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EUROPEAN SOCIAL CHARTER

7th National Report on the implementation of
the European Social Charter

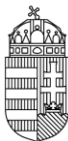
submitted by

THE GOVERNMENT OF HUNGARY

- Article 3, 11, 12 and 14 for the period 01/01/2012 - 31/12/2015
- Complementary information on Article 16 (Conclusions 2015)

Report registered by the Secretariat on
27 February 2017

CYCLE 2017



Ministry of Human Capacities

National Report

Thirteenth Report

**on the implementation of the commitments set forth in the Revised European Social
Charter**

**Submitted by:
The Government of Hungary**

covering the period from 1st January 2012 until 31st December 2015

Budapest, 2016

Pursuant to Article C of Part IV of the Revised European Social Charter, the implementation of the commitments undertaken in the Charter shall be submitted to the same supervision as the European Social Charter. Under the reporting procedure set out in Article 21 Part IV of the European Social Charter, the reporting obligation extends to the accepted articles of the European Social Charter. Pursuant to the decision of the Committee of Ministers of the Council of Europe adopted on 2 April 2014, the 2016 National Report relates to the topic “Health, social security and social protection”.

The Report covers the implementation of the following articles of the Revised European Social Charter, ratified and approved by Hungary, for the reporting periods indicated in the Table:

Provision	Period covered by the report
Article 3, paragraph (1)	From 1 January 2012 to 31 December 2015
Article 3, paragraph (2)	From 1 January 2012 to 31 December 2015
Article 3, paragraph (3)	From 1 January 2012 to 31 December 2015
Article 3, paragraph (4)	From 1 January 2012 to 31 December 2015
Article 11, paragraph (1)	From 1 January 2012 to 31 December 2015
Article 11, paragraph (2)	From 1 January 2012 to 31 December 2015
Article 11, paragraph (3)	From 1 January 2012 to 31 December 2015
Article 12, paragraph (1)	From 1 January 2012 to 31 December 2015
Article 13, paragraph (1)	From 1 January 2012 to 31 December 2015
Article 13, paragraph (2)	From 1 January 2012 to 31 December 2015
Article 13, paragraph (3)	From 1 January 2012 to 31 December 2015
Article 13, paragraph (4)	From 1 January 2012 to 31 December 2015
Article 14, paragraph (1)	From 1 January 2012 to 31 December 2015
Article 14, paragraph (2)	From 1 January 2012 to 31 December 2015
Article 16	Current legal status

With the exception of article 16, the Government of Hungary reported on the implementation of the above articles concerning the period between 1 January 2008 and 31 December 2011 in its 9th National Report. Article 16 was covered in the 11th National Report of 2014.

This National Report was prepared on the basis of the questionnaire approved by the Committee of Ministers of the Council of Europe on 26 March 2008, and with a view to the above-mentioned decision adopted on 2 April 2014. The report incorporates the answers of the Government to the specific questions and statements raised by the European Committee of Social Rights (hereinafter: “ECSR”) in its Conclusions of 2013 about the report on the provisions relating to the thematic group “Health, social security and social protection”, while in the Conclusions of 2016 in relation to Article 16 concerning the topic “Children, families and migrants”.

Given that, pursuant to Article 23 of the Charter, national organisations with membership of international employers' and employees' organisations may deliver an opinion on this National Report, the Report was sent to the relevant Parties of the (Hungarian) National Economic and Social Council (NGTT).

LIST OF REFERENCED LEGISLATION

- Fundamental Law of Hungary
- Act IV of 1991 on promotion of employment and provisions to the unemployed
- Act XI of 1991 on health governance and administration activity
- Act LXXIX of 1992 on the protection of foetal life
- Act III of 1993 on social administration and social services (Social Administration Act)
- Act XCIII of 1993 on occupational safety and health
- Act LIII of 1994 on judicial execution (Judicial Execution Act)
- Act XXXI of 1997 on the protection of children and the administration of guardianship (Child Protection Act)
- Act LXXX of 1997 on eligibility for social security benefits and private pensions and on the funding for these services (Social Insurance Act)
- Act LXXXI of 1997 on social insurance pensions (Pensions Act)
- Act LXXXIII of 1997 on the benefits of compulsory health insurance (Health Insurance Act)
- Act CLIV of 1997 on healthcare (Healthcare Act)
- Act XLII on the protection of non-smokers and on certain rules concerning the consumption and distribution of tobacco products
- Act XXV of 2000 on chemical safety
- Act XLIII of 2000 on waste management
- Act LXXXIV of 2003 on certain issues concerning the performance of healthcare activity
- Act CXL of 2004 on the general rules for public administrative proceedings and services
- Act CXXXII of 2006 on the development of the healthcare system
- Act XCIII of 2011 on the public health product tax
- Act CLIV of 2011 on the consolidation of county local governments and on the take-over of county local government institutions and certain healthcare institutions of the Municipal Government of Budapest
- Act CLXXXIX of 2011 on the local governments of Hungary
- Act CXCI of 2011 on the benefits for persons with changed working capacity and on the amendment of certain other acts
- Act I of 2012 on the Labour Code (Labour Code)
- Act II of 2012 on infringements, infringement proceedings and the infringement records system
- Act C of 2012 on the Criminal Code (Criminal Code)
- Act CXXXIV of 2012 on reducing smoking among young persons and on the retail sale of tobacco products
- Act CLXXXV of 2012 on waste
- Act CXCII of 2012 on the take-over by the State of certain specialised social and child protection institutions providing specialist care and on the amendment of certain other acts
- Act LXXVII of 2015 on the amendment of certain acts on healthcare and health insurance
- Act CXXIII of 2015 on basic healthcare

- Government Resolution 1257/2011 (VII. 21.) on the strategy of substituting social institutional capacities offering care and nursing to disabled persons and the tasks of the Government related to the implementation thereof
- Government Resolution 1230/2012 (VII. 6.) on Hungary's short-term and medium-term ragweed control plan
- Government Resolution 1039/2015 (II. 10.) on adopting the “Healthy Hungary 2014-2020” Health Sector Strategy
- Resolution 20/2001 (III. 30.) of the National Assembly on the national programme on occupational safety and health
- Government Decree No. 89/1995 (VII. 14.) on the occupational health service
- Government Decree No. 168/1997 (X. 6.) on the implementation of Act LXXXI of 1997 on social security pensions
- Government Decree No. 195/1997 (XI. 5.) on the implementation of Act LXXX of 1997 on eligibility for social security benefits and private pensions and on the funding for these services
- Government Decree No. 217/1997 (XII. 1.) on the implementation of Act LXXXIII of 1997 on the benefits of compulsory health insurance
- Government Decree No. 284/1997 (XII. 23.) on the fee of certain healthcare services provided upon the payment of a fee
- Government Decree No. 218/1999 (XII. 28.) on certain infringements
- Government Decree No. 201/2001 (X. 25.) on the quality requirements for drinking water and on the rules of inspection
- Government Decree No. 96/2003 (VII. 15.) on the general conditions of providing healthcare services and on the operating licensing procedure
- Government Decree No. 227/2003 (XII. 13.) on certain issues relating to medical treatment abroad
- Government Decree No. 301/2007 (XI. 9.) on the implementation of Act LXXX of 2007 on the right of asylum
- Government Decree No. 342/2007 (XII. 19.) on the procedural rules of exemption from the payment of early retirement contributions
- Government Decree No. 337/2008 (XII. 30.) on the implementation of Act CXXXII of 2006 on the development of the healthcare system
- Government Decree No. 354/2009 (XII. 30.) on the activity of occupational safety experts
- Government Decree No. 306/2010 (XII. 23.) on the protection of air
- Government Decree No. 323/2010 (XII. 27.) on the National Public Health and Medical Officer Service, the performance of public health administration tasks, and the designation of the pharmaceutical administrative body
- Government Decree No. 59/2011 (IV. 12.) on the National Institute for Quality and Organisational Development in Healthcare and Medicines
- Government Decree No. 323/2011 (XII. 28.) on the National Labour Office and the tasks and competences of the policy administration services under its control
- Government Decree No. 327/2011 (XII. 29.) on the rules of procedure applicable to the services provided to individuals with changed work capacity
- Government Decree No. 38/2012 (III. 12.) on government strategic management
- Government Decree No. 316/2012 (XI.13.) on the Directorate-General for Social Affairs and Child Protection

- Government Decree No. 6/2013 (I. 18.) on the detailed regulation of the market supervision activity
- Government Decree No. 39/2013 (II. 14.) on the production, trade and control of tobacco products, combined warnings and the detailed regulation of the imposition of the health protection fee
- Government Decree No. 340/2013 (IX. 25.) on the detailed regulation of medical treatment abroad
- Government Decree No. 439/2015 (XII. 28.) on the rules of managing the national blood inventory
- Decree of the Minister of Welfare No. 12/1991 (V. 18.) on the health criteria for organising holidays and camps for schoolchildren
- Decree of the Minister of Welfare No. 27/1996 (VIII. 28.) on reporting and investigating occupational diseases and cases of increased exposure
- Decree of the Minister of Welfare No. 51/1997 (XII. 18.) on health services provided under the compulsory health insurance scheme, aimed at the prevention and early recognition of diseases, and on the certification of screening tests
- Decree of the Minister of Welfare No. 18/1998 (VI. 3.) on epidemiological measures needed to prevent infectious diseases and outbreaks
- Decree of the Minister of Welfare No. 33/1998 (VI. 24.) on the medical examination of/report on occupational, professional and personal hygienic aptitude
- Decree of the Minister of Health No. 50/1999 (XI. 3.) on the minimum health and safety requirements for work with display screen equipment
- Decree of the Minister of Health No. 61/1999 (XII. 1.) on the protection of the health of workers exposed to the effects of biological factors
- Decree of the Minister of Health No. 65/1999 (XII. 22.) on the minimum safety and health requirements for the use of personal protective equipment by workers at workplaces
- Joint Decree of the Minister of Health and the Minister for Social and Family Affairs 25/2000 (IX. 30.) on the chemical safety of workplaces
- Decree of the Minister of Health No. 26/2000 (IX. 30.) on protecting against occupational carcinogens and preventing harm caused by them
- Joint Decree of the Minister of Health and the Minister of Environmental Protection No. 41/2000 (XII. 20.) on restricting certain activities related to hazardous substances and hazardous preparations
- Decree of the Minister of Health No. 1/2002 (I. 11.) on managing waste created at institutes of healthcare
- Joint Decree of the Minister of Social and Family Affairs and the Minister of Health No. 3/2002. (II. 8.) on the minimum workplace safety requirements
- Decree of the Minister for Employment and Labour Affairs No. 11/2003 (IX. 12.) on the safety regulations for industrial rope access activities
- Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (X. 20.) on the minimum professional conditions needed for providing health services
- Decree of the Minister of Health No. 2/2004 (XI. 17.) on the registration of health service providers and their operating licences, and on the professional health register
- Decree of the Minister for Employment and Labour Affairs No. 14/2004 (IV. 19.) on the minimum level of safety and health requirements for work equipment and its use
- Decree of the Minister of Health, Social and Family Affairs No. 47/2004 (V.11.) on certain organisational issues relating to the continuous operation of healthcare

- Decree of the Minister of Health, Social and Family Affairs No. 49/2004 (V. 21.) on district nurse services
- Decree of the Minister of Health No. 22/2005 (VI. 24.) on the minimum health and safety requirements relating to workers exposed to vibration
- Decree of the Minister of Health No. 66/2005 (XII. 22.) on the minimum health and safety requirements relating to exposure of workers to noise
- Decree of the Minister of Health No. 5/2006 (II. 7.) on rescue services
- Decree of the Minister of Health No. 12/2006 (III. 23.) on the protection of workers exposed to asbestos-related risks
- Decree of the Minister of Social and Labour Affairs No. 34/2007 (XII. 21.) on the assessment underlying exemption from the obligation to pay contributions for early retirement, and on the expert fees and authority fees of the exemption procedure
- Decree of the Minister of Social and Labour Affairs No. 32/2009 (XII. 23) on the detailed rules of using occupational safety fines for tendering and information purposes
- Decree of the Minister of Social and Labour Affairs No. 14/2010 (IV. 28.) on the administrative service fees payable in the licensing procedure for occupational safety experts
- Decree of the Minister of National Resources No. 12/2011 (III. 30.) on the operation of the Professional College of Healthcare
- Decree of the Minister of Human Capacities No. 20/2012 (VIII. 31.) on the operation of public education institutions and on the use of names by public education institutions
- Decree of the Minister for National Economy No. 2/2013 (I. 22.) on the safety zone of electricity utilities and producer, private and direct power lines
- Decree of the Minister for National Economy No. 17/2013 (VI. 4.) on the special rules concerning the designation, activity and supervision of organisations assessing the suitability of personal protective equipment
- Decree of the Minister of Human Capacities No. 51/2013 (VII. 15.) on the requirements relating to the prevention of injuries caused by sharp instruments used in the course of providing health services, to the management of risks deriving from the use of such instruments, and to providing information and training for persons performing healthcare activities
- Decree of the Minister of Human Capacities No. 71/2013 (XI. 20.) on the highest permissible amount of trans fatty acids in food products, the conditions and official control of the distribution of food products containing trans fatty acids, and the rules relating to monitoring the population's intake of trans fatty acids
- Decree of the Minister of Human Capacities No. 26/2014 (IV. 8.) on care provided for pregnant women
- Decree of the Minister for National Economy No. 35/2014 (XI. 19.) on the technical safety requirements relating to the operation of certain transportable pressure equipment and on the Bottled Gas Safety Regulations
- Decree of the Minister of Human Capacities No. 37/2014 (IV. 30.) on nutritional health prescriptions relating to public catering

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ARTICLE 3 – THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

I. Amendments made during the reporting period to legislations affecting the national policy on occupational safety, occupational health and the working environment

Act XCIII of 1993 on occupational safety and health (hereinafter: “Act on Occupational Safety and Health”) contains substantial changes as compared to the period covered by the 9th National Report. The amendments called for adaptation to the changes occurring in the meantime in setting up organisations, for updated definitions, and for regulations of a clarifying and supplementing nature based on practical experience. The main changes are the following:

With effect from 1 January 2012, the preamble of the Act on Occupational Safety and Health was amended as below:

“The objective of this Act is to establish the personnel, material and organisational conditions for safe work not endangering health, in the interest of protecting the health and ability to work of persons in organised employment and humanising working conditions, thereby preventing accidents at work and occupational diseases. In order to achieve this objective, the Parliament hereby passes the following Act defining the responsibilities, rights and obligations of the State, employers and employees”

Also with effect from 1 January 2012, the following new definitions were incorporated in Section 87 of the Act on Occupational Safety and Health:

- 9/B. *'Work performed in the households of natural persons as employers' shall mean an employment relationship established with a view to providing for the everyday needs of the employer and the persons and close relatives living in the employer's household.*
- 14. *'Employers' representative bodies' shall mean the national employers' organisations covered by the Act on the National Economic and Social Council, including the associations of such representative bodies.*

- 15. *‘Workers’ representative bodies’ shall mean the workers’ organisations covered by the Act on the National Economic and Social Council, including the associations of such representative bodies.*

A further change is that the definition of several concepts included in Section 87 of the Act on Occupational Safety and Health was modified or supplemented.

- In Section 87 point 3 of the Act on Occupational Safety and Health, in the definition of “Mine occupational accident”, the passage “*during mining activity*” was replaced by the passage: “*during activity supervised by the mining authority*”. [Effective: from 1 January 2012]

Suiting the effective legal regulations, the amendment extends the concept of “organised work” in such a way that for example the passage “public service” is replaced by “government service, public service”. [The cited provision included in Section 87, point 9 of the Act on Occupational Safety and Health, effective: from 1 March 2012].

With effect from 1 January 2013, Section 87, point 9 of the Act on Occupational Safety and Health was amended in compliance with the effective legal regulations, by changing the name of the bodies referred to in the provision (e.g. the passage “forces of order” was replaced by “forces of order, the Parliament Guard”).

- In the definition “Dangerous” included in point 11 and in the definition “Dangerous substance” included in point 12 of Section 87 of the Act on Occupational Safety and Health, the work “preparation” was replaced with “mixture”. [Effective: from 1 December 2013]

During the amendment of the Act on Occupational Safety and Health, the persons obliged to coordinate work were clarified. According to the new wording: “*In workplaces where employees of different employers work at the same time, work procedures shall be coordinated in such a way that there is no danger to workers or to others present in the work area. Within the framework of coordination, the employees affected and workers’ representatives and others present in the work area shall be informed of any risks regarding health and safety, and of the preventive measures adopted. The coordination of work shall be the responsibility of the main contractor defined in the Civil Code, or failing this, any other person or body who/that exercises actual control or who/that is mainly responsible for the workplace in question, or if there is no such person or body, the party on whose behalf the work is performed.*” [Section 40(2) of the Act on Occupational Safety and Health, effective: from 1 January 2012].

Section 49 of the Act on Occupational Safety and Health regulates the personnel requirements of safe work not endangering health. The amendment resulted only in slight changes in subsection (1):

“(1) *Employees may be employed in a particular position and under the condition that:*
a) they have appropriate physical aptitude for the work to be performed,
b) their employment does not endanger their health or physical integrity, and (in the case of young persons) does not have a deleterious effect on their healthy development,
c) their employment constitutes no danger to their ability to reproduce or to their foetus,

d) they do not endanger the health or physical integrity of others, and they have shown aptitude for the job, as defined by other legislation.

Medical aptitude for work shall be decided on the basis of medical examinations specified by separate legislation.”

[Effective: from 1 January 2012]

As a result of the amendment, the provisions included in Section 49 of the Act on Occupational Safety and Health have been supplemented with two new subsections.

“(3) In respect of employees working night shifts regularly or in at least one-quarter of their annual working hours (section 89 of the Act on Occupational Safety and Health) according their work schedule, the employer is obliged to ensure medical examinations before starting employment or during employment at regular intervals as prescribed in the rule relating to employment relations.

(4) Employees must be scheduled for work during the day, if during the medical examinations it is found that working at night endangers the health of the employees mentioned in subsection (3), or that there is a causal link between their disease and working at night.”

[Effective: from 1 January 2012]

In the interest of increasing the occupational safety of employees, the amendment determines stricter rules relating to risk assessment. According to the former regulations, in the case of employers in hazard category Class I, i.e. engaged in the most dangerous activity, it was considered appropriate to perform risk assessment for the first time within six months after starting the employer's activity at the latest, while in other cases, that is independently from the hazards of the activity performed by the employer, risk assessment had to be performed for the first time within twelve months after starting the activity.

As a main rule, the amendment eliminates this distinction, and provides with regard to all employers in general that: *“Unless otherwise provided for by law, employers are required to carry out risk assessment, risk management and the definition of preventive measures before starting the activity, and any time after that in duly justified cases, but at least once in every three years. The requirements set out in Section 56 can be recorded in the risk assessment.”*

[Section 54(3) of the Act on Occupational Safety and Health; effective: from 1 December 2013].

The new provisions define in 4 points what is regarded as a justified case in respect of risk assessment, risk management and the definition of preventive measures.

“Justified cases shall be construed as the following:

a) any change in the applied activity, technology, work equipment or working methods,

b) any change linked to the original activity, which may have resulted in a change in the working conditions having a significant impact on the occupational safety and health of workers, including the working climate, exposure to noise and vibration, air conditions (quantitative and qualitative changes in pollutants, such as gaseous substances, dust and fibrous pollutants),

c) any occupational accident, extreme exposure or occupational disease occurring due to any deficiency in the applied activity, technology, work equipment or working methods, furthermore

d) if the risk assessment did not cover the factors defined by specific legislation.”

[Section 54(3)a-d) of the Act on Occupational Safety and Health; effective: from 1 December 2013].

Pursuant to the new rules, the amendment states that: instead of “the proposed inspection date of the planned risk assessment” the employer must document “the proposed date of the next risk assessment planned”. [Section 54(5)g) of the Act on Occupational Safety and Health; effective: from 1 December 2013].

Section 54(7) contains regulations relating to the employer's tasks concerning safe work not endangering health. The phrase “in due time” was removed from point a), and the passage “during the planning phase at the earliest” was removed from point d). Point i) contains a new rule. In the interest of safe work not endangering health, employers shall: *“provide for carrying out the responsibilities recognized as specialised occupational safety or occupational health activities in accordance with this Act, and shall appoint a person or organisation qualified according to this Act to perform such activities.”* [Effective: from 1 January 2012]

Section 54(9) contains a new rule: *Upon the conclusion of risk assessment, the employer shall decide – relying on the findings of the risk assessment – the most effective course of action in terms of protection, the modes of collective technical protection and personal protection, as well as the proposed preventive measures with respect to work organisation and health.* [Effective: from 1 January 2012]

In accordance with the amendment, instead of the occupational safety and health authority, the occupational hygiene and health body shall exercise professional control over the occupational health service. [Section 58(4) of the Act on Occupational Safety and Health, effective: from 1 January 2015]

As a result of the amendment, the wording of Section 68(1)-(3) has changed. According to the wording of new subsection (1):

“(1) If the injured person wishes to contest the employer’s actions, or negligence, regarding the reporting or investigation of an accident at work, or the employer’s failure to investigate an occupational disease or increased exposure, or if the worker disputes the employer’s assessment of the extent of the injury, he/she may turn to the territorially competent occupational safety and health authority. The occupational safety and health authority shall direct the person alleging to have suffered an occupational disease, or complaining about the employer’s failure to investigate such occurrence to the doctor competent for reporting or to the occupational hygiene and health body.”

