to finance specialized services. At present, residential facilities accommodate elderly people who have differing nursing care needs as well as differing assets and incomes. For this reason, the costs of providing care for them are quite different. The amount of funding contributed by the state for persons who would be able to live independently and who have higher incomes is unjustifiably high.

It is expedient to adjust the per capita operation norms of persons in long-term residential care to the actual caring needs of the persons being cared for. The aim is that in addition to determining percentages for several levels of per capita treatment, the system would assess and rate the care recipients on a regular basis.

In order to keep budget expenditure within a justifiable level, the capacity regulation yet to be shaped will include a concrete upper limit, a cap, for a given area and amount of care in specific cases, above which it will not be possible for the financing system to accept new capacities, including accommodations, services, or number of care recipients, into coverage.

In the case of long-term care, reinforcing volunteer work is very important. It will be necessary to expand forms of care-giving offered by family members as well as to recruit volunteers.

Efficient and responsible management of public money requires the closer professional and financial monitoring of all service providers who receive state funding.