As a result of the amendment, the wording of subsection (2) has changed:

“(2) If the deterioration of the affected worker’s health is attributable to work, or to etiological factors occurring during work, and the body or person referred to in subsection (2) of Section 64 failed to report the occupational disease in question, the worker shall be entitled to seek remedy at the territorially competent occupational safety and health authority. The occupational safety and health authority shall forward the suspicion of an occupational disease to the body specified in the decree on reporting and investigating occupational diseases and cases of increased exposure for conducting preliminary inquiries and for reporting.”

In the scope of the amendment it is clarified in a separate subsection who can be regarded as a party during the proceedings relating to the reporting and investigation of occupational accidents and occupational diseases. According to the wording of new subsection (3):

“(3) During the proceedings referred to in subsections (1) and (2), the injured person, or if the injured person has died or is unable to act on his/her own behalf due to health reasons, then the injured person’s relative shall be treated as a party. In the claim the relationship between the injured person and his relative must be deemed likely.”

[The amendments are effective: from 1 January 2012]

The amendment repealed the passage “of Hungarian citizenship” in Section 69 of the Act on Occupational Safety and Health. [repealed: from 1 December 2013]

As a result of the amendment, the designation “the occupational safety and health authority's inspector” has been replaced by “the occupational safety and health authority” [section 84 (2), (3) and (4); effective: from 1 April 2015], and the designation “acting inspector” has been replaced by “acting government official” [Section 84(1)b); effective: 1 April 2015].

As a result of the amendment, the failure to fulfil the obligation of coordinating work borne by employers is also considered an event on the basis of which a fine can be imposed.

According to the new wording: *“The occupational safety and health authority shall impose occupational safety fines against employers failing to fulfil the requirements of safe work not endangering health, and thereby seriously endangering the life, physical integrity or health of the workers, or against the person or body responsible for fulfilling the obligation of coordination referred to in subsection (2) of Section 40.”* [Section 82(1) of the Act on Occupational Safety and Health, effective: from 1 January 2012].

In the scope of the amendment, the wording of subsection (5) has also been changed. In subsection (5)a)-i), the circumstances taken into consideration and assessed when imposing the occupational safety fine are determined in greater detail, in a more differentiated manner. The passage *“based on the extent of endangerment, assessing the personnel and material circumstances of the failure”* has been removed from subsection (5).

According to the new wording of subsection (5):

“The occupational safety and health authority shall levy the fine on the basis of:

- a) the extent of the endangerment;*
- b) the number of persons exposed;*
- c) the duration of the endangerment, and whether it is a repeat offense;*
- d) the amount of legislation infringed upon;*
- e) the foreseeable consequences of the endangerment;*
- f) the extent of the resulting injury or health impairment;*
- g) the number of workers employed by the employer or the person or body responsible for fulfilling the obligation of coordination referred to in subsection (2) of Section 40, and their net annual turnover or balance sheet total;*
- h) the measure of exceeding the permissible limits of etiological factors at work; and*
- i) the personnel and material circumstances of any other infringement leading to the endangerment based on which the fine is levied.”*

[Section 82(5) of the Act on Occupational Safety and Health, effective: from 1 January 2012]

According to the new wording of Section 82(6) of the Act on Occupational Safety and Health: *“The fines imposed under subsection (1) hereof shall be paid to the treasury special appropriation account of the occupational safety and health authority.”* [Effective: from 1 January 2012]

Section 83/B provides for the appropriate publication of occupational safety fines suiting data protection rules. According to the new wording of subsection (2):

(2) The official register shall contain the particulars of employers sanctioned and upon whom the authority conducting the occupational safety inspection – or in the case of the judicial review of an administrative decision, the court – has imposed occupational safety fines by final and executable decision for any breach of occupational safety regulations. The register shall contain:

- a) the employer's name, registered office, tax number, and if the employer is a natural person with no tax number, the name, residential address and tax identification code of this person;*
- b) the date and number of the resolution establishing the infringement, and the date when it became operative and enforceable;*
- c) a description of the infringement;*
- d) the fact and amount of the occupational safety fine;*

[Effective: from 1 December 2013]

A new paragraph e) has been added to Section 83/B(2), according to which the official register shall contain *“the date and number of the final and executable court ruling in the case of judicial review, the date when it became operative, indicating also the court ruling adopted in connection with the administrative decision”*. [Effective: from 1 December 2013]

According to the wording of new subsection (2a):

“(2a) The register referred to in subsection (1) shall be construed as an official public register, with the exception of the data under paragraph a) of subsection (2).” [Effective: from 1 July 2013]

Section 83/B(4) of the Act on Occupational Safety and Health contains a new provision, according to which the occupational safety and health authority shall erase the data contained in the register after a period of two years has expired following the date when the resolution became final and executable, or from the date of the final and executable court ruling in the case of judicial review, rather than from the date when the final and executable resolution was made. Subsection (4) also refers to data published on the website of the occupational safety and health authority. [Effective: from 1 December 2013]

According to new subsection (5), the data recorded in the register must also include the name, residential address and tax identification code of the natural person with no tax number committing the infringement, on whom an occupational safety fine has been imposed. Furthermore, subsection (5) contains a new provision, according to which: *“Upon the judicial review of the administrative decision, the authority shall make public the data referred to in paragraph e) of subsection (2), if the court dismissed the action or reversed the administrative decision, by posting such data on its website.”* [Effective: from 1 July 2012]

As a result of the amendment, the provisions included in Section 83/B have been supplemented with two new subsections.

“(7) The occupational safety and health authority, if it receives notice that a petition has been lodged for the judicial review of its resolution, shall:

- a) publish the data referred to in subsection (2) taking into account the decision included in the final and executable court ruling,*
- b) take measures for having the data referred to in subsection (5) – if already published – removed from the website.”*

[Section 83/B(7) of the Act on Occupational Safety and Health; effective: from 1 January 2012]

“(8) Data may be disclosed from the official register free of charge, in a form enabling individual identification, to the Hungarian Central Statistical Office for statistical use.”
[Section 83/B(8) of the Act on Occupational Safety and Health; effective: from 24 December 2015]

A further change is that Section 81(2) of the Act on occupational safety and health was repealed as of 24 December 2015. This rule made it possible for the occupation safety and health authority to provide information for tenderers determined in the Act on Public Procurement on the obligations relating to workers' health and safety.

As a result of the amendment of the Closing Provisions of the Act on occupational safety and health, subparagraphs do), dq) and dv) of paragraph d) under subsection (4) of Section 88 have been removed from the statutory power granted to the minister responsible for employment policy. [Section 88(4)d)do), dq) and dv) of the Act on occupational safety and health; repealed: from 1 January 2015].

II. Occupational safety and health

Council Directive 2010/32/EU implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU was published in the Official Journal of the European Union on 1 June 2010. The primary objective of the directive is to achieve the safest possible working environment by preventing injuries to workers caused by all medical sharps (including needle-sticks) and protecting workers at risk in the hospital and healthcare sector.

The transposition of this EU directive is realised by Decree 51/2013 (VII. 15.) EMMI of the Ministry of Human Capacities on the requirements relating to the prevention of injuries caused by sharp instruments used in the course of providing health services, to the management of risks deriving from the use of such instruments, and to providing information and training for persons performing healthcare activities.

The decree applies to healthcare service providers employing workers, to natural persons performing healthcare activities and employed by the healthcare service provider under a public servant relationship, employment relationship, public service relationship, government service relationship or service relationship, and to trainees and students participating in services and activities related to the healthcare sector.

The decree – in compliance with other legal prescriptions relating to workers exposed to biological risks – contains detailed rules relating to risk assessment, risk management and risk prevention to be performed by the healthcare service provider, prescriptions relating to training workers and providing them with information, and requirements concerning the measures taken after sharp injuries to workers.

The decree contains certain sections of the Methodological Letter issued by the National Centre for Epidemiology in Epiinfo, special issue no. 2 of 2003, “on the prevention of viral infections spread through blood and body fluids during medical care”, which relate to the

prevention of infections spread from the infected patient to the medical staff as a result of contamination with blood or body fluids, generally during accidents involving injuries.

Besides the EMMI Decree, a number of relating prescriptions was incorporated in Act XI of 1991 on health governance and administration activity (hereinafter: Ehi), as of 1 May 2013:

- in order to prevent injuries, the healthcare service provider shall – in compliance with fulfilling its occupational safety and health obligations prescribed in the legal act, and as laid down in the decree of the Minister for Healthcare – ensure the protection of healthcare workers against risks deriving from the use of sharp instruments needed for performing healthcare activities [section 4/C of Ehi];
- the administrative body for health, within its sphere of administrative and coordination responsibilities, shall supervise and inspect compliance with the above within its powers as an official authority [section 4/C of Ehi];
- the definition of sharps as determined in the directive [Ehi. 4/C. §];
- the possibility of imposing a health fine in the case of violating the legislation relating to the prevention of sharp injuries, occurring in hospitals or at other healthcare service providers [section 13/A(1)j) of Ehi].

Besides the Act on Occupational Safety and Health presented above, compliance with the directive and the protection of workers' health is realised by the following legal acts concerning health and safety at work:

- a) Decree of the Ministry of Health No. 61/1999 (XII. 22.) on protecting the health of employees exposed to the effects of biological factors;
- b) Decree of the Ministry of Health No. 65/1999 (XII. 22.) on the minimal safety and health requirements concerning workers' use of personal protective equipment at work;
- c) Decree of the Ministry of Health No. 1/2002 (I. 11.) on the treatment of waste created at healthcare institutes, which contains provisions – in compliance with Clause 6 of the Annex to the Directive – relating to the measures aimed at eliminating workers' exposure to injuries and/or infections caused by sharps, with special respect to safety prescriptions relating to the handling of such sharps and to the elimination of contaminated waste containing such instruments (collection, storage, transfer, transportation, disinfection, registration, disposal, training on waste management tasks);
- d) Decree of the Minister of Welfare 18/1998 (VI. 3.) on epidemiological measures needed to prevent infectious diseases and outbreaks, which – in compliance with Clauses 6 and 10 of the Directive – describes the measures to be taken immediately in the case that healthcare workers are exposed to certain notifiable infectious diseases (e.g. accidental injection of infectious material, wound or injury caused with a contaminated instrument, injury caused with a needle or cannula inserted in the artery or vein of a patient with an infectious disease).

The following further legal acts amended with the purpose of legal harmonisation were submitted to the European Commission on 9 August 2013:

- Act CII of 1997 on the amendment of Act XCIII of 1993 on occupational safety and health
- Act XLVII of 1997 on the management and protection of healthcare data and related personal data
- Act CLIV of 1997 on healthcare

- Act LIII of 2002 on the amendment of Act IV of 1991 on provisions for the unemployed, Act XCIII of 1993 on occupational safety and health, Act LI of 2001 on vocational training contribution and support for the development of training, Act CI of 2001 on adult training, Act III of 1993 on social administration and social services, Act XXII of 1992 on the Labour Code, and certain other legislation
- Act XI of 2004 on the amendment of Act XCIII of 1993 on occupational safety and health
- Act CXXIX of 2006 on the amendment of Act XCIII of 1993 on occupational safety and health
- Decree of the Minister of Social and Labour Affairs No. 18/2007. (V. 10.) on the amendment of certain ministerial decrees relating to organising a uniform occupational safety and health authority
- Act CXII of 2011 on informational self-determination and the freedom of information
- Act CLXXVI of 2011 on the amendment of certain acts on healthcare
- Act CXCI of 2011 on the benefits for persons with reduced working capacity and on the amendment of certain other acts
- Government Decree No. 273/2011. (XII. 20.) on the detailed rules relating to the amount and imposition of occupational safety fines
- Decree of the Minister of National Resources No. 21/2012. (IV. 4.) on the amendment of certain ministerial decrees concerning healthcare
- Decree of the Minister for National Economy 48/2012. (XII. 28.) on the amendment of certain ministerial decrees within the competence of the Minister for National Economy, relating to the setting up of district (metropolitan district) offices
- Decree of the Minister of Human Capacities 11/2013. (II. 7.) on the amendment of ministerial decrees within the competence of the Minister of Human Capacities, relating to the setting up of district (metropolitan district) offices

III. Legal acts repealed in the reporting period

- **Government Decree No. 342/2007. (XII. 19.) on the procedural rules of exemption from the payment of early retirement contributions**

The regulation was repealed as of 1 April 2015 by Section 114 of Government Regulation 70/2015. (III. 30.) on the amendment of certain government regulations relating to the reorganisation of the regional state administration system.

- **Government Decree No. 323/2011 (XII. 28.) on the National Labour Office and the tasks and competences of the administrative bodies under its control**

The regulation was repealed as of 1 January 2015 by Section 24 of Government Regulation 320/2014. (XII. 13.) on the designation of the public employment service, the occupational safety and health authority and the employment authority, and on performing the official and other tasks of these bodies.

- **Decree of the Ministry for Social and Labour Affairs No. 34/2007 (XII. 21.) on the assessment underlying exemption from the obligation to pay contributions for early retirement and the expert fees and authority fees of the exemption procedure**

The decree was repealed as of 1 October 2015 by Section 17 of Decree 21/2015. (VIII. 28.) NGM of the Ministry for National Economy on the amendment of certain ministerial decrees concerning occupational safety and health for the purposes of legal harmonisation, and on the amendment of certain ministerial decrees concerning employment and vocational training.

- **Decree of the Ministry for Social and Labour Affairs 32/2009. (XII. 23.) on the detailed rules of using occupational safety fines for tendering and information purposes**

The decree was repealed as of 1 January 2015 by Section 20 point d) of Decree of the Minister for National Economy No. 55/2014. (XII. 31.) on the amendment of ministerial decrees relating to the termination of the National Labour Office and the reorganisation of the vocational and adult training institutional system.

2) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR is requesting information concerning the details of the coherent national occupational safety and health policy referred to in the previous report, based on consultation with the representatives of employers and employees.**

The previous National Report covered the period from 1 January 2008 to 31 December 2011. Resolution 20/2001 (III. 30.) of the National Assembly on the national programme on occupational safety and health defined a long-term occupational safety and health programme until 2007, after which Hungary did not have an accepted and implemented national (countrywide) programme on occupational safety and health (following preparation it was not accepted, and consequently it was not implemented either).

- **The ECSR is requesting detailed information concerning any new national strategy on occupational safety and health.**

In the reporting period Hungary did not have an accepted and implemented national strategy/programme on occupational safety and health. However, the elaboration of the document titled the National Policy of Occupational Safety has already been underway, which in accordance with the occupational safety strategy of the EU relating to the period of 2014-2020, sets out the long term improvement objectives of occupational safety for the period of 2016-2022. The Government of Hungary adopted the National Policy of Occupational Safety beyond the reporting period.

The goals announced:

The Directorate of Occupational Safety and Labour Affairs of the National Labour Office (hereinafter: NMH MMI), within its administrative responsibilities determined in Section 11 paragraph (1) and Section 16 paragraph (16) of Government Regulation 323/2011 (XII. 28.) on the National Labour Office and the tasks and competences of the policy administration services under its control, determined the performance objectives relating to the

implementation of the professional policies of the occupational safety and health and labour inspectorates operating in the metropolitan and county government offices.

Occupational safety and health focuses on protecting the rights of employees to health and safety, while labour affairs are focused on protecting employees' other guaranteed rights to wages, rest, holiday and employment. The two areas together are regarded as the so-called labour inspection system in European practice.

In Hungary, the act *on the promulgation of the 81st Convention on labour inspection in industry and trade accepted by the International Labour Conference at its 30th session held in 1947* records the tasks and objectives of the “labour inspection system”: provisions relating to safety, health, the employment of children and young people, working hours, wages and other related issues.

The aim is to set up a professionally strong inspectorate, which requires knowledge and observation of the legal acts, to maintain the professional results achieved during its operation, and to enforce completely European legal acts and national regulations.

General principles:

1. Occupational safety and health inspectorates must seek to reveal all irregularities occurring at workplaces, in the scope of which they must reveal and inspect the etiological factors of occupational safety and health; an outstanding professional task of occupational safety and health inspectorates is to inspect the legality of establishing employment relations, and the enforcement of employees' financial interests and right to rest as ensured in the legal act.
2. Legality and equal treatment must be asserted during the application of the law. Apart from the legal requirements, the principles and rules of procedure of uniform professional interpretation must also be realised. As a result of the procedures, uniform, gradual and proportionate measures should be aimed at.
3. Special attention must be paid to observing the provisions included in the rules of administrative procedures, and other procedural rules within their sphere of operations. Special attention must be paid to observing the deadlines during the procedures. The deadlines must be monitored by all county inspectorates.
4. Leading officials must assert inspection integrated in the process, with special respect to the accuracy and up-to-date nature of data input. During the use of the Inspectors' Auditing Information System and the relating data recording process, data complying with the internal professional prescriptions must be entered continuously, making sure that on the basis of the data displayed no doubts occur in connection with the authenticity of the official register.
5. Leading officials must pay special attention to the assertion of the nationally elaborated professional principles during the application of the law.

The outstanding indicators of the occupational safety and health authority are determined annually in the objectives. The achievement of the professional objectives is regularly

evaluated (e.g. special examination of dangerous industries, electrical hazards, noise, dust, dangerous substances, carcinogenic and mutagenic substances, biological etiologic factors).

- **The ECSR is requesting information on the campaign organised and the inspections carried out by the occupational safety and health authority.**

The occupational safety and health authority analyses and evaluates the data deriving from official inspections and investigations of occupational accidents and health detriments, on the basis of which it plans, organises and conducts targeted audits and audit actions year after year. In the scope of this, the Capital City of Budapest and the county government offices acting in the role of occupational safety and labour affairs examine the areas designated for inspection all over the country according to uniform criteria established by the specialised administrative body.

The targeted audits and audit actions are prepared by the specialised administrative body, and after concluding the audits it analyses the data received.

The occupational safety and health authority publishes on its website the summarising reports prepared on the basis of the experience obtained during the inspections, so they can be accessed by employers, employees and other interested parties any time.

1. National audit actions and targeted audits carried out in the reporting period:

Targeted audits in 2012

- Targeted occupational health auditing of mining workplaces (8-26 October 2012)
- Targeted auditing of autumn harvest work in agriculture (1-5 October 2012)
- Targeted auditing of psycho-social risk management (Phase I: 1-31 October 2012; Phase II: 5-23 November 2012)

Targeted audits in 2013

- Targeted auditing of activities involving the risk of biological etiologic factors (6 May-30 June 2013)
- Targeted auditing of the occupational safety inspection of the operation of lifting machinery (inspection interval: 1 August -30 September 2013)
- Targeted auditing of electrical safety (inspection interval: 1 September - 31 October 2013)
- Targeted occupational health auditing of mining, in cooperation with the partner authority (inspection interval: 1 September -31 October 2013)
- Audit actions due to extraordinary weather conditions, depending on heat alert

Targeted audits in 2014

- Targeted auditing of activities involving the risk of injuries and/or infections caused by sharps used in the course of providing healthcare services (3 March-30 April 2014)
- Targeted auditing of building construction activities (12 May-30 June 2014)
- Targeted auditing of the safety of material handling (1 September -31 October 2014)
- Targeted occupational health auditing of mining, in cooperation with the partner authority (10-21 November 2014)

Targeted audits in 2015

- Targeted occupational safety auditing of wood industry activities (2nd quarter of 2015)
- Targeted occupational safety and health auditing aimed at preventing infections and diseases caused by biological etiologic factors (31 August-30 September 2015)
- Targeted occupational health auditing of mining, in cooperation with the partner authority (2-16 November 2015)
- Audit actions due to extraordinary weather conditions (3rd degree heat alert) (periods between 6-8 July 2015 and 7-11 August 2015).

A detailed report on the audit actions and targeted audits carried out in 2012 and 2013 was submitted in the 2014 report (in the form of an appendix due to its length). Similarly to the previous years, a detailed summarising report was prepared on all audit actions and targeted audits in 2014 and 2015 too; these reports are not attached hereto due to their length, only a short summary is provided.

A summary of the results of the audit actions and targeted audits carried out in 2014:

a) Targeted auditing of activities involving the risk of injuries and/or infections caused by sharps used in the course of providing healthcare services

The audit actions were justified by the number of injuries caused by needles or other sharp instruments used in large numbers by healthcare workers. Such injuries give cause for concern, because when injured, workers may be infected with over 20 different types of blood-borne diseases.

Workers employed in healthcare are at high risk of infections transmitted by blood and body fluids. Most often, the risk of infections caused by Hepatitis B (HBV), Hepatitis C (HCV) and the Human Immunodeficiency Virus (HIV) must be taken into account.

Preliminary professional consultation took place with the Office of the Chief Medical Officer (hereinafter: OTH) in connection with conducting the targeted audit. The targeted audit covered the examination of the fulfilment of the *occupational safety and health requirements* relating to the prevention of injuries caused by sharp instruments used in the course of providing health services, to the management of risks deriving from the use of such instruments, and to providing information and training for persons performing healthcare activities.

The targeted audit contributed to defining more clearly the powers and competences of two authorities – the policy administration services of public health of the metropolitan and county government offices, and the occupational safety and health inspectorates – authorised to inspect the prescriptions included in Decree of the Minister of Human Capacities No. 51/2013 (VII. 15.) on the requirements relating to the prevention of injuries caused by sharp instruments used in the course of providing health services, to the management of risks deriving from the use of such instruments, and to providing information and training for persons performing healthcare activities. The two authorities were helpful and cooperative.

During the targeted audit, the occupational safety and health inspectors took measures to terminate the deficiencies revealed, and they issued warnings in the case of less significant irregularities. Especially in the case of the providers of basic healthcare services it was found that they were not aware of the legal regulations concerning occupational safety and health

affecting their work, and the work performed by their service providers involved in occupational safety and health activities was not professionally acceptable. The inspectors provided information, presented and explained the relating legal prescriptions to help employers. Since the targeted audit, a number of employers have provided feedback on eliminating the deficiencies, or contacted the inspectorates to ask further questions. The professional consultations with the employers proved to be useful and successful.

b) Targeted auditing of building construction activities

The auditing of building construction activities was justified by the fact that based on the immediate reports submitted in the 1st-3rd quarter of 2013, 12 fatal accidents took place in Hungary because of irregular work, representing one-third of fatal occupational accidents.

A further professional reason for carrying out the targeted audit was that during construction work, significant health hazards and risks deriving from the activities and from the working environment must also be taken into consideration (e.g.: stress deriving from hard physical work, possible exposure to dust, noise and vibration exceeding the limit values, the unfavourable effects of the outdoor environment, etc.).

During the targeted audit, in the area of occupational safety and health, the inspectorates inspected first of all the requirements relating to work performed at a height, the safe construction of scaffoldings, the installation and safe condition of load lifts, civil engineering and road construction work (excavation work, earthmoving equipment, load lifting with excavator), master builder and professional work, the safety requirements of electrical equipment, risk assessment, the regulations relating to the provision of personal protective equipment, the information and training provided for employees.

From the aspect of occupational health, the audits covered the special risk assessment requirements relating to certain etiological factors at the workplaces, preventive measures relating to environments not harmful to health, the provision and use of personal protective equipment providing appropriate protection, the storage of hazardous substances/mixtures, the conditions of first aid at work, drinking water supply, providing social rooms.

Construction industry is still one of the most dangerous industries, where the highest number of occupational accidents resulting in fatal or serious injuries took place last year. During building construction work, numerous health hazards and risks must be taken into consideration.

Despite frequent inspections, unfortunately no improvement can be seen. Large investment are still characterised by the fact that building construction work is performed by several employers, with a confused network of main contractors and subcontractors. As a result of this, it is difficult to coordinate and manage the construction and the work performed by the different contractors on a given building site.

At construction sites where workers employed by several employees work simultaneously, the project supervisors representing the main contractor on the site do not always have information about the chain of subcontractors. The protection of workers against etiological factors at the workplace (e.g. noise, vibration, dust, chemicals, etc.) is often not covered by risk assessment or is missing from the measures taken by the employers.

Improvements took place in the field of installing electric switchboards and also in the realisation of temporary electrical networks, but irregularities were still observed in respect of the placement of electrical wiring and the use of extension cords with damaged insulation.

It was still a problem to provide employees with personal protective equipment. The lack of providing personal protective equipment was most frequently observed in the case of the presence of substances harming the respiratory system (e.g. harmful, irritant gases, steams and dusts causing hypersensitivity reactions).

During work at a height, in most cases employers provided personal protection equipment against falling, but such equipment was not always available on the working site, the employer did not require its use, or the suspension points were not determined.

On building sites the danger of falling in or down is the most serious risk. Here the deficiencies of collective technical protection on the building sites must be pointed out, and the lack of ensuring appropriate personal protective equipment. A positive development is that no irregularities calling for measures were detected in the case of the majority of the facade scaffolding systems made from prefabricated units.

Civil engineering sites are characterised by the lack of appropriately enclosed or propped trenches and pits, or their deficient construction, and by the violation of the prohibition of load on the plane of rupture, and creating irregular slopes.

Carrying out an overall inspection is more difficult, if the contractor's seat or business site is not situated in the county where the inspection takes place. Irregularities in the field of occupational safety and health occur in the highest numbers in the case of companies coming from the eastern regions of the country and from the other side of the eastern borders. Inspecting employers employing foreign workers and enforcing the measures taken during the proceedings is time consuming. After the removal of the ability of the occupational safety and health authority to impose sanctions in cases of non-compliance, some employers became uninterested in observing occupation health and safety rules.

Employers are still making excuses referring to limited financial possibilities for not fulfilling their occupational safety and health obligations.

The audits were received favourably by most employers who understood the aim of the audits. The majority of the employers understand that it is also in their interest to eliminate the deficiencies revealed during the official inspections. The inspections were less popular among employees, because after the inspections they were made to use the protective equipment, which they found uncomfortable.

c) Targeted auditing of the safety of material handling

The auditing of the safety of material handling was justified by the fact that based on the immediate reports submitted in the 1st-3rd quarter of 2013, 9 fatal accidents took place because of irregular material handling, representing one-quarter of fatal occupational accidents.

During the targeted audit, the inspectorates first of all examined the circumstances of manual handling, the technical safety condition of the tools and lifting machinery used during

handling and storage, and they examined the documents prescribed in the legal acts/standards only where concrete technical or safety deficiencies were revealed.

The diversity of the lifting machinery is indicated by the fact that during the targeted audit a number of different types of work equipment – not really covered by audits so far – came into the authority's focus of attention (e.g. stackers used in warehouses, work platforms, hoists for raising vehicles, continuous handling equipment, storage racks).

The audits were mainly aimed at employers typically operating in the given counties. The audit covered the handling processes taking place in construction industry, agriculture, waste transportation and production, the work equipment and lifting machinery used during such processes as well as the legality of their use, and also storage racks and lifting machinery used in trade and in warehousing/storage facilities. The working conditions of employees operating such work equipment and lifting machinery were also examined.

When selecting the employers subjected to the audit, the inspectors also made an effort to inspect first of all employees the activity of whom in connection with lifting machinery had already attracted their attention, e.g. employers, where a lot of deficiencies had been revealed or where (serious) occupational accidents had occurred in connection with lifting machinery for example in the past 5 years.

Overall, the targeted auditing of the handling activity of the employers involved was concluded with unfavourable experience. The targeted audit identified a significant number of employers who operated lifting machinery and work equipment irregularly. Furthermore, the authority revealed several severe infringements in respect of inspecting lifting machinery.

Taking into consideration the experience obtained during the targeted audit, the Labour Inspection Department of the Ministry for National Economy (hereinafter: NGM) elaborated recommendations to facilitate material handling and the operation/use of lifting machinery.

d) Targeted occupational health auditing of mining, in cooperation with the partner authority

The targeted audit was justified by the fact that during mining work, health hazards and risks – often unforeseen – deriving from the activities and from the working environment must also be taken into consideration (e.g. stress deriving from hard physical work, possible exposure to dust, noise and vibration exceeding the limit values, the unfavourable effects of the outdoor environment, etc.). Suiting the joint auditing practice of the previous years, the occupational safety and health authority carried out the targeted audit in cooperation with the Hungarian Office for Mining and Geology (hereinafter: MBFH) and the mining inspectorates.

The aim of the audit was to promote safer work at the audited mining workplaces via the inspectors' inspections and measures, to terminate working conditions endangering employees' health, and to prevent by this the occupational accidents, occupational diseases and cases of increased exposure.

In respect of the supervision of mines, Section 86 paragraph (1) point d) of the Act on Occupational Safety and Health refers the performance of occupational health tasks to the competence of the occupational safety and health authority.

During the targeted auditing of mining activities focusing on occupational health, occupational safety inspectors found that at mining workplaces where it was possible to realise modernisations and developments, they also paid more attention to creating a proper working environment and providing appropriate personal protective equipment, which resulted in the improvement of the occupational safety and health situation at these workplaces.

At the same time, the targeted audit drew attention to numerous deficiencies and irregularities in respect of occupational safety and health (e.g. in respect of the assessment and management of risks deriving from exposure to dust and vibration), and the occupational safety and health authority took the necessary measures to eliminate these.

The national audit carried out on top of the audit plan included the following:

e) European Union campaign to prevent slips and trips (1 April-30 September 2014)

The campaign was launched, because the Senior Labour Inspectors' Committee (hereinafter: SLIC) started a European Union campaign in 2014 to prevent slips and trips. Hungary also joined the campaign through the auditing activity of the occupational safety and health authority.

The set of criteria determined for the campaign conducted by the Inspectorates was elaborated by the SLIC. The occupational safety inspectors working for the Inspectorates carried out their audits on the basis of a uniform set of criteria elaborated by the European Union.

The aim of the campaign was to prevent accidents and injuries caused by same-level slips and trips. The campaign was aimed at the following industries:

- food industry
- metalworking
- healthcare
- catering industry (HORECA)
- retail and wholesale trade (warehousing)

For six months starting from April 2014, occupational safety inspectors closely monitored employers to find out whether they had taken the necessary measures in order to prevent occupational accidents caused by slips and trips.

When necessary, the inspectors obliged employers to eliminate the irregularities, and in the case of detecting serious and direct hazards, they also imposed occupational safety fines.

The results of the audits will be summarised and evaluated at EU level in February 2015. Overall, the campaign ended with negative experience. However, immediate measures were relatively rare during the campaign. The large number of cases when employers were obliged to eliminate deficiencies within a set deadline indicates that employers still do not pay enough attention to eliminate hazards deriving from slips and trips.

The results of the audit have been submitted to the Estonian occupational safety and health authority in charge of summarising the audit at EU level.

A summary of the results of the audit actions and targeted audits carried out in 2015:

a) Targeted occupational safety auditing of wood industry activities

The targeted audit was justified by accidents causing limb loss occurring because of the occupational safety deficiencies of wood industry technologies. A further professional reason for carrying out the targeted audit was that during wood industry work, significant health hazards and risks deriving from the activities and from the working environment must also be taken into consideration (e.g. stress deriving from hard physical work, possible exposure to dust, noise and vibration exceeding the limit values, the unfavourable effects of the outdoor environment, etc.).

The targeted audit covered the condition of wood industry workplaces, the inspection and use of machines, as well as occupational health issues, such as the storage and use of dangerous substances and mixtures. A further criterion covered the inspection of risk assessment relating to certain etiological factors at workplaces (e.g. exposure to noise and dust), and the assessment and examination of the working conditions of employees working in the industry.

According to the findings of the acting government officials, the employers' machinery varies widely. The highest number of deficiencies was observed in the case of older machines and self-made equipment. In many cases, employers concentrate on productivity, and they use fewer resources for protecting employees.

Workers employed at enterprises with fewer than 10 employees are especially exposed to occupational hazards and health risks, as most often they do not have the necessary occupational safety knowledge and skills, and they do not have a service provider who would cooperate with them in creating safe working conditions not endangering health and in preventing occupational accidents and occupational diseases.

In the technical field it must be noted that in an extremely high number of cases the lack or inadequacy of different protective housings called for measures taken by the acting government officials. The phenomenon can still be observed that employers themselves remove the protective equipment (e.g. they remove the protective housing, or turn off protective locking devices), saying that they only make work more difficult.

Based on the data obtained during the targeted audit it can be established that the number of frame saw machines, slitting machines, machines for manufacturing plywood and veneered panels, and surface-coating machines is far below the number of band saws, circular saws and hand-operated woodworking machines.

Based on the examination of special preventive measures related to certain etiological factors at workplaces it can be established that due to the nature of the technology, workplaces were generally characterised by so-called "combined exposition", i.e. employers were exposed to the effects of several different etiological factors at the same time.

Deficiencies can often be observed in the occupational safety and health documents prepared by the employers. The occupational health service does not substantially contribute to the preparation of these documents, and for this reason very often the health damaging effects of work are not assessed from the aspect of occupational safety.

For the above reasons, efficient and consistent audits by the occupational safety and health

authority are absolutely essential, given that many employers were only willing to take their occupational safety obligations seriously as a result of the audits.

During the audits, the government officials also supported employers, employees and occupational safety representatives by providing information for them, which, together with the official measures taken to eliminate the irregularities revealed, may play an outstanding role in preventing occupational accidents, cases of increased exposure and occupational diseases.

Besides the data obtained on the basis of the audit criteria, experience shows that besides equipment normally used in wood industry, wood industry enterprises also use numerous other work equipment. The acting government officials often observed deficiencies in the field of material handling, and they also revealed numerous irregularities relating to electricity. Furthermore, they took measures because of irregularities deriving from the lack of the maintenance of rack-mounted grinding machines and other work equipment (e.g. ladders, lighting equipment), but irregularly performed work at height was also revealed, as well as the hazard of falling in an open inspection pit.

Despite the overall difficult situation of the industry, the audit was received favourably by the majority of the employers. A significant proportion of the audited employers found out about the targeted auditing of wood industry planned in 2015 on the website of the Labour Inspection Department of the Ministry for National Economy or via their occupational safety service provider, which resulted in voluntary compliance, and in some cases government officials detected a significantly lower number of irregularities.

b) Targeted occupational safety and health auditing aimed at preventing infections and diseases caused by biological etiologic factors

The reason for carrying out the targeted audit was that as compared to the previous years, in 2013 and 2014 the number of occupational infectious diseases reported by the health and agricultural industry significantly increased; from the aspect of occupational safety and health this is primarily due to the failure of carrying out risk assessment relating to biological etiologic factors, and, as a consequence of this, to the fact that employers do not take the necessary preventive measures (risk management), as well as to the deficiencies of risk communication. The experience obtained during the national occupational safety and health inspections also drew attention to these irregularities.

Besides the working conditions linked with biological etiologic factors, the government officials carrying out the audit also had to examine the cooperation between the employers and the occupational health service in creating a working environment not endangering health, preventing health injuries, and performing tasks prescribed by specific legal acts and qualified as special occupational health activities.

Based on the results of the targeted audit it can be established that generally annual risk assessments relating to biological etiologic factors were carried out only by employers, in the case of which the occupational health service also cooperated in carrying out the risk assessment, and where such measures had already been taken as a result of earlier occupational safety inspections.

As compared to the experience obtained during the targeted audit carried out in 2013, overall

there were fewer cases of employers disregarding their most important occupational safety and health obligations prescribed in the case of biological factors; however, the government officials carrying out the audit still revealed a large number of deficiencies and irregularities, and took the necessary measures to eliminate these.

During the audits, the government officials also supported employers, employees and occupational safety representatives by providing information for them, which, together with the official measures taken to eliminate the irregularities revealed, may play an outstanding role in preventing occupational infectious diseases.

c) Targeted occupational health auditing of mining, in cooperation with the partner authority

The targeted audit was justified by the fact that during mining work, health hazards and risks – often unforeseen – deriving from the activities and from the working environment must also be taken into consideration (e.g. stress deriving from hard physical work, possible exposure to dust, noise and vibration exceeding the limit values, the unfavourable effects of the outdoor environment, etc.).

The aim of the audit was to promote safer work at the audited mining workplaces via the inspections and measures, to terminate working conditions endangering employees' health, and to prevent by this the occupational accidents, occupational diseases and cases of increased exposure.

The targeted occupational health audit conducted by the occupational safety and health authority was prepared by the Labour Inspection Department of the Ministry for National Economy. The audits were carried out jointly with the mining supervisory authority, on the basis of a centrally elaborated uniform set of criteria, according to the list of mining workplaces agreed upon with the individual Mining Divisions within the system of government offices.

During mining activities, the occurrence of numerous – sometimes unforeseeable – occupational hazards and health risks must be taken into account.

Technical developments have improved workers' working conditions, increased their safety, but mining is still one of the most dangerous industries on the basis of the risks of occupational accidents and diseases. At the audited mining workplaces where it was possible to realise modernisations and developments, they also paid more attention to creating a proper working environment, reducing workers' exposition to risks (e.g. noise, vibration, dust), and providing appropriate personal protective equipment, which resulted in the improvement of the occupational safety and health situation at these workplaces.

Despite the targeted audits carried out in the previous years, government officials still revealed a large number of deficiencies and irregularities, e.g.: in respect of the assessment and management of risks deriving from exposition to dust and vibration, and they took measures to eliminate them.

The national audit actions carried out on top of the audit plan included the following:

d) Audit actions due to extraordinary weather conditions (3rd degree heat alert) (periods between 6-8 July 2015 and 7-11 August 2015).

Based on Section 4 of the national official audit plan for 2015, the head of the specialised administrative body may initiate audit actions on top of the audit plan in the case of extraordinary events or circumstances affecting occupational safety and health (e.g. increase in the number of serious occupational accidents, change in the statistical tendency of occupational accidents and diseases, unfavourable changes in certain industries, extreme weather conditions, change in legal acts, etc.).

The reason for the targeted audit was that the Chief Medical Officer ordered the highest degree of heat alert (3rd degree – alert signal). During heat alert, the loading and stress on workers increases significantly, which represents an increased risk to their health and safety (e.g. increased risk of accidents and thermal shock: sunstroke, heat exhaustion, heatstroke). In recent years several cases of fatal heatstroke occurred. Due to the heat alert, audit actions were performed in the period of 6-8 July 2015 and then of 7-11 August 2015.

The audit actions primarily covered workplaces, where workers could be exposed to increased loading and stress because of the unfavourable climate environment, especially outdoor workplaces (e.g. road construction, agricultural work, guarding activities, etc.).

The audit actions performed by the metropolitan and county occupational safety and health authorities were prepared by the Labour Inspection Department of the Ministry for National Economy. Upon ordering audit actions, in an announcement the Labour Inspection Department of the Ministry for National Economy called employers' attention to that given the extreme weather conditions; they must pay special attention to workers' health and safety.

On summarising the experience obtained from the audit actions it can be established that the majority of the audited employers are prepared for measures aimed at preventing the unfavourable effects of climate conditions. Besides ordering heat alerts repeatedly, the favourable changes are also due to occupational safety audits, increasingly wider information campaigns, and media communication.

The occupational safety and health authority of first instance took the necessary measures to eliminate the deficiencies and irregularities revealed during the audit actions.

During the audits, the government officials also supported employers, employees and occupational safety representatives by providing information for them, which, together with the official measures taken to eliminate the irregularities revealed, may play an outstanding role in preventing health injuries (e.g. sunstroke, heatstroke) and occupational accidents occurring as a result of the heat.

2. Targeted own-initiative (county) audits

Targeted own-initiative (county) audits are planned taking into consideration specific features based on the county's industrial, economic and accident situation.

Experiences:

Based on the reports made on the targeted audits carried out it can be established that counties in general tried to select the area to be audited on the basis of the given county's specific features and the employers' hazardous work processes.

The criteria for the targeted audits were prepared by the policy administration services. Some policy administration services preliminarily submitted the criteria of their targeted own-initiative audits to the specialised administrative body. The criteria also covered issues concerning the special field of occupational safety and health.

Often, when selecting the targeted areas, the policy administration service carried out its targeted own-initiative audit based on the preliminarily ordered national targeted audit and its criteria. Some policy administration services audited common activities, such as workplaces with screens, but it must be noted that such activities cannot be regarded dangerous.

Targeted audits carried out by other policy administration services covered the following industries and activities: agriculture; processing industry and in particular wood industry; construction industry; use of hazardous carcinogenic substances; surface treatment; vehicle repairs; work in confined spaces; welding activity; provision and use of personal protective equipment; safety of equipment; kitchens with cooking facilities; chemicals used in hotels with thermal baths.

Based on information provided by policy administration services it can be established that targeted own-initiative audits were concluded with success. During the inspections, targeted audits were favourably received both by employers and employees. Employers adopted a constructive attitude towards the audits. During the audits, the employers or employees were not reluctant, there were no atrocities. Employers accepted the auditors' findings during the audits.

In the case of a large proportion of the audited employers, the auditors revealed occupational safety and health irregularities, which may justify closer inspection of the employers in the future suiting priority industries and specific regional features, in order to ensure the legality of employment.

The Ministry for National Economy reviewed the reports submitted on the targeted audits and informed the parties involved about its observations concerning the audit.

- **The ECSR is requesting information on the frequency of consultations between the representatives of employers and employees at different levels, and how such consultations take place.**

Permanent collaboration between social partners (government, employer and worker representation) is essential for realising modern occupational safety and health. The Occupational Safety and Health Committee consisting of negotiating groups determined in the Act on Occupational Safety and Health performs the reconciliation of occupational safety and health interests at national level based on its own rules of procedure (e.g. negotiation, giving opinion, taking a position, recommendation, supporting the occupational safety and health information system, determining the content of occupational safety and health training and education, etc.), where administrative and secretarial tasks are performed by the occupational safety and health authority.

The tasks of the tripartite organisation consisting of the representatives of employees, employers and the government include discussing all current issues concerning occupational safety and health, discussing current problems from several aspects, reaching compromise proposals.

The documents relating to the given issues are handed over to the committee members in advance for forming an opinion, all issues are discussed in detail at the committee meetings, and in every case a memorandum is prepared on the contributions, issues raised and proposals, which is then sent to the participating parties. At the meeting of the Occupational Safety and Health Committee, the parties may request further information and data, and the answer is provided to the concerned parties subsequently in writing, and any of the parties may recommend agenda items for the next meeting.

The table below contains the dates when the Occupational Safety and Health Committee met during the reporting period, and the issues discussed:

Year 2012		
Date	Agenda item	Memorandum
18/05/2012	Providing information on the experience of the Occupational Safety and Health Information System obtained in 2011	X
	List of applicants proposed by experts as eligible for support in the tender procedure for the use of occupational safety and health related fines.	
	Report on the results of the 2009-2010 tender procedure for the use of occupational safety and health related fines.	
24/05/2012	Accepting the report on the Occupational Safety and Health Situation of the National Economy in 2009-2011.	X
	Providing information on the Occupational Safety and Health Information System.	
	Report on the results of the 2009-2010 tender procedure for the use of occupational safety and health related fines.	
	Support proposal relating to the tenders concerning the use of occupational safety and health related fines in 2011.	
29/05/2012	Support proposal relating to the tenders concerning the use of occupational safety and health related fines in 2011.	X
07/06/2012	Support proposal relating to the tenders concerning the use of occupational safety and health related fines in 2011.	X
08/10/2012	Starting reconciliation in the interest of performing the tasks of the Occupational Safety and Health Committee as set out in Section 79 paragraph (1) point g) of the Act on Occupational Safety and Health.	X
	Discussing the demands for modifying the Occupational Safety and Health Committee's rules of procedure.	
	Report on the visit of the SLIC delegation to Hungary.	

07/11/2012	Starting reconciliation in the interest of performing the tasks of the Occupational Safety and Health Committee as set out in Section 79 paragraph (1) point g) of the Act on Occupational Safety and Health.	X
	Discussing the proposals for modifying the Occupational Safety and Health Committee's rules of procedure.	
10/12/2012	Setting up a subcommittee in the interest of performing the tasks of the Occupational Safety and Health Committee as set out in Section 79 paragraph (1) point g) of the Act on Occupational Safety and Health, and summarising the professional ideas of the three negotiating groups.	X
	Accepting the modification of the Occupational Safety and Health Committee's rules of procedure.	
	Providing information on the legislative plan of the Directorate of Occupational Safety and Labour Affairs of the National Labour Office for the first half of 2013.	
Documents submitted for review beyond meeting	Proposal for the list of applicants for the occupational safety and health fines.	

Year 2013		
Date	Agenda item	Memorandum
03/06/2013	2012 report on the occupational safety and health situation of the national economy + Occupational Safety and Health Information System report.	X
	Providing information on legislation in the first half of 2013, and on the tenders submitted concerning the occupational safety and health fines	
24/09/2013	Voting on the draft national report to be submitted to the Commission on the practical implementation of Directive 89/391/EEC and its individual directives, and Directive 2009/148/EC, Directive 91/383/EEC and Directive 94/33/EC in the period between 2007-2012.	X
03/12/2013	Report on the work of the Occupational Safety and Health Committee in 2013. Report on occupational safety and health legislation in 2013. Report on the experience obtained during tender management. Proposal for the 2014 work plan of the Occupational Safety and Health Committee, and the occupational safety and health legislation proposed to be amended.	X
Documents submitted for review beyond meeting	The professional content of the occupational safety and health training supplementing the training course under the National Training Register determined in Section 79 paragraph (1) point g) of the Act on Occupational Safety and Health.	

Year 2014		
Date	Agenda item	Memorandum
27/03/2014	Providing information on the activity of the Occupational Safety and Health Committee's working group performed so far.	X
	2013 report on the occupational safety and health situation of the national economy + Occupational Safety and Health Information System report.	
	Report on the activity performed by the Occupational Safety and Health Information Service of the Hungarian Office for Mining and Geology in 2013.	
26/06/2014	Discussing the 2013 report on the occupational safety and health situation of the national economy.	X
	Discussing the document entitled "Manual for carrying out occupational risk assessment".	
	Information session entitled "The situation of reporting occupational diseases in Hungary".	
30/09/2014	Providing information on the experience obtained during the targeted auditing of building construction activities in 2014.	X
	Providing information on the activity performed so far in the scope of the TÁMOP 2.4.8. project entitled "Improving occupational safety and health, improving labour inspections.	
	Providing information on the tenders concerning fines in 2011.	
	Providing information and the lack of reporting occupational diseases, illustrated with the example of asbestos.	
15/12/2014	Discussing current issues: - Short introduction of the history of MÉDOSZ (Trade Union of workers employed in agriculture, forestry, food industry and water industry). - Publication of Government Regulation 318/2014 (XII. 13.) on the modifications relating to the termination of the National Labour Office and establishing the National Office for Vocational Training and Adult Training.	X
Documents submitted for review beyond meeting	"Manual for carrying out occupational risk assessment"	

Year 2015		
Date	Agenda item	Memorandum
18/03/2015	Providing information on the restructuring of the organisation.	X
	Accepting the modifications to the rules of procedure.	
	Providing information on the operation of the Occupational Safety and Health Counselling Service in 2014.	

	Determining the tasks for 2015, determining the composition and tasks of the working group.	
25/06/2015	Providing information on the work performed by the working group in charge of preparing the National Policy for Occupational Safety and Health.	X
	Discussing the new proposed regulation on the minimum level of safety and health requirements for work equipment and its use.	
	Report on the realisation of the TÁMOP 2.4.8. project.	
29/09/2015	Discussing the 2014 report on the occupational safety and health situation of the national economy.	X
	Providing information on legal amendments affecting occupational safety and health.	
16/12/2015	Providing information on legal amendments relating to cutting administrative red tape.	X
	Amendment to Decree 5/1993 (XII. 26.) MüM of the Ministry of Labour Affairs on the implementation of certain provisions of Act XCIII of 1993 on occupational safety and health.	
	Annual review	

Main objectives and elements of partnership:

Due to the social and economic changes occurring in Hungary in the past two decades, and as a result of accessing the European Union, the labour market and employment policy plays a more significant role than before. The progress made during the past years and the harmonisation of law following Hungary's accession to the European Union resulted in changing a number of legal acts. As a result of the changes, the enforcement of occupational safety came into the focus of attention, which is similarly important for employees, employers and authorities.

Ensuring the guaranteed rights of employees is of primary significance, as well as creating safe working environments not endangering health, promoting by this the conditions and high quality work. On the one part, the initiation contributes to the preservation and further development of the valuable features of employment and employment culture, while on the other part it makes it possible to establish partnerships between the authority and labour market participants. Basically, partnership is built on cooperation, while at the same time the authority cannot disregard sanctioning as a possible form of prevention, if it is done in the interest of protecting employees' interests. The presence of illegal employment, the unfavourable development of the number of occupational accidents, and complaints submitted by employees are alarming for all responsible persons and organisations. Recognising that in Hungary it is not enough to take measures in the interest of suppressing negative phenomena simply by using administrative tools, we find it necessary to join forces in the framework of a partnership. It is of common interest that trust and mutual respect should be achieved among labour market participants.

The employers joining the partnership reject all forms of illegal employment.

The safe employment of workers – their life, physical integrity and health – is of utmost

importance for national economy, and it is also the employers' fundamental obligation. For this reason, employers participating in the partnership undertake to ensure their employees safe working environments and working conditions, which do not endanger health, possibly to an extent exceeding basic requirements.

They shall not establish contractual, particularly sub-contractual relationships with entrepreneurs that cannot be found at their registered seat, or have representatives that cannot be contacted in person, or are undergoing liquidation, or with entrepreneurs, which, according to the employer's knowledge, violate workers' rights or fail to fulfil the minimum occupational safety requirements.

They undertake not to breach occupational safety rules in order to reach a more favourable position in market competition. In accordance with this, during price formation they shall not promise or assert prices that do not cover workers' wages and contributions or the fulfilment of occupational safety prescriptions (e.g. the necessary technology, working and protective equipment, aptitude tests). By guaranteeing workers' working hours and rest periods, their basic constitutional right to rest is ensured, which also forms part of protecting their health. Accordingly, employers participating in the partnership shall observe the prescriptions relating to ensuring rest periods, granting leave and recording working hour data relating to performing work. Partners regard the right to wages (and supplements determined in legal acts or in the collective agreement) as one of the most fundamental workers' rights, the enforcement of which they shall ensure by the payment of wages suiting the deadline and as determined in the legal acts. They undertake to ensure the employment of occupational safety experts even exceeding the minimal number of employees prescribed in the legal act, with special respect to regional and professional distribution and to the technological hazards, and they also undertake to provide such experts with all information needed for their work, create an appropriate working environment for them and promote their professional improvement.

Besides providing occupational health services, they undertake to involve the service intensively in creating healthy and safe working conditions, pursuant to the relating prescriptions. In the case of the simultaneous employment of workers employed by several employers, they undertake to make sure that the employers acting on the same area of work – or on areas related to each other via certain effects – record the terms and conditions of occupational safety in a contract, with special respect to the issue of responsibility for hazard-free work coordination. In the scope of this, besides the protection of employees, they shall also pay special attention to the protection of other persons present (e.g. moving) in the work area. They shall ensure the enforcement of rights linked to designating occupational safety representatives. In the interest of performing an interest reconciliation activity concerning safe work not endangering health, they shall set up and operate a joint occupational safety body. They shall do their best to ensure sound labour relations at the workplace.

The occupational safety and health authority undertakes, for example, to inform the partners regularly, via electronic means, about changes in the legal acts and about the interpretation of the law from the aspect of law enforcement.

Where possible, it shall make it possible for the partners to make observations and proposals concerning the content and orientation of the codification, in the phase of preparation of legal amendments within its competence.

With a view to elaborating good practices, it shall take into consideration professionally

acceptable proposals that are in compliance with the organisation's fundamental objectives and spirit.

Based on the approval and with the support of the partners, it shall organise workshops, where it shall present the audit experience, concrete legal cases and the governing court decision to promote the correct application of the legal acts concerning occupational safety and labour affairs. It shall send the partners these governing court decisions via electronic means.

It shall forward the link ensuring electronic access to the current information and documentary publications prepared by the Occupational Safety and Health Counselling Service and published on the website.

In order to make sure that this document propagates good practices suiting national legal acts on occupational safety and European expectations, the authority shall inform its partners about calls for applications financed from occupational safety fines, and it shall send them professional publications and the programme of the conferences via electronic means. Depending on its capacities, it can hold labour and occupational safety inspections at its partners, based on preliminary notification. The obligation to send preliminary notifications does not cover cases, when the authority obtains knowledge of reports of general interest or complaints relating to partners.

It shall make sure that, if possible, during its audits it does not hinder the partner's ordinary activity more than justified.

Partners registered by the authority and listed on its website may use the sign “For Safe Employment – Partner”

- on their products,
- on their publications,
- at their events, and
- when providing information – verbally or in writing – during providing their services or advertising them.

[With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:]

2) to issue safety and health regulations;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

I. Amendments made during the reporting period to legislations determining the requirements of safe work not endangering health

In the reporting period the following substantial amendments were made to the legal acts relevant to the industry:

- **Act XXV of 2000 on chemical safety**

Section 10 of the act entered into force as of 1 January 2010, lays down the following in respect of labelling and packaging pursuant to Regulation (EC) No 1272/2008 of the European Parliament and of the Council on classification, labelling and packaging of substances and mixtures, amending and repealing Directives 67/548/EEC and 1999/45/EC, and amending Regulation (EC) No 1907/2006 (hereinafter: CLP):

“Section 10 (1) As of 1 December 2010 hazardous substances can be placed on the market only if they have been labelled and packaged pursuant to the CLP. Hazardous substances classified, labelled and packaged suiting the prescriptions of this act and already placed on the market before 1 December 2010, are not required to be relabelled and repackaged until 1 December 2012.

“(2) As of 1 June 2015 hazardous mixtures can be placed on the market only if they have been labelled and packaged pursuant to the CLP. Hazardous mixtures classified, labelled and packaged suiting the prescriptions of this act and already placed on the market before 1 June 2015, are not required to be relabelled and repackaged until 1 June 2017.

(3) The authentic Hungarian translation of the Community Register – if it is not available in the Hungarian language in the Annex referred to in Section 1(2)e) of the CLP – shall be published by the administrative body for health on its website.”

As of 1 January 2012, the act has been modified in respect of the reporting of hazardous substances and mixtures, as a result of which the product register of hazardous mixtures has become directly accessible to the inspecting authority, and the process of the procedures relating to reports made by manufacturers and distributors, and reporting changes has become traceable:

Section 6 (1) Manufacturers and distributors of hazardous substances and hazardous mixtures on the territory of Hungary – with the exception provided in paragraph (2) – are obliged to notify such hazardous substances and hazardous mixtures to the administrative body for health via electronic means, at the same time as starting the manufacturing or distributing activity relating to them, pursuant to the provisions included in the regulation issued by the Minister for Healthcare on the basis of the authorisation included in Section 34 paragraph (4) point a), attaching the safety data sheet or the safety data sheet and the draft

label to it, if the hazardous substance is not yet included in the Hungarian register pursuant to Section 5 paragraph (3), or if the hazardous mixture is not yet included in the product register. The notifier is obliged to report via electronic means any changes to the safety datasheet of the hazardous substance or mixture reported by it, or the termination of distribution.

The amendment resulted in the supplementation of Section 7 paragraph (3), and in the case of paragraph (4) it resulted in a change of content:

“(3) The notifier shall bear responsibility for all data supply relating to the notification of hazardous substances, and for the authenticity of the data. The administrative body for health may call upon the notifier to supply further data – within the data set of the safety data sheet determined in the legal act – relating to the health hazards of the hazardous substance.

(4) The administrative body for health confirms acceptance of the notification via electronic means, within 15 days following receipt of the notification complying with the formal and content requirements. The administrative body for health records the notified hazardous substance in the Hungarian register according to Section 5 paragraph (3).” [Effective: from 1 January 2012]

The amended provision is in compliance with the amendment to Section (8) paragraphs (3) and (5) of the act.

“(3) The notifier shall bear responsibility for the authenticity of the data required in connection with the notification of hazardous mixtures. The administrative body for health may call upon the notifier to supply further data – within the data set of the safety data sheet determined in the legal act – relating to the health hazards of the hazardous mixture.

(5) The administrative body for health confirms acceptance of the notification via electronic means, within 15 days following receipt of the notification complying with the formal and content requirements. The administrative body for health records the notified hazardous mixture in the product register according to Section 23.” [Effective: from 1 January 2012]

The passage “interministerial committee” coordinating chemical safety was replaced with “council”. [Section 25 paragraphs (1)-(5); effective: from 1 September 2012]

A new provision of the act is that in procedures relating to the authorisation of biocidal products, the administrative body for health and the competent authority determines the conditions for authorisation based on consultation. [Section 31/C; effective: from 6 July 2013]

- **Decree of the Minister of Health No. 44/2000 (XII. 27.) on the detailed rules of procedures and activities relating to hazardous substances and hazardous preparations**

In the reporting period, the following substantial amendments were made to the decree:

The change relating to notification via electronic means included in the act on chemical safety was adopted, according to which notifications must be submitted to the National Centre for Public Health, as ensured by the Specialised Information System of the Office of the Chief Medical Officer.

In respect of the classification, packaging and labelling of the substances and in respect of risk assessment, the concepts of substance, mixture and placement on the market have been defined. The concept of professional user has been modified.

As a result of harmonisation with the CLP Regulation, the sections and annexes describing content and formal requirements relating to the hazard classification and labelling of hazardous substances have been repealed.

- **Joint Decree of the Minister of Health and the Minister for Social and Family Affairs No. 25/2000 (IX. 30.) on the chemical safety of workplaces**

The concept of hazardous substance and hazardous mixture have been defined more accurately, and the concept of chemical substance has been defined. [Section 3 points a)-b), w); effective: from 1 October 2015]

Due to organisational changes, the designation “sub-regional (metropolitan district) public health institutes of the metropolitan and county government office” has been replaced by the designation “district (metropolitan district) public health institute of the district (metropolitan district) office of the metropolitan and county government office”. [Section 7 paragraph (4) point d); effective: from 1 January 2013]

Section 5 regulates employers' obligations in respect of the identification of hazardous substances and risk assessment. A new provision is that employers must obtain supplementary information needed for risk assessment – the safety data sheet pursuant to Regulation (EC) No 1907/2006 of the European Parliament and of the Council (REACH Regulation) – from the manufacturer (importer), distributor or further user (hereinafter together: supplier). During risk assessment, the limit values determined in Annex 1 and 2 must be taken into consideration, as well as the data of health examinations already carried out. [Section 5 paragraph (2); effective: from 1 October 2015]

The amendment states that the employer must make sure that a register relating to substance types that can be identified with the safety data sheet according to a specific legal act is kept of the hazardous substances and hazardous mixtures used at the workplace. [Section 7 paragraph (4) point c); effective: from 1 October 2015]

- **Joint Decree of the Minister of Social and Family Affairs and the Minister for Health No. 3/2002. (II. 8.) on the minimum level of safety requirements for workplaces**

Due to organisational changes, the designation “occupational safety inspectorate of the metropolitan and county government office” has been replaced by “metropolitan and county government office as occupational safety and health authority”. [Section 6 paragraph (6); effective: from 1 April 2015]

- **Decree of the Minister of Health No. 12/2006 (III. 23.) on the protection of workers exposed to asbestos-related risks**

Due to organisational changes, the designation “occupational safety inspectorate of the metropolitan and county government office (hereinafter: occupational safety inspectorate)” has been replaced by “metropolitan and county government office as occupational safety and health authority (hereinafter: occupational safety and health authority)”. [Section 6 paragraphs (1) and (7), Section 16 paragraph (3); effective: from 1 April 2015]

- **Decree of the Minister of Health No. 22/2005 (VI. 24.) on the minimum health and safety requirements relating to workers exposed to vibration**

According to the new wording: *“In respect of vibrations affecting the entire body, based on individual authorisation in maritime shipping and in air transport, an exemption from the limit value determined in this legal act can be granted by the minister for employment policy, provided that compliance with the occupational health requirements has been established. The expert opinion preliminarily issued by the Office of the Chief Medical Officer must be attached to the request”*. [Section 8 paragraph (1); effective: from 1 January 2015]

Due to organisational changes, the designation “the policy administration service of the metropolitan and county government office performing health insurance fund tasks” has been replaced by the designation “metropolitan and county government office acting in the scope of its health insurance fund responsibilities”. [Section 4 paragraph (3) point d); effective: from 1 April 2015]

Due to organisational changes, the designations “occupational safety inspectorate” and “from the occupational safety inspectorate” have been replaced by “occupational safety and health authority” and “from the occupational safety and health authority”. [Section 7 paragraph (3), Section 4 paragraph (6) point i); effective: from 1 April 2015]

- **Decree of the Ministry for National Economy No. 27/1996 (VIII. 28.) on reporting and investigating occupational diseases and cases of increased exposure**

Due to organisational changes, the designation “Directorate of Occupational Safety and Labour Affairs of the National Labour Office (hereinafter: directorate of occupational safety and labour affairs)” has been replaced by “the ministry led by the minister responsible for employment policy (hereinafter: ministry)”. [Section 3 paragraph (1); effective: from 1 January 2015]

In Section 3 paragraph (4) of the decree, the passage “to the Hungarian Institute of Occupational Health (hereinafter: OMFI)” has been replaced by “to the directorate of occupational safety and labour affairs”, [section 3 paragraph (4); effective: from 10 February 2012], and during subsequent amendment of the decree, the passage “to the directorate of occupational safety and labour affairs” has been replaced by “to the Office of the Chief Medical Officer (hereinafter: OTH)”. [Section 3 paragraph (4); effective: from 1 April 2015]

Due to organisational changes, the designation “occupational safety inspectorate” has been replaced by “occupational safety and health authority”. [Section 3 paragraph (1); effective: from 1 April 2015]

In Section 5 paragraph (9) of the decree, the passage “the policy administration service of the metropolitan and county government office performing health insurance fund tasks” has been replaced by the passage “the metropolitan and county government office acting in the scope of its health insurance fund responsibilities”. [Section 5 paragraph (9); effective: from 1 April 2015]

In Section 5 paragraph (10) of the decree, the passage “National Health Insurance Fund” has been replaced by “the metropolitan and county government office acting in the scope of its

health insurance fund responsibilities”. [Section 5 paragraph (10); effective: from 1 April 2015]

The changes in names due to organisational changes have been adopted in the entire text of the decree, including its annexes.

- **Decree of the Minister of Health No. 50/1999 (XI. 3.) on the minimum health and safety requirements for work with display screen equipment**

Due to organisational changes, the designation “occupational safety inspectorate of the metropolitan and county government office” has been replaced by “metropolitan and county government office as occupational safety and health authority”. [Section 9; effective: from 1 April 2015]

- **Decree of the Minister of Health No. 61/1999 (XII. 22.) on protecting the health of employees exposed to the effects of biological factors**

According to the amendment: *“The employer shall immediately inform the occupational safety and health authority and the district (metropolitan district) office of the metropolitan and county government office acting in the scope of its public health responsibilities (hereinafter: district office acting in the scope of its public health responsibilities) about all accidents, technological and operational failures, which may result or may have resulted in the spreading of biological factors belonging to group 3 or 4”*.

[Section 7 paragraph (2); effective: from 1 April 2015]

According to the changed wording: *“If as a result of exposition to biological factors a single employee got infected or became ill, upon the initiation of the occupational health service’ doctor, taking into consideration – if necessary – the opinion of the district office acting in the scope of its public health responsibilities, the occupational safety and health authority, with the participation of the occupation health service, determines the group of employees subject to observation – due to the same exposition –, and initiates the reassessment of the estimates described in Section 3”*. [Section 14 paragraph (3); effective: from 1 April 2015]

Due to organisational changes, the designations “occupational safety inspectorate” and “to the occupational safety inspectorate” have been replaced by “occupational safety and health authority” and “to the occupational safety and health authority”. [the opening passage of Section 7 paragraph (1), Section 11 paragraph (3), Section 13 paragraph (1), Section 16 paragraph (2) and paragraph (3) point b), and Section 7 paragraph (3), the closing passage of Section 11 paragraph (2), the subheading preceding Section 12, Section 12 paragraph (1), Section 13 paragraph (6) and (7); effective: from 1 April 2015]

Passages “district public health institute” and “to the district public health institute” have been replaced by passages “district office acting in the scope of its public health responsibilities” and “to the district office acting in the scope of its public health responsibilities”. [Section 16 paragraph (2), Section 13 paragraphs (6) and (7); effective: from 1 April 2015]

- **Decree of the Minister of Health No. 65/1999 (XII. 22.) on the minimal safety and health requirements concerning workers' use of personal protective equipment at work**

Due to organisational changes, the designation “occupational safety inspectorates of the metropolitan and county government offices” has been replaced by “metropolitan and county government office as occupational safety and health authority”. [Section 10; effective: from 1 April 2015]

- **Decree of the Minister of Health No. 66/2005 (XII. 22.) on the minimum health and safety requirements relating to exposure of workers to noise**

As a result of the amendment, the wording of Section 6 paragraph (3) and Section 14 paragraph (1) of the decree has changed as follows:

“6. § (3) If in the framework of the measures included in Section 5 paragraph (4) the occupational safety and health representative or the occupational health service's doctor finds that

a) there is an inconsistency between the result of the hearing tests and the records, or

b) noise measurement is not performed suiting normal operation,

they shall send the records to the occupational safety and health authority together with their observations. In a resolution, the occupational safety and health authority orders the repeated performance of the noise measurement, taking into consideration the opinion of the Office of the Chief Medical Officer (hereinafter: OTH).” [Effective: from 1 April 2015]

“14. § (1) If due to the nature of work the full and proper use of the personal hearing protection device would constitute a greater risk to health and safety than non-use of the device, upon the initiation of the occupational safety and health representative and the occupational health service – after compliance with the occupational health requirements has been established – the minister responsible for employment policy (hereinafter: minister) may allow derogations from the provisions included in Section 9 paragraph (1), taking into consideration the preliminary opinion of the OTH”. [Effective: from 1 January 2015]

The passage “directorate of occupational safety and labour affairs” has been replaced by “minister”. [Section 14 paragraph (2); effective: from 1 January 2015]

- **Government Decree No. 89/1995 (VII. 14.) on the occupational health service**

Due to organisational changes, the designation “competent occupational safety inspectorate” has been replaced by “competent metropolitan and county government office acting under the authority of the occupational safety and health authority”, while the passage “labour centre” has been replaced by “metropolitan and county government office acting as public employment service”. [section 5 paragraph (2), the designations included in Annex 1; effective: from 1 April 2015]

- **Decree of the Minister for National Economy No. 33/1998 (VI. 24.) on the medical examination of/report on occupational, professional and personal hygienic aptitude**

The concepts of vocational training institute and employment relationship have been defined more accurately, as well as giving an opinion on employability. [section 1 points e), m), effective: from 1 January 2013; Section 1 point l), effective: from 5 December 2013]

As of 5 December 2013, new provisions have been added to Section 16/B paragraph (2) and sections 16/C-D. According to the new wording:

“Opinion on employability in public employment

16/B. § (1) Opinion on employability is requested by the metropolitan and county government office acting as public employment service in the case of public employment by local governments, or by the public employer in the case of other forms of public employment, before starting public employment.

(2) With the exception defined in paragraph (3), opinions on employability tests are issued

a) by the medical expert of the health service provider with an operating licence authorising it to provide basic occupational health services, or

b) in the case of public employment by local governments, by the agency providing occupational health services competent for the registered seat of the metropolitan and county government office acting as a public employment service, and in the case of other forms of public employment by the medical expert competent for the employment location, on the form determined in Annex 16.

(3) In the case of public workers employed at armed forces, opinions on employability are issued by the basic service units of such armed forces with an operating licence issued by the health authority.

(4) The opinion is a compulsory requisite for public employment.

(5) The fee of issuing an opinion on employability is borne by the party requesting the examination, pursuant to the legal act on the fee of certain healthcare services provided upon the payment of a fee.

(6) The opinion on employability is valid for two years following the date of issue.

Opinion on employability for work in the public interest applied during infringement proceedings

16/C. § (1) The opinion on employability for work in the public interest applied during infringement proceedings is requested by the perpetrator applying for work in the public interest, before starting work in the public interest. In the case of work in the public interest imposed as punishment, the perpetrator is obliged to take the information document received about the organisation paying the fee of the opinion with him/her to the examination.

(2) The opinion on the employability examination is issued

a) by the medical expert of the health service provider with an operating licence authorising it to provide basic occupational health services, chosen by the perpetrator applying for work in the public interest, or

b) by the medical expert of the agency providing occupational health services competent for the registered seat of the district (metropolitan district) office of the metropolitan and county government office acting as a public employment service, on the form determined in Annex 16.

(3) The opinion is a compulsory requisite for starting work in the public interest.

(4) The fee of issuing the opinion must be paid within 60 days after issuing the opinion, in the case of work in the public interest imposed as punishment.

(5) The opinion on employability is valid for 12 months following the date of issue.

Opinion on employability for work in the public interest imposed in criminal cases

16/D. § (1) *Opinion on employability in the case of work in the public interest is requested by the probation officer service before determining the workplace in the public interest, by providing the convict's name and determining the scope of work that can be performed as work in the public interest.*

(2) *The opinion on the employability examination is issued*

a) *by the medical expert of the health service provider with an operating licence authorising it to provide basic occupational health services, chosen by the probation officer service,*

b) *by the medical expert of the agency providing occupational health services competent for the registered seat or site of the probation officer service, or*

c) *the medical expert of the agency providing occupational health services signing a contract relating to performing the task,*

on the form determined in Annex 16.

(3) *The opinion is a compulsory requisite for starting work in the public interest.*

(4) *The fee of issuing the opinion is borne by the Office for Public Administration and Justice.*

(5) *The opinion on employability is valid for 12 months following the date of issue.”*

The passage “labour centre” has been replaced by “metropolitan and county government office acting as public employment service”. [Section 16/B paragraph (1); effective: from 29 April 2015]

- **Government Decree No. 354/2009 (XII. 30.) on the activity of the occupational safety expert**

The amendment states that occupational safety experts, who were included in the register of the occupational safety and health authority on 31 December 2009 in respect of the special fields included in Annex 1 points 1-22, and do not have the qualifications determined in Section 2 paragraph (1), may submit, upon the expiration of their licence, an application for another licence regarding the given special field, at the regional chamber of engineers competent for their place of residence, provided that before 1 January 2006 they had been recorded in the register of forensic service providers in respect of one of the forensic fields suiting the special fields determined in Annex 1 points 1-22 pursuant to the legal act. [Section 8 paragraph (3); effective: from 5 September 2014]

Passages “to the OMMF” and “on the website of the OMMF” have been replaced by “occupational safety and health authority” and “on the website of the occupational safety and health authority”. [Section 2 paragraph (2), Annex 2 point 8; effective: 1 January 2015]

- **Decree of the Minister of Social and Labour Affairs No. 14/2010 (IV. 28.) on the administrative service fees payable in the licensing procedure for occupational safety experts**

Due to organisational changes, the designation “Directorate of Occupational Safety and Labour Affairs of the National Labour Office (hereinafter: directorate of occupational safety and labour affairs)” has been replaced by “the minister responsible for employment policy (hereinafter: minister)”. [Section 1 paragraph (1) point a); effective: from 1 January 2015]

The amendment states that in the case of procedures within the minister's competence, the applicant shall pay the fee onto the bank account of the ministry led by the minister (hereinafter: authorising body), as determined in Annex 1.

[Section 2 paragraph (1) point a); effective: from 1 January 2015]

At the same time, Annex 1 point 1.1. has been replaced by a new provision:

“In the case of procedures within the competence of the minister responsible for employment policy:

Bank account name: Ministry for National Economy, Administration appropriation allocation fund account Bank account number: 10032000-01460658-00000000”

[Annex 1 point 1.1.; effective: from 1 January 2015]

- **Decree of the Minister for Employment and Labour Affairs No. 11/2003 (IX. 12.) on the safety regulations for industrial rope access activities**

The primary aim of the amendment was to regulate vocational qualifications needed for performing particularly dangerous activities. [Section 9; effective: from 13 November 2013]

The passage “to a legal entity or a business organisation without a legal entity” has been replaced by “to a legal entity”. [Section 1 paragraph (3); effective: from 15 March 2014]

II. Decrees and regulations that entered into force in the reporting period

- **Government Decree No. 6/2013 (I. 18.) on the detailed regulation of the market supervision activity**

Effective date: 2 February 2013 In Section 2 paragraph (1) point i) of the regulation, the Directorate of Occupational Safety and Labour Affairs of the National Labour Office was designated as market surveillance authority in the case of personal protective equipment. Section 218 paragraph (1) of Government Regulation 70/2015. (III. 30.) on the amendment of certain government regulations relating to the reorganisation of the regional state administration system amended Section 2 paragraph (1) of the regulation. The amendment designated the minister responsible for employment policy as of 1 April 2015.

- **Decree 35/2014 (XI. 19.) NGM of the Ministry for National Economy on the technical safety requirements relating to the operation of certain transportable pressure equipment and on the Bottled Gas Safety Regulations**

Effective date: 4 December 2014

- **Decree of the Minister for National Economy No. 17/2013 (VI. 4.) on the special rules concerning the designation, activity and supervision of organisations assessing the suitability of personal protective equipment**

Effective date: 4 July 2013

- **Decree of the Minister for National Economy No. 2/2013 (I. 22.) on the safety zone of electricity utilities and producer, private and direct power lines**

Effective date: 21 February 2013

2) KEY DATA AND STATISTICS

Decree of the Minister of Health No. 26/2000 (IX.30.) on protecting against occupational carcinogens and preventing harm caused by them

Cytogenetic (toxicogenomic) risk assessments at workplaces, performed in the reporting period by the National Institute for Chemical Safety (hereinafter: OKBI), and from spring 2015 by its legal successor, the National Centre for Public Health (hereinafter: OKK):

Year	Inspected workplace type	Inspected employees persons	Measure type
2012	Control (not exposed)	24	Not necessary
	Oil industry	127	Risk management, follow-up
	Chemical industry	10	Risk management
	Pharmaceutical industry	11	Risk management
2013	Control (not exposed)	21	Not necessary
	Oil industry	121	Risk management, follow-up
	Chemical industry	10	Risk management
	Pharmaceutical industry	11	Risk management
2014	Control (not exposed)	14	Not necessary
	Oil industry	127	Risk management, follow-up
	Chemical industry	10	Risk management
	Pharmaceutical industry	11	Risk management
2015	Control (not exposed)	10	Not necessary
	Oil industry	134	Risk management, follow-up
	Pharmaceutical industry	10	Risk management

3) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR is requesting detailed information on the transposition of Directive 2009/104/EC into national law, its practical implementation, the basis for compulsory risk assessment at work, the preventive measures adapted to the nature of risks, providing information and training for employees, and the timetable for performance.**

Compliance with the directives determined in the conclusion is ensured by the following legal acts:

Compliance with Directive 2009/104/EC of the European Parliament and of the Council concerning the minimum safety and health requirements for the use of work equipment by workers at work (second individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC):

- was ensured by Decree 14/2004 (IV. 19.) FMM of the Ministry for Employment and Labour Affairs on the minimum level of safety and health requirements for work equipment and its use; repealed: from 5 May 2016,
- as of 6 May 2016, the above decree was replaced by Decree 10/2016. (IV. 5.) NGM of the Ministry for National Economy on the minimum level of safety and health requirements for work equipment and its use.

Directive 2008/46/EC of the European Parliament and of the Council amending Directive 2004/40/EC on minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields) (18th individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC):

Directive 2013/35/EU of the European Parliament and of the Council on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields) (20th individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC) and repealing Directive 2004/40/EC was published in the Official Journal of the European Union on 29 June 2013. The deadline of transposing the requirements set out in the Directive into national law: 1 July 2016. On the basis of the authorisation granted in Section 15 paragraph (9) point b) of Act XI of 1991 on health governance and administration activity, the Ministry of Human Capacities is responsible for transposing the Directive into national law.

Risk assessment is carried out by the employer, always taking into consideration the valid legal prescriptions and the actual risks at work. In the case of changes in legislation, the authority always publishes information on its website, and it also provides information on changes in its quarterly journal entitled “Occupational Safety and Safety Technology”, as a current issue.

The occupational safety and health authority published methodological manuals for psychosocial risk assessments in 2013, and for general risk assessments in 2014, to support the elaboration of professional documents at an appropriate standard.

- **The ECSR is requesting information on the measures taken in the interest of the transposition of Directive 2009/148/EC and on the measures taken in the interest of drawing up an inventory of contaminated buildings and materials.**

Compliance with Directive 2009/148/EC is ensured by Decree of the Minister of Health No. 12/2006 (III. 23.) on the protection of workers exposed to asbestos-related risks, and by the following legal acts:

- Decree of the Minister of Health No. 26/2000 (IX.30.) on protecting against occupational carcinogens and preventing harm caused by them;
- Act XCIII of 1993 on occupational safety and health;
- Act LXXVIII of 2001 on amending Act IV of 1991 on promotion of employment and provisions to the unemployed, Act LXVI of 1994 on the Wage Guarantee Fund, Act XLIX of 1991 on bankruptcy proceedings, liquidation proceedings and voluntary liquidation, and Act XCIII of 1993 on occupational safety and health;
- Act XI of 2004 on amending Act XCIII of 1993 on occupational safety and health; Act CXXIX of 2006 on amending Act XCIII of 1993 on occupational safety and health;
- Act CLXI of 2007 on amending the Act XCIII of 1993 on occupational safety and health.

The provisions of Decree of the Minister of Health No. 12/2006 (III. 23.) shall be applicable to all activities performed in the scope of organised work, when during work employees are or may be exposed to risks deriving from asbestos or materials or products containing asbestos, or from activities performed with products containing asbestos. The employer must send

written notification about the activities falling under the scope of the decree to the metropolitan and county government office, as the occupational safety and health authority, competent for the working site, 15 days before starting work, for the purpose of registration. The provisions of the legal act did not change substantially in the reporting period.

The table below shows the number of asbestos demolition activities notified to the occupational safety and health authority between 2012 and 2015, and the number of affected employees. The annual number of complete and incomplete notifications is also shown in the table.

Description	2012	2013	2014	2015
Number of notified asbestos demolition activities	101	125	153	235
Total number of affected employees according to the above notifications	354	570	561	1226
Number of complete notifications	69	88	89	120
Number of incomplete notifications	32	37	64	115

The occupational safety and health authority examines the content of the notifications on the site, and, if necessary, it takes measures to ensure observation of the legal prescriptions.

Compliance with Directive 2004/37/EC is ensured by Decree of the Minister of Health No. 26/2000 (IX. 30.) on protecting against occupational carcinogens and preventing harm caused by them. The occupational safety and health authority attaches outstanding significance to the observation of the provisions of the legal act, and activities performed with carcinogenic substances are always examined during inspections. Activities performed with carcinogenic substances (including changes) must always be notified to the authority, and the authority keeps a register of them. The authority regularly performs inspections based on notifications, and also examines whether employers observe legal prescriptions.

- **The ECSR is requesting information concerning measures taken in Hungary in the interest of asbestos removal.**

By transposing Directive 76/769/EEC, Joint Decree of the Minister of Health and the Minister of Environmental Protection No. 41/2000 (XII. 20.) on restricting certain activities related to hazardous substances and hazardous preparations introduced a ban on the distribution and use of crocidolite, amosite, anthophyllite asbestos, actinolite, tremolite asbestos and chrysotile fibres and products containing such fibres.

In European legislation, as of 1 June 2009 Directive 76/769/EEC was repealed by Regulation 1907/2006/EC (REACH), and from this date the restriction on asbestos and Articles containing certain asbestos fibres are included in Annex XVII point 6 of the Regulation. Pursuant to the restriction, the manufacturing, distribution and use of asbestos fibres and Articles containing intentionally added asbestos fibres is prohibited. The use of Articles containing asbestos fibres, which were already installed and/or in service before 1 January 2015 is still allowed until they are disposed of or reach the end of their useful life.

- **The ECSR is requesting information on rules relating to the protection of temporary workers, in particular whether the scope of the legal acts relating to occupational safety and health cover temporary workers and workers employed in the framework of fixed-term contracts. The ECSR is requesting concrete examples to demonstrate how access to medical examinations and representation at work is ensured for such workers.**

In Hungary, the enforcement of occupational safety and health provisions does not depend on whether workers are employed in the framework of fixed-term or open-term employment contracts, or whether they are temporary agency workers. The legal acts relating to occupational safety and health are completely identical in the case of workers employed in the framework of fixed-term employment contracts, temporary agency workers, and workers employed in the framework of open-term employment contracts. In Hungary, legal acts relating to occupational safety and health cover all types of organised work, disregarding the organisational or ownership structure in the framework of which it takes place.

Organised work: work performed within the framework of employment relationship – not including work in the household of a natural person employer within the framework of simplified employment –, public employment, government service, civil servant or public servant relationship, judges' service relationship, judicial staff's service relationship, prosecution service relationship, legal relationship of employment relationship nature in the case of cooperative membership, at vocational training institutes during the fulfilment of vocational training requirements in the framework of student status, based on a student contract, under university student relationship during practical training, work performed as convict or other detainee, work in the public interest applied during infringement proceedings and work in the public interest imposed in a criminal case, work performed at the organisations of the Defence Forces, at workplaces set up for defence purposes on areas administered by the ministry led by the minister responsible for defence or on temporary construction sites, at the National Military Security Service, or at business organisations where ownership rights are exercised by the minister responsible for defence, at law enforcement agencies, at the Parliament Guard, at local governments' fire services in service relationship, voluntary activities in the public interest in accordance with the act on voluntary activities in the public interest, and social work organised (initiated, controlled or approved) by the employer.

The legal acts relating to occupational safety and health must also be applied to other persons present in the work area (e.g. passers-by, visitors, service users, etc.).

- **The ECSR is requesting information on how self-employed persons and domestic workers are subjected to the rules of occupational safety and health.**

In Hungary the legal acts on occupational safety and health must be applied comprehensively to employees employed in the framework of organised work. If a self-employed person employs an employee, then this employee is subject to the act on occupational safety and health. The same stands for domestic workers, but inspection performed in private households is difficult, because the occupational safety and health authority does not keep records of private persons and the type of contracts under which they employ domestic workers, and the possibility of inspections performed in private households is also quite restricted with a view to respecting privacy (e.g. in the case of remote workers inspection can only be performed as previously announced, following a notice sent 3 days earlier, and only during the day).

However, self-employed persons also bear the legal obligation to enforce the prescriptions of occupational safety and health to protect other persons present in the area of their activity.

- **The ECSR is requesting information on consultations with the representatives of employers and employees during the preparation of legal acts on occupational safety and health.**

Within the framework of the Occupational Safety and Health Committee, which regularly meets with the participation of employers, employees and the governments, any party can initiate consultation in respect of all issues of occupational safety and health.

Problems occurring before legislative changes take effect (in the legislative period) and also after their effective date can be discussed in the Occupational Safety and Health Committee, and parties make use of this possibility. On the basis of the Act on Occupational Safety and Health, the Occupational Safety and Health Committee gives a preliminary opinion on legal act concepts and the drafts of other provisions and measures, as well as on reports and periodical programmes, stating its unanimous position or the different opinions of the negotiating groups in the submissions.

The Occupational Safety and Health Committee holds negotiations and takes a position, or issues a recommendation or opinion on occupational safety and health issues submitted by the negotiating groups, issues recommendations concerning occupational safety and health requirements exceeding the provisions determined in the legal acts relating to occupational safety and health, makes decisions in the field of training and education in respect of issues on determining the knowledge relating to the rules of safe work not endangering health.

[With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:]

3. to provide for the enforcement of such regulations by measures of supervision;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS, MEASURES TAKEN TO IMPLEMENT THE LEGISLATION, KEY DATA AND STATISTICS

1. Public health and epidemiological safety

- Health and Toxicology Information Service

Pursuant to Act XXV of 2000 on chemical safety:

“(1) The administrative body for health collects, processes and organises toxicological, public health and clinical data in the framework of the national register of hazardous substances and hazardous mixtures, and in the framework of the product register.

(2) The administrative body for health keeps the national register referred to in paragraph (1) – and the product register in the case of hazardous substances – on the basis of the data reported. The body performing the registration, listing and recording of hazardous substances and hazardous mixtures sends the data determined in paragraph (1) to the administrative body for health.

(3) Upon request, the administrative body for health provides information on the data registered by it in connection with hazardous substances and hazardous mixtures, in accordance with the legal prescriptions relating to the publicity of data of public interest. The administrative body for health ensures non-stop access to such data.

In the reporting period, the National Institute for Chemical Safety (hereinafter: OKBI) was the administrative body for health performing the above tasks, and from spring 2015 its legal successor, the National Centre for Public Health (hereinafter: OKK). The OKBI and the OKK operates a Health and Toxicology Information Services (hereinafter: HTIS) in accordance with the above, ensuring non-stop emergency service. In the framework of providing information on the registered data as determined in the legal act, the most important task of the HTIS is to provide information in the case of intoxication or upon suspicion of intoxication, both to healthcare centres and to the population; in the latter case first-aid information is provided about what to do.

In the reporting period the HTIS answered calls as summarised below:

	Emergency calls	Other calls
2012	1,306	575
2013	1,550	678
2014	1,694	766
2015	1,689	602

2) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR is requesting information on differences between government statistical data and EUROSTAT data.**

The Central Statistical Office provides the EUROSTAT with data gathered according to the methodology (ESAW) and by the deadline set forth by the Regulation (EU) No 349/2011 of 11 April 2011 implementing Regulation (EC) No 1338/2008 of the European Parliament and of the Council on Community statistics on public health and health and safety at work, as regards statistics on accidents at work.

The table below shows the number of accidents at work resulting in the loss of earning capacity for more than 3 days or in death from the total number of accidents at work reported to the Department for Labour Inspectorate and to the National Office of Mining and Geology, excluding the data relating to those working for the “Social public services” (TEOR’08 84.2) subsector, those belonging to the category of armed forces (FEOR’08 0), as well as data relating to self-employed persons and persons employed as assisting family members.

Number of accidents at work according to ESAW

Year	Total number of accidents	Number of fatal accidents
2012.	17,129	65
2013.	17,236	55
2014.	19,572	81

From data supplied, the EUROSTAT publishes those relating to sectors A and C-N, as well as the indicators standardised by sectors in the EU Member States.

Data provided by the occupational safety and health authority supplied is based on information deriving from the processed occupational accident records submitted by the employers.

In the reporting period the occupational safety and health authority possesses the following data:

	2012	2013	2014	2015
Number of occupational accidents	17,025	17,222	19,661	21,088
Number of fatal occupational accidents	62	75	78	84
Occupational accident rate per 1,000 persons	4.4	4.4	4.8	5.0
Fatal occupational accident rate per 100,000 persons	1.6	1.9	1.9	2.0

The table below contains data supplied by the National Public Health and Medical Officer Service, Office of the Chief Medical Officer (hereinafter: OTH) on occupational diseases:

	2012	2013	2014	2015
Number of occupational diseases	120	168	191	277
Number of fatal diseases	5	0	8	3
Number of occupational diseases per 10,000 employees	0.4	0.6	0.7	1.0

- **The ECSR is requesting detailed up-to-date information on the activity of occupational safety and health inspectorates and their available resources (including the number of inspections performed), and on measures taken against employers with insufficient knowledge of occupational safety and health rules, providing inadequate training or not providing training at all for employees.**

As a result of the modernisation of Hungarian public administration in 2011, metropolitan/county government offices with individual policy administration services were set up. Occupational safety and health inspectorates became organisational units of the occupational safety and health policy administration service of metropolitan and county government offices, having their own competences and responsibilities. (A total number of 20 inspectorates were set up instead of the former 7 regional inspectorates.)

The National Occupational Safety and Labour Inspectorate (hereinafter: OMMF) was integrated into the National Labour Office (hereinafter: NMH) as of 1 January 2012. The Hungarian Institute of Occupational Health (hereinafter: OMFI), which used to operate independently and was responsible for tasks relating to professional methodological control, for the preparation of legal acts, for vocational training and further training in the field of occupational health, for communication with national and foreign partner institutes, for examining and treating outpatients and inpatients with occupational diseases referred to it, and for approving occupational diseases notified in the country, also continued its operation as a department of the Directorate of Occupational Safety and Labour Affairs of the National Labour Office (NMH MMI).

mellett a fővárosi és megyei kormányhivatalok munkavédelmi és munkaügyi As from 1 January 2015, upon termination of the NMH, occupational safety and health supervision was allocated to the Ministry for National Economy (hereinafter: NGM). Occupational safety and health policy administration services continued to operate as divisions within the departments of government offices responsible for employment. The internal and external reintegration of the metropolitan and county government offices took place on 1 April 2015. The Occupational Health Department of the NMH MMI now operates as the Occupational Health Department of the Office of the Chief Medical Officer (OTH) controlled by the Ministry of Human Capacities.

Consequently, in accordance with Government Decree No. 320/2014. (XII. 13.) on the designation of the public employment service, the occupational safety and health authority and the employment authority, and on performing the official and other tasks of these bodies, as from 1 January 2015, the minister responsible for employment policy (as the occupational safety and health authority, appeal authority) and the government offices acting within the powers of the occupational safety and health authority (as the authority of first instance) are the competent inspecting authorities. The government office's area of competence in respect of occupational safety and health is at county level. The Government Decree referred to, as

from 1 January 2015, has appointed in addition to the minister the occupational safety and labour affairs administrative bodies of the metropolitan and county government offices to carry out the administrative tasks of the occupational safety authorities. Within the framework of the reorganisation of the regional public administration the administrative bodies ceased to exist from 1 April 2015, therefore from this point in time the government offices took over the role of occupational safety and health authority of first instance.

The minister for national economy is responsible for the professional control of the activity of government offices acting within the power of the occupational safety and health authority, as occupational safety and health authorities.

Indicators describing the activity of occupational safety and health inspectorates, broken down per year:

Average number of inspectors between 2012 and 2015:

Year	Average number of inspectors (persons)
2012	100.41
2013	105.48
2014	103.25
2015	98.80

Average number of inspectors: theoretical ratio for the correct measurement of the performance of inspectorates. In the case of every performance target and assessment, the requirements calculated for this unit are determined. The ratio also takes into account the absences of employees (sickness, holidays, vacancies, training, blood donation, funeral, etc.), so there are no cases of certain persons (or organisational units) not being able to fulfil the requirements for example because of long-term inactivity, or fluctuation that takes place in the meantime – although individual performances may be above average –, because this ratio handles this so-called lost time.

Tables with detailed data on the work of occupational safety and health inspectors:

Year	Number of visits	Number of employers inspected	Number of employers affected by irregularities	Staff affected by visits (visit sheet data)	Inspected staff affected by irregularities
	number	number	number	persons	persons
2012	30,795	16,761	<p>The National Labour Office was set up on 1 January 2012, and from this point professional control has been performed by the National Occupational Safety and Labour Inspectorate (OMMF) integrated into the office as a directorate.</p> <p>The Hungarian Institute of Occupational Health (OMFI), which used to operate independently and was responsible for tasks relating to professional methodological control, for the preparation of legal acts, for vocational training and further training in the field of occupational health, for communication with national and foreign partner institutes, for examining and treating outpatients and inpatients with occupational diseases referred to it, and for approving occupational diseases notified in the country, also continued its operation as a department of the Directorate of Occupational Safety and Labour Affairs of the National Labour Office (NMH MMI). Indicators describing the activity of occupational safety and health inspectorates, broken down per year: 13,293</p>	440,819	236,644
2013.	30,724	17,172	14,006	417,980	243,680
2014.	31,658	16,941	14,027	338,345	210,147
2015.	25,501	13,721	11,211	264,111	173,550

Year	Prescribing elimination of deficiencies		Prohibiting employment		Suspending use			Suspending activity		
	decision	measure	decision	affected number of employees	decision	work equipment	affected number of employees	decision	activity	affected number of employees
2012	12,288	64,118	2,307	5,179	4,250	11,391	13,420	3,194	7,991	12,486
2013	12,657	66,657	2,345	5,192	4,315	11,765	14,979	3,513	9,219	17,356
2014	12,450	63,754	2,279	4,886	4,255	12,076	14,643	4,523	12,562	16,778
2015	9,844	51,783	1,631	3,498	3,642	10,826	11,440	3,952	11,257	13,717

Year	Occupational safety and health fine			Administrative fine		On-the-spot fine		Procedural fine	
	decision	HUF	affected number of employees	decision	HUF	cases	HUF	cases	HUF
2012	644	188,566,341	1,400	69	2,425,000	265	2,623,000	259	19,443,890
2013	680	150,948,246	1,551	0*	0*	0*	0*	249	19,840,000
2014	623	156,058,435	1,189	0*	0*	0*	0*	185	10,993,000
2015	476	116,299,325	920	0*	0*	0*	0*	174	10,046,000

* cannot be imposed as a sanction any longer due to changes in the legislation

In respect of employers with insufficient knowledge of occupational safety and health rules, providing inadequate training or not providing training at all for employees – depending on the severity of the risk –, occupational safety and health inspectors issue a warning calling their attention to the prescriptions and rules, or they make a decision demanding elimination of the deficiency, if the deficiency revealed does not present a direct risk to life and physical integrity. An occupational safety and health fine can only be imposed in cases listed in the legal act, when severe and direct threat has been proved.

Inspectorates inspect fulfilment of the obligation ordered in the enforceable decision (follow-up inspection) by performing random checks. If during follow-up inspection it is found that the employer failed to fulfil its obligations, the acting inspector imposes a procedural fine on such employer.

The table below shows the development of the number of follow-up inspections, and the number and amount of procedural fines imposed.

Year	Follow-up inspections	Procedural fines	
	number	number	amount (HUF)
2012	1,543	259	19,443,890
2013	1,155	249	19,840,000
2014	3,375	185	10,993,000
2015	2,324	174	10,046,000

An essential criteria is the inspection of occupational safety and health training. Starting from 2012, one of the priorities included in the guidelines of occupational safety and health inspections is that “Increased guidance and counselling shall be provided in respect of occupational safety and health knowledge – especially to micro-, small and medium-sized enterprises and private employers – in order to avoid irregular work due to the lack of knowledge, and to avoid occupational accidents or health injuries.”

As of 2013, the special inspection of training is also included in the definition of the indicators, according to which the annual number of measures taken in the interest of improving the content and efficiency of occupational safety and health training courses should be at least 50 per inspector on average.

The number of measures taken in the reporting period because of the lack of inadequacy of occupational safety and health training:

Year	2012	2013	2014	2015
Number of measures (nationwide)	3,505	7,503	7,466	5,461

[With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:]

4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

In the reporting period no substantial changes took place in the operation of occupational health services; only the supervisory bodies were reorganised as described elsewhere. The effect of this on their everyday work can be neglected.

2) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR is requesting information on the proportion of medical experts specialised in occupational health in relation to the number of employees, the number of employers employing medical experts specialised in occupational health full-time, the number of employers where medical experts specialised in occupational health perform these tasks part-time, besides filling other positions too, and on the strategies and incentives small and medium-sized enterprises have in order to facilitate employees' access to occupational health services.**

In 2015, occupational health services were provided by 2,665 medical experts for 2,168,206 employees participating in organised work. 982 of the medical experts providing service performed their tasks involving exclusively occupational health activities in the framework of full-time employment, while 1,683 medical experts performed these tasks part-time, besides filling other positions too (e.g.: general practitioner, other medical positions). No data has been collected concerning the distribution of “full-time” and “part-time” medical experts working at employers. Surveys show that one medical expert provided occupational health services for 817 employees.

In Hungary, it is prescribed by law that occupational health services must be operated for employees participating in organised work.

Pursuant to Section 58 of the Act on occupational safety and health, employers are obliged to ensure basic occupational safety and health services in the interest of performing their prescribed tasks. Occupational safety and health services can be provided via service providers operated by the employers, or via external service providers, based on contracts concluded with the employers.

The detailed regulation of the tasks prescribed by law are included in further implementing regulations: Government Decree No. 89/1995 (VII. 14.) on the occupational health service, and Decree of the Minister of Welfare No. 27/1995 (VII. 25.) on the occupational health service.

In view of the above, no strategies and incentives have been developed to promote the occupational health service.

ARTICLE 11 – THE RIGHT TO PROTECTION OF HEALTH

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:

1. to remove as far as possible the causes of ill-health;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

I. The health condition of the Hungarian population

The health condition of the Hungarian population is, in international comparison, exceedingly unfavourable, it significantly lags behind the possibilities deriving from the socio-economic development of the country. The rather high ratio, at international level, of early mortality has also worsened the chances of sustainable development and the international competitiveness of Hungarian economy.

Although the health condition of the Hungarian population has been improving for two decades now, it still considerably lags behind most Member States of the European Union (hereinafter: EU) in almost each health index.

Comparing the life expectancy at birth of the EU Member States and considering the economic performance of the individual countries, Hungary is stated to be positioned in the mid-range of the economically underdeveloped countries, regarding life expectancy.¹ As regards life expectancy at birth, a continually rising tendency has been observed among Hungarian men and women since 1993, although the lag is still considerable. According to the data of WHO, HFA (*WHO Health for All Database*), average life expectancy at birth was 72 years for men and 78.7 years for women in 2013.

Regarding life expectancy at the age of 65, Hungarian women and men could expect 18.4 years and 14.5 years, respectively, at their age of 65 in 2013.² The Hungarian data hardly lag behind those of the EU13 countries, however, both women and men face a 4-year lag in comparison with the EU15 figures.

The diseases of the circulatory system and tumour diseases were responsible for three quarters of total mortality and for over two thirds of early mortality before the age of 65 in Hungary in 2013. Despite the recently improving values in the ratio of death due to circulatory diseases and malignant tumours, Hungary significantly lags behind the EU15 and, in many cases, the EU13 countries, moreover, the lag is mainly increasing in the individual causes of death.³ Men's early mortality made up 34 % of total mortality in 2013, and the distribution of the

¹ Helyzetkép a magyar lakosság egészségéről (*Overview of the Health Condition of the Hungarian Population*), 2013, OEFI

² http://www.ksh.hu/docs/hun/eurostat_tablak/tabl/tsdde210.html

³ Egészségjelentés (*Health Report*), 2015

causes of their death significantly differed from that applicable to women. Although tumours (35 %) and circulatory diseases (31 %) were responsible for most deaths among men, too, early mortality due to the external reasons for morbidity and mortality (12 %) represented a considerably bigger ratio than with women.

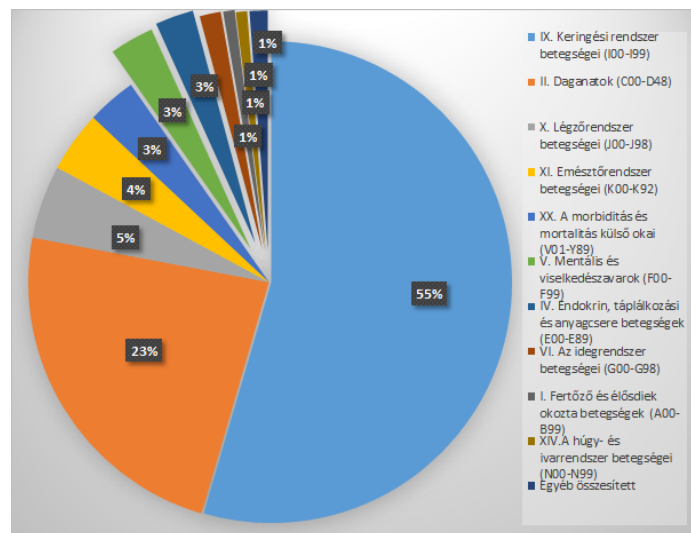
Regarding the years lived in deteriorated health condition and the *Disability Adjusted Life Year* (DALY) summarizing “premature” mortality, cardiovascular diseases (28 %), malignant tumours (18 %) and musculoskeletal disorders (11 %) play a significant role.⁴ Two chronic non-contagious diseases (circulatory diseases and malignant tumours) make up three quarters of deaths. The succeeding three causes of mortality (gastrointestinal diseases, injuries and respiratory diseases) represent a similar ratio, approx. 5 % each.

Total mortality, by causes of death

As there is a significant difference in the breakdown of men's and women's causes of death, they shall be presented separately.

Most of women's total mortality was caused by circulatory diseases (55 %), followed by tumours (23 %), then respiratory diseases (5 %) and gastrointestinal diseases (4 %) in 2013. The external reasons for morbidity and mortality, mental and behavioural disturbances, endocrine, nutritional and metabolic disorders were each responsible for 3 % of women's total mortality.

Breakdown of women's total mortality by causes in Hungary, 2013

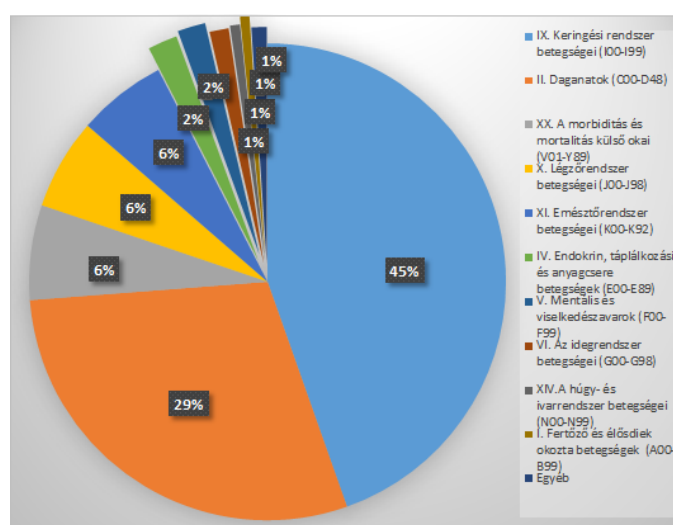


⁴ Global Burden of Diseases, Injuries, and Risk Factors Study 2010. Institute for Health Metrics and Evaluation, Seattle. <http://www.healthmetricsandevaluation.org/gbd> accessed 17.05.2013.

2013	Women
Cause of death	Grand total Age of the deceased
Grand total Cause of death	64,884
IX. Circulatory diseases (I00-I99)	35,379
II. Tumours (C00-D48)	15,214
X. Respiratory diseases (J00-J98)	3,187
XI. Digestive diseases (K00-K92)	2,649
XX. External causes of morbidity and mortality (V01-Y89)	2,143
V. Mental and behavioural disorders (F00-F99)	1,927
IV. Endocrine, nutritional and metabolic diseases (E00-E89)	1,672
VI. Neurological diseases (G00-G98)	923
I. Contagious and verminous diseases (A00-B99)	508
XIV. Genitourinary diseases (N00-N99)	489
Other total	793
XIII. Musculoskeletal and connective tissue diseases (M00-M99)	292
III. Haematic and haematogenous diseases, certain disorders of the immune system (D50-D89)	126
XVII. Congenital disorders (Q00-Q99)	118
XVI. Certain conditions in the perinatal period (P00-O96)	109
XVIII. Complaints, symptoms not classified elsewhere (R00-R99)	74
XII. Cutaneous and subcutaneous diseases (L00-L98)	55
XV. Pregnancy, parturition and post-partum diseases (O00-O99)	13
VIII. Otology and mastoid diseases (H60-H95)	6
VII. Ocular and orbital diseases (H00-H59)	

Among men, the first two most frequent causes of death did not differ from those observed among women, i.e. here again circulatory diseases (45 %) and tumours (29 %) were the leaders. Still, three other diseases, each up to 6 % was responsible for the total mortality: external reasons for morbidity and mortality, respiratory diseases and gastrointestinal diseases.

Breakdown of men's total mortality by causes in Hungary, 2013



2013		Men
Cause of death	Grand total Age of the deceased	
Grand total Cause of death	61,894	
IX. Circulatory diseases (I00-I99)	27,600	
II. Tumours (C00-D48)	18,060	
XX. External causes of morbidity and mortality (V01-Y89)	3,981	
X. Respiratory diseases (J00-J98)	3,822	
XI. Digestive diseases (K00-K92)	3,741	
IV. Endocrine, nutritional and metabolic diseases (E00-E89)	1,244	
V. Mental and behavioural disorders (F00-F99)	1,179	
VI. Neurological diseases (G00-G98)	807	
XIV. Genitourinary diseases (N00-N99)	419	
I. Contagious and verminous diseases (A00-B99)	396	
Other	645	
XVI. Certain conditions in the perinatal period (P00-O96)	170	
XVII. Congenital disorders (Q00-Q99)	158	
XIII. Musculoskeletal and connective tissue diseases (M00-M99)	115	
III. Haematic and haematogenous diseases, certain disorders of the immune system (D50-D89)	81	
XVIII. Complaints, symptoms not classified elsewhere (R00-R99)	77	
XII. Cutaneous and subcutaneous diseases (L00-L98)	38	
VIII. Otolology and mastoid diseases (H60-H95)	6	
VII. Ocular and orbital diseases (H00-H59)		
XV. Pregnancy, parturition and post-partum diseases (O00-O99)		

Every fourth individual dies before the age of 65 in Hungary. The Hungarian values in early mortality (i.e. before 65 years of age) are 70-80 % higher than the EU average. The breakdown of early mortality by causes considerably differs from the breakdown of total

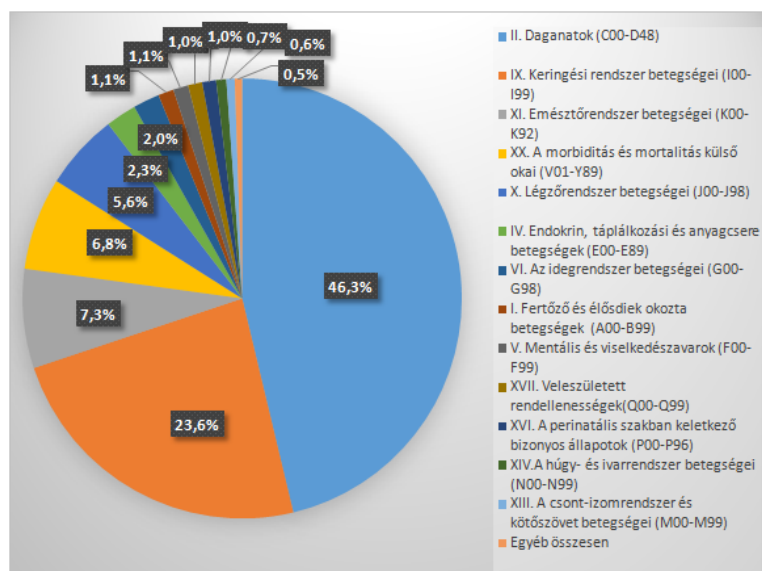
mortality, as malignant tumours, which represent the highest ratio, make up nearly 40 %, circulatory diseases nearly 30 %, injuries and gastrointestinal diseases around 10 % each.⁵

The mortality ratios of those below 65 years of age developed similar to total mortality in both sexes, compared to the EU countries. A declining tendency has been seen in both sexes in Hungary since 2005, although men have shown a more explicit pace of improvement. Although no major difference was observed versus the EU13 countries, the lag behind the EU15 countries is quite significant. The ratio of early mortality in Hungary was nearly double (189 %) for women and over double (233 %) for men than in the EU15 countries in 2011.

Early mortality, by causes of death

As regards early mortality (i.e. death before 65 years of age), which represents 17 % of women's total mortality, tumours (46 %) and circulatory diseases (24 %) take the first and second place. These are followed by other causes that reach nearly identical ratios among the causes of early mortality: gastrointestinal diseases, external reasons for morbidity and mortality, and respiratory diseases.

Breakdown of women's early mortality by causes in Hungary, 2013



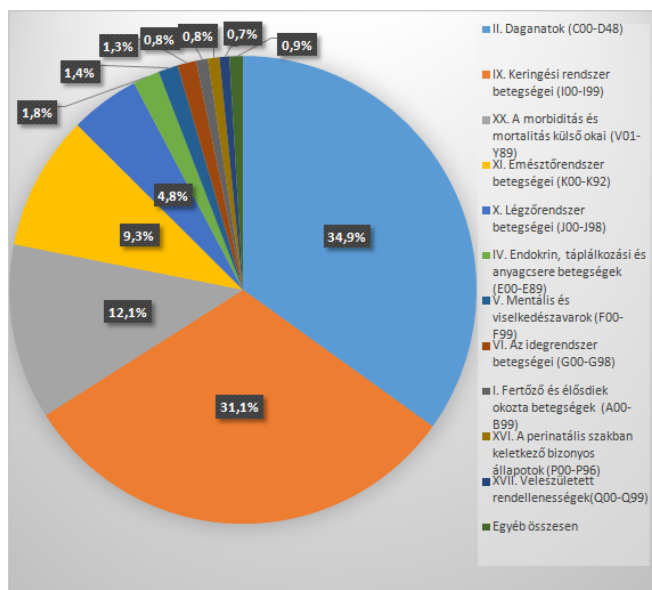
⁵ Helyzetkép a magyar lakosság egészségéről (Overview of the Health Condition of the Hungarian Population), 2013, OEFI

Women	2013
Cause of death	0-64
Grand total Cause of death	10,729
II. Tumours (C00-D48)	4,957
IX. Circulatory diseases (I00-I99)	2,531
XI. Digestive diseases (K00-K92)	781
XX. External causes of morbidity and mortality (V01-Y89)	729
X. Respiratory diseases (J00-J98)	600
IV. Endocrine, nutritional and metabolic diseases (E00-E89)	242
VI. Neurological diseases (G00-G98)	209
I. Contagious and verminous diseases (A00-B99)	123
V. Mental and behavioural disorders (F00-F99)	119
XVII. Congenital disorders (Q00-Q99)	112
XVI. Certain conditions in the perinatal period (P00-O96)	109
XIV. Genitourinary diseases (N00-N99)	80
XIII. Musculoskeletal and connective tissue diseases (M00-M99)	66
Other total	58
III. Haematic and haematogenous diseases, certain disorders of the immune system (D50-D89)	24
XVIII. Complaints, symptoms not classified elsewhere (R00-R99)	19
XV. Pregnancy, parturition and post-partum diseases (O00-O99)	11
XII. Cutaneous and subcutaneous diseases (L00-L98)	4
VII. Ocular and orbital diseases (H00-H59)	0
VIII. Otologic and mastoid diseases (H60-H95)	0

Men's early mortality made up 34 % of total mortality in 2013, and the distribution of the causes of their death significantly differed from that applicable to women. Although tumours (35 %) and circulatory diseases (31 %) were responsible for most deaths among men, too, early mortality due to the external reasons for morbidity and mortality⁶ (12 %) represented a considerably bigger ratio than with women.

⁶ A reference by injuries shall be made to the members of the groups sorted by the external reasons for morbidity and mortality in a subsequent part of the Report.

Breakdown of men's early mortality by causes in Hungary, 2013



Men

2013

Cause of death	0-64
Grand total Cause of death	21,249
II. Tumours (C00-D48)	7,416
IX. Circulatory diseases (I00-I99)	6,602
XX. External causes of morbidity and mortality (V01-Y89)	2,574
XI. Digestive diseases (K00-K92)	1,981
X. Respiratory diseases (J00-J98)	1,023
IV. Endocrine, nutritional and metabolic diseases (E00-E89)	392
V. Mental and behavioural disorders (F00-F99)	290
VI. Neurological diseases (G00-G98)	275
I. Contagious and verminous diseases (A00-B99)	172
XVI. Certain conditions in the perinatal period (P00-O96)	170
XVII. Congenital disorders (Q00-Q99)	146
Other total	197
XIV. Genitourinary diseases (N00-N99)	86
XVIII. Complaints, symptoms not classified elsewhere (R00-R99)	40
XIII. Musculoskeletal and connective tissue diseases (M00-M99)	34
III. Haematic and haematogenous diseases, certain disorders of the immune system (D50-D89)	27
XII. Cutaneous and subcutaneous diseases (L00-L98)	10
VIII. Otology and mastoid diseases (H60-H95)	0
VII. Ocular and orbital diseases (H00-H59)	0
XV. Pregnancy, parturition and post-partum diseases (O00-O99)	0

Health expectancy at birth

Alongside life expectancy at birth, one of the most important health indices is health expectancy (in years) at birth. Health expectancy at birth in 2013 reached 60.1 years and 59.1 years among women and men, respectively; this lags behind the EU Member States' relevant figures by 1.4 years for women and 2.3 years for men. In 2014, the health expectancy at birth for women was 60,8, while for men 58,9 years. This number are still lagging behind the relevant figures of EU Member States by 1.0 year for women and 2.5 years for men.

Infant mortality⁷

The infant mortality data also improved in the reporting period versus the previous report data. Infant mortality has been decreasing in Hungary since 2005: boys have seen a dynamic decrease of 33 %, whereas girls have reached a mere 27 %. Despite the improvement, the Hungarian data in 2011 were still significantly less favourable than in the EU15 countries: the ratio was 139 % and 136 % among girls and boys, respectively. Compared with the EU13 figures, the Hungarian data proved to be nearly equal among girls but much lower (78 %) among boys in 2012.

Infant mortality, by main groups of causes						
Year	Total infant mortality*	Including:				
		contagious diseases, diseases caused by parasites (A00-	respiratory diseases (J00-J99)	congenital growth disorders (Q00-Q99)	certain conditions related to the perinatal period (P00-P96)	external reasons for morbidity and mortality (V01-Y98)
			Number			
1970	5,449	41	597	930	3,307	53
1980	3,443	35	256	719	2,094	96
1990	1,863	25	111	419	1,100	55
2000	900	6	45	204	534	36
2001	789	14	29	189	472	26
2002	693	10	20	147	428	24
2003	690	5	29	155	416	20
2004	628	6	25	126	396	15
2005	607	6	27	154	336	15
2006	571	3	13	161	307	24
2007	577	7	6	147	339	11
2008	553	3	6	133	352	15
2009	495	4	3	132	306	8
2010	481	2	2	134	299	5
2011	433	4	4	122	250	10
2012	438	3	2	109	272	12
2013	454	6	10	98	279	12
2014	421	2	11	118	236	11

*Number of deceased below one year of age

Source: Central Statistical Office

⁷ Infant mortality: number of deaths occurring after the life birth but before the first year of age. Children born alive and dead at the birth anniversary are not considered still-born.

II. Amendments to legal regulations pertaining to healthcare management

Amendments in 2012

- **Act XLII of 1999 on the Protection of Non-Smokers and Certain Regulations on the Consumption and Distribution of Tobacco Products (hereinafter Non-smoking Act)**

On 26 April 2011 the National Assembly approved the amendment of the Non-smoking Act which was aimed at the enhanced protection of non-smokers and smokers from the harmful effects of smoking, concurrently regarding the promoted exercise of the constitutional rights to health and a healthy environment. Under the amendment of the Act which entered into force on 1 January 2012, the legislative provisions on the spatial restriction of smoking were made significantly more stringent, prohibiting smoking in any enclosed place as the chief rule.

The Non-smoking Act was further amended in 2012. The provision on the designation of an enclosed smoking area was supplemented, stating that the smoking area may be designated with the advance permit of the healthcare state administration organization, moreover, the street department may also control the observation of smoking restrictions relevant to public places and may impose an on-site fine of up to HUF 30,000 on the violator of the smoking restriction caught in the act.

- **Act CXXXIV of 2012 on Reducing Smoking among Young Persons and on the Retail Sale of Tobacco Products**

The Act refers the retail sale of tobacco products in the exclusive management of the State, for restricting the availability of tobacco products. The State assigns the retail sale of tobacco products under a concession contract. Tobacco products may only be sold in national tobacco shops as of 1 July 2013.

For the special protection of young persons, the tobacco product retailer is obliged to ask the consumer (who seems to be a juvenile) to provide an authentic certification of his/her age. The customs authority may impose a penalty on the tobacco product retailer for the non-observation of provisions on young persons' special protection. Most of the statutory provisions have been in effect since 1 July 2013.

- **Act CLIV of 1997 on Health (hereinafter. Health Act)**

Instead of regions, the breakdown is by subregions and, accordingly, rules relevant to the subregional health promotion program, instead of the regional health promotion program, have come into effect and the Subregional Healthcare Council has also been established.

For healthcare service providers owned or operated by the state and offering in- and outpatient specialty care, the exercise of founder's rights (establishment, reorganization, termination), the approval of a decision on an investment exceeding the healthcare provider's ordinary scope of business and the approval of the organizational and operational rules of the institution fall within the minister's management right.

- **Act LXXXIV of 2003 on Certain Issues of Performing Healthcare Activities**

The Act stipulates that the employer may order 16 hours a calendar week healthcare duty the most from the weekly 40 hours full time employed healthcare worker's ordinary working time.

- **Act XI of 1991 on Healthcare Official and Management Activities**

The range of irregularities supporting the imposition of healthcare penalties has been extended: these sanctions may be applied also against those who fail to meet their reporting data supply and registration obligation, moreover, healthcare service providers without an operating permit and healthcare workers failing to attend the compulsory aptitude test may also be subject to such sanctions.

- **Act CXXXII of 2006 on the Development of the Healthcare System**

The obligation of specialty care is now imposed instead of the former regional obligation of specialty care which, based on Section 141 (3) of the Health Act, poses an obligation on the Hungarian State to provide the out- and inpatient specialty care identified in a special legal regulation by using the contracted specialty care capacities for the beneficiaries of the healthcare services in compulsory health insurance, in the healthcare area defined in this Act.

Accordingly, the obligation to operate a specialized healthcare institution represents an obligation of the local governments under Section 152 (3) of the Health Act.

In case of permanent decrease in demand for healthcare services, the healthcare state administration organization is now allowed, at the operator's initiative, to permit a decrease in the rate of capacities and a change in the professional structure; and the healthcare state administration organization may decide ex officio for the reduction of capacities, for the benefit of health care.

The appeal against decisions specifying and/or modifying capacities and the healthcare area was cancelled; no judicial review proceedings against a decision specifying and/or modifying the specialty care capacity or the healthcare area may suspend the implementation of a decision as of 1 February 2012.

Following the amendment of the Act, the operator (and not the healthcare service provider) may initiate any capacity transfers.

- **Decree of the Minister of Human Capacities No. 20/2012 (of 31.08.) on the Operation of Educational Institutions and on the Use of Names of Public Educational Institutions**

The legal regulation was adopted on 31 July 2012 and most of its provisions entered into legal force on 1 September 2012. As regards the child's and student's health promotion, the Decree stipulates that the aim of comprehensive health promotion in school is that each child takes part in health promotion activities that can effectively improve their entire physical and moral welfare, health and health condition and are systematically performed in the everyday life of the educational institution in the time period spent in the educational institution.

According to Section 128 (3), special attention shall be paid, based on the child's and student's rights to health and security, to specific tasks related to comprehensive health promotion in the everyday operation of the educational institution, covering the following: healthy nutrition; everyday physical education and physical activity; physical and moral health promotion, prevention of the use of drugs leading to behavioural dependence and addiction; prevention of battery and school violence; accident prevention and first aid; personal hygiene.

- **Government Decree No. 96/2003 (of 15.07.) on the General Conditions of Providing Healthcare Services and the Operating Permit Procedure**

The definitions were modified and supplemented, adjusted to the actual content of healthcare services. As regards definitions, the definition of participant, healthcare service in variable sites and mobile healthcare service is of outstanding importance.

The legal regulation clarifies the person exercising the power of granting an operating permit for healthcare service providers' participants, it stipulates the rules of granting an operating permit for specialty care at home, hospice treatment at home and healthcare activities in variable sites, and the provisions on temporary operating permit are terminated.

The amended legal regulation gives a detailed account of the rules on participation, it expands the cases of withdrawing the operating permit (e.g. disqualification from the chamber due to compulsory membership in the chamber, or service provider prohibited from performing healthcare activities) and the range of measures taken after the findings of the audit. The provisions on suspension are subject to change.

- **Government Decree No. 227/2003 (of 13.12.) on Certain Issues Regarding Treatment Abroad**

Supplemented on account of the agreement with EUROTRANSPLANT.

- **Government Decree No. 337/2008 (of 30.12.) on the Implementation of Act CXXXII of 2006 on the Development of the Healthcare System**

Regarding medical care provided by certain healthcare providers in several areas, due to their professional specialities, and for medical care of national priority and provided at the highest level of progressivity there is now an opportunity (with the omission of designating the areas by professions and applying the requirement of no overlap) to designate a healthcare area covering several regions or the entire territory of Hungary; and for certain treatments received on the basis of a waiting list the entire area shall be designated as the treatment area for all the providers offering such a treatment in the specific healthcare area.

In purview of the amended provision, the healthcare state administration organization exercising its power, the Office of the Chief Medical Officer of State may, contrary to its previous obligation, now potentially ask the technical college for its opinion, in order to make a decision on rearrangement, provided a new profession were created at the provider as a result of the rearrangement.

- **Government Decree No. 323/2010 (XII. 27.) on the National Public Health and Medical Officer Service, the Fulfilment of Special Management Tasks in Public Health and the Designation of the Pharmaceutical State Administration Organization**

The range of activities where the Office of the Chief Medical Officer of State is designated as the party exercising the power is extended. Attachment 3 is amended, on account of a merger among public healthcare institutions.

- **Decree of the Minister of Health No. 2/2004 (XI. 17.) on the Registration of Healthcare Service Providers and their Operating Permit and on the Healthcare Technical Register**

There was a change in the range of data registered for healthcare service providers, the providers' professional organizational units, the licensed professions made by them, certain activities performed within a single profession and the operating permits entitling the holder to provide healthcare services; the IDs of providers and their professional organizational units were specified. The data of the party resorting to participation and the participating professional organizational unit need to be linked in the registration, noting however that the unique IDs of the participating professional organizational units shall not be identical.

- **Decree of the Minister of Health, Social and Family Affairs No. 47/2004 (of 11.05.) on certain organizational issues concerning the continuous provision of healthcare services**

The Office of the Chief Medical Officer of State has a national database on the emergency patient care system organized within inpatient specialty care and its regional order, and this grants continuous IT support for patient management within the emergency patient care system.

- **Decree of the Minister of Health No. 5/2006 (of 07.02.) on rescue**

The National Ambulance Service supplies the National Technical Information System of the National Public Health and Medical Officer Service, via its IT system, with a daily electronic report (comprising specific data in a form prohibiting any individual's identification [date of birth, time (hour, day, month, year) of treatment, sex, place (settlement) of catching the disease, BNO10 chief disease group; disease treatment: in situ, transport to hospital, death at the scene or during transport]) on any and every travel for emergency treatment in the preceding 24 hours, in order to keep track of the public health and epidemic conditions.

- **Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (of 20.10.) on the Minimum Technical Conditions of Providing Healthcare Services**

Completely revised and comprehensively amended, with regard to certain professions.

Amendments in 2013

- **Act XI of 1991 on Healthcare Official and Management Activities**

The compulsory data for registering healthcare service providers and their operating permits, including the data classified as certified public registration, are defined in the Act.

The list of additional deficiencies contributed to extending the option of imposing a healthcare penalty.

- **Act CXXXII of 2006 on the Development of the Healthcare System**

The Act defines the registration of capacities, related healthcare areas and reserve capacities as the capacity registration, and it details the range of registered data (by transferring them from the implementation decree).

The totality of rules applicable upon the non-fulfilment of the specialized health care obligation represents a new element and chapter in the regulation, so that the healthcare state administration organization could provide continuous health care for the residents in the specific provider's healthcare area.

- **Government Decree No. 96/2003 (of 15.07.) on the General Conditions of Providing Healthcare Services and the Operating Permit Procedure**

The Decree specified the rules concerning the competence of healthcare state administration organizations authorized to issue an operating permit.

In line with the change in the organizational structure of public administration, the township public healthcare institutions are identified (instead of the micro regional public healthcare institutions) with regard to the permits issued beyond the competence of the Office of the Chief Medical Officer of State.

The rules applicable upon changes in minimum conditions were amended: in case of incomplete compliance, the healthcare state administration organization obliges the provider to fulfil the conditions by setting a term and upon the ineffective lapse thereof it withdraws the operating permit.

In case of any issue requiring quality development, the authority in charge of quality assessment, i.e. the National Institute for Quality and Organizational Development in Healthcare and Medicine (hereinafter: GYEMSZI) shall be notified.

In case of suspending the healthcare service, the authority issuing the operating permit for the designated service provider shall, for the sake of continuous health care, take actions for the designation of a provider to temporarily provide the service.

The list of cases justifying the withdrawal of the operating permit was extended with the case of terminating the participant's contract.

- **Government Decree 337/2008 (of 30.12.) on the Execution of Act CXXXII of 2006 on the Development of the Healthcare System**

The Decree particularized the rules applicable upon the non-fulfilment of the specialized health care obligation.

The rules concerning the data content of capacity registration were raised from the implementation decree to the grade of acts.

The range of optionally financed professions was modified in some professions, in the Annex to the Government Decree.

- **Government Decree No. 323/2010 (of 27.12.) on the National Public Health and Medical Officer Service, the Fulfilment of Special Management Tasks in Public Health and the Designation of the Pharmaceutical State Administration Organization**

Annex 3 to the Decree was modified, with a list of the registered seat and competence area of the township public healthcare institutions.

- **Government Decree No. 39/2013 (of 14.02.) on the Production, Marketing and Control of Tobacco Products, Combined Warnings and the Detailed Rules of Imposing the Health Protection Penalty**

The terms related to smoking and tobacco products, the conditions of producing, importing and delivering from other EU Member States any tobacco products, the thresholds, markings, the rules on the health protection penalty, the conditions of marketing tobacco products, the market surveillance of tobacco products and data supply were defined.

The majority of tobacco products⁸ may only be marketed in a packaging holding photos, illustrations and health protection warnings as of 1 January 2013.

- **Decree of the Minister of Health No. 2/2004 (of 17.11.) on the Registration of Healthcare Service Providers and their Operating Permit and on the Healthcare Technical Register**

Following the amendment of the legal regulation, the operating permits not modified, based on an application, until 1 January 2013 had to be modified ex officio, in accordance with the new requirements.

The provision in Annex 3 to the Decree concerning the progressivity level of professions optionally financed in inpatient treatment was deleted.

- **Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (of 20.10.) on the Minimum Technical Conditions of Providing Healthcare Services**

The minimum conditions of the profession related to gastroenterology and paediatrics day-care were modified.

- **Decree of the Minister of Health, Social and Family Affairs No. 47/2004 (of 11.05.) on Certain Organizational Issues Concerning the Continuous Provision of Healthcare Services**

⁸ exc. tobacco products for sneezing, “snuff”

The Decree defined the forms of supervising specialist interns in duty: in addition to personal presence, availability on the phone and call-in method.

- **Decree of the Minister of Human Capacities No. 20/2012 (of 31.08.) on the Operation of Educational Institutions and on the Use of Names of Public Educational Institutions**

The amendments in 2013-2014 stipulated that the aim of psychic health promotion in educational institutions is to promote balanced psychic development, support the child's and student's adaptation to the environment, prepare for adverse environmental effects and offer solution strategies thereto, thereby mitigating the harmful consequences, and to have a positive effect on personality-related changes.

Amendments in 2014

- **Act CLIV of 1997 on Health**

Healthcare services may, in certain cases, be provided in lack of an operating permit and a liability contract, by way of being registered on the basis of a report (in the frames of personal participation, freelance activity). This means that, adjusted to the actual conditions of healthcare services, the commencement and performance of healthcare activities was facilitated for enterprises and private persons in these cases.

The rules concerning deceased persons and death investigation have significantly changed and expanded; provisions were adopted on death investigation consultants and the register kept about them.

- **Amendment of Act XLVII of 1997 on the Management and Protection of Healthcare and Related Personal Data**

Act XLVII of 1997 on the Management and Protection of Healthcare and Related Personal Data was amended in 2014, in connection with Section 3 Decree of the Minister of Health, Social and Family Affairs No. 49/2004 (V. 21.) on Regional Services by District Nurses (“Section 3. The district nurse shall be responsible for: a) protecting women, including ac) participating in the organization of public targeted screening examinations”), according to the following:

“Section 16/A The healthcare state administration organization and, within her responsibilities stipulated in the Ministerial Decree on Regional Healthcare by District Nurses and the Ministerial Decree on Healthcare Services Available within Compulsory Health Insurance and Aimed at the Prevention and Early Recognition of Diseases, the district nurse may, for the purpose of organizing the public targeted screening examination and the public health screening examination (for the purpose under Sections 4 (1) c) and d) and 4 (2) b)), manage the healthcare and identification data (if directly connected with the arrangement of the screening examination) of the persons within the target group of the screening examination until closing the arrangement of the screening examination.”

- **Act XI of 1991 on Healthcare Official and Management Activities**

The Office of the Chief Medical Officer of State has taken over the data registration of healthcare workers employed by the healthcare service provider (HENYÍR), and providers are obliged to report any changes in the registration data to the healthcare state administration organization on a monthly basis. The Act stipulates that the registration of freelance workers and personal participants, both operating on the basis of a report, shall be certified, and the Act defines the range of registered data.

- **Act CXXXII of 2006 on the Development of the Healthcare System**

The rules of accepting excess capacity and withdrawing capacity are stipulated in basic terms in the Act and in details in the government decree on the implementation thereof.

- **Government Decree No. 96/2003 (VII. 15..) on the General Conditions of Providing Healthcare Services and the Operating Permit Procedure**

The personal participant and personal participation are defined in conformity with the Health Act; and the administrative term of the permission procedure is stated to be invariably 30 days, due to a new rule on the administrative term (of 21 days) in Act CXL of 2004 on the General Rules of Administrative Proceedings and Services (hereinafter: Administrative Proceedings Act).

The amended legal regulation particularizes the rules of the proceedings applicable upon the personal participant's report and the employed physician's participation in basic care. The compulsory substantive parts of the standard form to the operating permit, as provided in Annex 3 to the Government Decree, were modified.

- **Government Decree 337/2008 (XII. 30.) on the Execution of Act CXXXII of 2006 on the Development of the Healthcare System**

The regulation concerning capacity acceptance procedures was considerably modified and extended; the minister for healthcare may define observable technical priorities in the specific proceedings.

The withdrawal of capacities is defined in the regulation.

- **Government Decree 323/2010 (XII. 27.) on the National Public Health and Medical Officer Service, the Fulfilment of Special Management Tasks in Public Health and the Designation of the Pharmaceutical State Administration Organization**

The rules concerning the legal status and organization of the Office of the Chief Medical Officer of State were amended.

- **Amendment of Government Decree No. 43/1999 (III. 03.) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund**

“(13a) Regional district nurse providers with a funding contract for medical care, supplemented with cervix screening, shall send a monthly report on the treated cases (with the data content conformant with the record image on the website of the National Health Insurance Fund) to the National Health Insurance Fund until the 5th working day of the month following the relevant month. The fee due after each case is HUF 2000, payable in the second month after the relevant month.

(13b) The district nurse provider keeps a register (with the data content conformant with Annex 33) on the treatment of insured persons attending cervix screening at the district nurse.”

The amendment was promulgated on 21 July 2015.

In the form of additional regulations, the provision was supplemented, noting that the amount of the fee for a case includes the remuneration due to the district nurse for cervix screening. The district nurse's remuneration equals 45% of the actual fee.

- **Decree of the Minister of Health No. 2/2004 (XI. 17.) on the Registration of Healthcare Service Providers and their Operating Permit and on the Healthcare Technical Register**

The Decree stipulated the data content (not provided in the Health Act) underlying the registration of healthcare service providers and their operating permits.

Annex 2 to the Decree was amended with regard to the range of certified professions, and Annex 1 to the Decree was deleted.

- **Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (of 20.10.) on the Minimum Technical Conditions of Providing Healthcare Services**

The conditions concerning certain professions were subject to extensive modification.

Amendments in 2015

- **Act CLIV of 1997 on Health**

The rules on basic care are hereinafter provided in Act CXXII of 2015 on Basic Care.

According to the title “Rescue” in the Health Act there is a special paragraph referring to the state ambulance service and its responsibilities, focusing on and reinforcing the specific conditions and status of the National Ambulance Service relevant to the performance, coordination and organization of its specific activity.

The Act also stipulates that any change in the healthcare workers' basic and operational registration data are electronically and monthly forwarded by the organization keeping the registration to the Office of the Chief Medical Officer of State.

Section 28 (4) of Act CCXXIV of 2015 supplemented the Health Act with the below provision from 1 January 2016:

“The Minister is authorized to stipulate the rules concerning the legal status, responsibilities and competence of health promotion offices and the substantive requirements of the township (metropolitan district) healthcare plan in a decree.”

- **Act XI of 1991 on Healthcare Official and Management Activities**

Section 6 (1) of the Act is supplemented with point r) which permits the healthcare state administration organization to take direct and immediate actions if patient care is temporarily suspended in a healthcare service provider subject to care obligations, for a sudden reason.

- **Act CXXXII of 2006 on the Development of the Healthcare System**

After the statutory amendments the permit shall be subject to, instead of the professional organization appointed by the Government, the opinion of the health insurance company and the collection and assessment of capacity occupancy data provided by the same, in procedures for capacity regrouping and the designation/modification of a healthcare area.

- **Act XLII of 1999 on the Protection of Non-Smokers and Certain Regulations on the Consumption and Distribution of Tobacco Products (hereinafter: Non-smoking Act)**

The amendment in 2015, primarily aimed at meeting the obligation of law approximation, was based on Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the Manufacture, Presentation and Sale of Tobacco and Related Products. It entered into force later, as of 20 May 2016.

The first phase in the amendment of the Non-smoking Act for law approximation covered an amendment of Act LXXVII of 2015 on the Amendment of Certain Acts on Health Care and Health Insurance:

- the definition of tobacco product, smoking, combined health protection warning, collective package was supplemented with the definition of health protection warning, general warning, information, herbal product for smoking and packaging unit;
- the packaging unit, the label on the collective package and the tobacco product shall not contain any element or solution that, while creating a false impression, promotes the tobacco product and thereby inspires its consumption;
- supplemented with an obligation to measure the hazardous substance emission of cigarettes, with fees related to flavouring and additives, the prohibition of cross-border distance selling and the regulation in a government decree of the rules of the marketing of new tobacco products.

The second phase in law approximation covered an amendment and regulation of the definition of electronic cigarette, refill container and electronic device imitating smoking, including their use, prohibition of use, all the accessories and parts of marketing restrictions applicable also to the refill container.

- **Act CXXXIV of 2012 on Reducing Smoking among Young Persons and on the Retail Sale of Tobacco Products**

In the form of Act CCXXIV of 2015 the scope of the law is supplemented in 2015 with electronic cigarettes and electronic devices imitating smoking. [effective: from 20 May 2016]

- **Government Decree 39/2013 (II. 14.) on the Production, Marketing and Control of Tobacco Products, Combined Warnings and the Detailed Rules of Imposing the Health Protection Penalty**

Various amendments were made in 2015 on the basis of Directive 2014/40/EU, in view of fulfilling the obligation of law approximation: (definition of new tobacco product category, herbal product for smoking, waterpipe tobacco, pack, manufacturer, flavouring, characteristic flavouring, characteristic causing addiction, emissions, highest emission level and toxicity; prohibition of the placing on the market of tobacco products containing characteristic flavours and flavourings in any of their components; definition of signs on the packaging of the tobacco product). The law approximation of the Directive and the implementation decisions is continuously ongoing and is expected to last until 20 May 2020.

- **Government Decree 96/2003 (VII. 15.) on the General Conditions of Providing Healthcare Services and the Operating Permit Procedure**

The rules of competence were amended:

- adjusted to the changes in the state administration organizational system, the competence of the township office (instead of the township public healthcare institution) is designated in all the cases where the power of permission falls beyond the competence of the Office of the Chief Medical Officer of State;
- the range of healthcare services within the permission competence of the Office of the Chief Medical Officer of State was extended with the permission of the professions of in vitro fertilization, clinical genetics, genetic consulting, molecular genetic laboratory diagnostics.

For permits for certain professions to be practiced (biobank, cell bank, in vitro fertilization, clinical genetics, genetic consulting, molecular genetic laboratory diagnostics), the legal regulation imposed an obligation to collect the technical opinion of the Human Reproduction Committee of the Medical Research Council.

The suspension of the activity will not in the future be subject to the operator's approval, as the operator's information will be satisfactory. For issues requiring quality development, the National Centre for Patients' Rights and Documentation shall proceed as the authority in charge of qualitative assessment, in place of the National Institute for Quality and Organizational Development in Healthcare and Medicine.

- **Government Decree No. 337/2008 (of 30.12.) on the Execution of Act CXXXII of 2006 on the Development of the Healthcare System**

The amendment stipulates that the competence areas of the CT and MRI diagnostic professions would not be defined by progressivity levels, contrary to the statutory requirements for other professions.

- **Government Decree No. 323/2010 (of 27.12.) on the National Public Health and Medical Officer Service, the Fulfilment of Special Management Tasks in Public**

Health and the Designation of the Pharmaceutical State Administration Organization

In connection with regional integration, the addressees of the competences are now the county government office and the township office, instead of the county and township public healthcare offices. As regards the public health tasks, the Government Office of the Capital City of Budapest is competent in the territory of Budapest and Pest County.

The Government delegated the competency for the human medical research to the Office of the Chief Medical Officer.

- **Decree of the Minister of Health No. 2/2004 (XI. 17.) of the Minister of Health on the Registration of Healthcare Service Providers and their Operating Permit and on the Healthcare Technical Register**

In connection with authorized professions, Annex 2 to the Decree was amended with regard to rehabilitation professions, and acupuncture as a segment of traditional Chinese medicine was registered as a new profession.

- **Decree of the Minister of Health No. 5/2006 (II. 07.) on Rescue**

The rules concerning healthcare services during events and equipment in ambulance cars were amended.

- **Amendment of Decree of the Minister of Health, Social and Family Affairs No. 49/2004 (V. 21.) on Regional Services by District Nurses**

The “performance of cervix screening for public health” was identified as the district nurse's responsibility, the relevant personal and objective conditions and the term of certifying entitlement were all defined with effect from 1 October 2015.

III. Amendments to legal regulations pertaining to specialized healthcare services

- Based on Decree of the Minister of National Resources 12/2011 (III. 03.) on the Operation of the Healthcare Technical College, the members of the divisions were appointed and assigned. The members of the councils are currently being delegated by the technical organizations.
- Concurrent with the emergence in Hungary of the PET-MRI procedure, the personal and objective minimum conditions inevitable for the operating permit procedure were specified through the amendment of Decree of the Minister of Health, Social and Family Affairs 60/2003 (X. 20.) on the Minimum Technical Conditions of Providing Healthcare Services, and in relation therewith, the new 5501 PET-MRI profession code was also developed through the amendment of Decree of the Minister of Health No. 2/2004 (XI. 17.) on the Registration of Healthcare Service Providers and their Operating Permit and on the Healthcare Technical Register.

- The two legal regulations imposing the obligation to make neonatal objective hearing screenings in neonatal and PIC departments entered into effect from 1 September 2015.
- Decree of the Minister of Welfare No. 51/1997 (XII. 18.) on Healthcare Services Employed within Compulsory Health Insurance for the Prevention and Early Recognition of Diseases and on the Certification of Screening Tests
- Decree of the Minister of Health, Social and Family Affairs 60/2003 (X. 20.) on the Minimum Technical Conditions of Providing Healthcare Services

The relevant technical guideline, including the description of the tool and the method, is similarly effective as of 1 September 2015. As regards the fulfilment of personal and objective conditions, the development was made in the frames of Social Infrastructure OP, scheme 2.2.8. Any other necessary developments in the otorhinolaryngology centres will be financed in the scheme for the intersectorial development of early childhood intervention.

- Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (X. 20.) on the Minimum Technical Conditions of Providing Healthcare Services

The amendment was required for the sake of financing Dóri House and Tabitha House, both specialized in children's palliative treatment, from the Health Insurance Fund. (The legal regulation has been amended. The minimum conditions of the hospice house are separated from the paediatric palliative department in Annex 2. The statutory amendment is subject to constitutional review.)

- Decree of the Minister of Human Capacities 26/2014 (IV. 08.) on Prenatal Care

The new pocketbook on prenatal care is completed, the necessary statutory amendment is also performed and was promulgated in the February issue of Egészségügyi Közlöny (Official Journal of the Ministry of Health).

The fundamental objective is the overall accessible, high quality care of pregnant women. The new Decree provides that each Hungarian pregnant woman undergoes the compulsory screening tests and, for low-risk pregnancy in specialty care, the pregnant woman may, apart from the district nurse and the GP providing basic care, choose a midwife to provide care in the prenatal period.

The aim through the improved efficiency of prenatal care is to decrease the number of fetal and infant death and premature birth and to give birth to as many as possible mature and healthy new-borns.

In the one-year period since Decree of the Minister of Human Capacities No. 26/2014 (IV. 08.) on Prenatal Care was promulgated, some comments have been received from the Office of the Chief Medical Officer of State and from the basic care areas in connection with the application of the new rules. A substantially more transparent, more informative and simpler to use pocketbook on prenatal care was issued in February 2016.

- In the coordination of the National Centre for Patients' Rights and Documentation and with the participation of the relevant sections of the Technical College, 3 technical

guidelines were published in Egészségügyi Közlöny (official journal of the Ministry of Health) in 2016:

- On Pit and Fissure Sealing
 - On the Screening, Diagnostics, Treatment and Ophthalmological Care of Preterms' Retinopathy
 - On Non-neurogenic Urinary Incontinence in Adulthood
- In connection with the provisions of the Health Act concerning the accreditation of healthcare services, the standards underlying the accreditation have been drafted in project 6.2.5. of Social Renewal Operative Programme, and their assessment by the technical organizations is currently ongoing.
 - Government Decree No. 439/2015 (of 28.12.) on the Rules of National Blood Assortment Management defines certain basic terms related to the management of the national blood assortment, including the definition of labile and stable blood product, national blood assortment, national demand and national self-supply.

The legal regulation stipulates the applicable procedure in case the blood assortment fails to cover the national demand, as well as the cases of export, including export for humanitarian purposes. The requirements and conditions pertaining to healthcare service providers collecting industrial plasma and industrial plasma donors are also defined; moreover, the strategically vital objective of national blood assortment supply justifies the need for industrial plasma donors to give whole blood at least yearly. The definition of national blood assortment and the reinforcement of the voluntary and free-of-charge blood-donor system proved inevitable also considering the trends in recent years, as the number of blood donations are decreasing and the blood donors' community is continually ageing.

- The amendment of the Health Act contributed to the declaration of health emergency in case of disaster risk and any other unforeseen events requiring the treatment of a great number of injured persons, e.g. major accident (rail crash, air crash, explosion, earth slide etc.), which facilitates the more efficient and quicker settlement of the event.
- Decree of the Minister of Human Capacities No. 37/2014 (IV. 30.) on the Nutritional Health Requirements of Public Catering

A series of comprehensive technical and social discussions preceded the creation of the Decree. The Health Act stipulates that meals in public catering (with special regard to public catering in healthcare, social and children's institutions) shall be of a quality and nutritional value corresponding to the physiological needs. Apart from the personal and objective minimum conditions relevant to organizations and institutions providing public catering services in educational institutions, in institutions offering social care, child welfare basic care (day-nurseries for children's day-care, temporary homes for children's temporary care) and child protection specialty care (children's homes) and in patient catering, the Decree stipulates the values of permissible daily energy and salt intake by age groups, the guide on raw material dosage, the requirements on the use of certain food ingredients and the principles of dietary planning. It prescribes that all individuals requiring medically certified dietary nutrition shall be offered a diet conforming to their condition in inpatients' care in medical institutions and in educational institutions. The Decree also prohibits the supply of certain foodstuffs (e.g. energy drinks, sugared and carbonated soft drinks, alcoholic beverages; caffeinated drinks

exc. tea and chocolate milk for children below 18 years of age) in public catering. The transformation of public catering contributes to increased fruit and vegetable consumption, the reduced intake of salt and saturated fatty acids, an increase in the quantity of polyunsaturated fatty acids and age group-conformant energy intake, which in the long run results in a major decrease in total mortality and in mortality deriving from cardiovascular diseases and tumour diseases and, concurrently, an increase in life expectancy.

- Decree of the Minister of Human Capacities 71/2013 (XI. 20.) on the maximum Permissible Volume of Trans Fatty Acids in Food Products, the Conditions and Regulatory Control of Marketing Food Products Containing Trans Fatty Acid and on Rules for Tracking the Public Intake of Trans Fatty Acid

The European Union does not currently have any effective regulations on the trans fatty acid content of food products. After Denmark (2004) and Austria (2009), Hungary was the third EU country to adopt such a regulation, mainly as a component of the prevention of cardiovascular diseases. The Decree entered into effect in the end of 2013 and is applicable as of 18 February 2014.

The limit values in the Hungarian Decree correspond to those in the Danish and Austrian regulations, so, accordingly, it is prohibited to market any food products wherein the volume of trans fatty acids exceeds 2 grams in each 100-gram total fat content of the food product delivered or sold to the final consumer. Additionally, the regulation prescribes the creation of a national database with the volume of trans fatty acids in food products and the continuous tracking of public data on trans fatty acid intake.

Denmark saw a significant (approx. 20 %) decrease in the occurrence of cardiovascular diseases in the third year of entry into force of the decree. A similar result in Hungary would mean that approx. 6,000 people's lives could be saved, including nearly 30 % thereof below the retirement age (0-64 years of age). This is a highly essential aspect also because, according to OECD data, mortality related to ischemic heart disease is very high in Hungary, almost three times higher than the OECD average, so the decreased daily intake of trans fatty acid prognosticates a significant decrease in mortality caused by coronary disease in Hungary.

IV. Drug Focus Point

The drug users' outpatient and inpatient care represents a shared responsibility of the healthcare and the social care system. The Ministry of Human Capacities coordinates and supervises the drug users' care and the functioning of the care system, with the assistance of its technical support institutions and consulting bodies.

Several out- and inpatient healthcare forms and treatment units are accessible all over the country to treat drug users. The need for drug addicts' outpatient specialty care was recognized in the 1980s when the first services were actually facilitated.

The care is typically offered by public institutions operated by the state/local governments (hospitals, clinics) and non-profit religious/NGO organizations. As regards the current treatment possibilities, there are no specialized treatment programs targeted at the users of specific drug types, but the programs are generally targeted at the users of all the drug types or generally at the addictions and those struggling with psychiatric problems. An exception

applies to opioid substitution therapy which has been accessible to drug users long struggling with opiate dependence in Hungary since 1994.

That is still a key factor of the Hungarian system that the legal option of treatment/prevention interventions is accessible as an alternative to the normal criminal proceedings, the prosecution and the judicial proceedings. The majority (60 % in 2014) of enrolments on a treatment program is linked to this.

The drug users' care does not form a special category in either the social or the healthcare system but in general it belongs to the group of addictology and psychiatric care.

Care arrangement and administration in treating and caring for drug users

Both the healthcare and social care system play an equal role in the drug users' treatment.

These types of care services are financed from the funds of the National Health Insurance Fund, with regard to healthcare, and through subsidies and funds awarded in tenders financed from the social funds supervised by the National Office for Rehabilitation and Social Affairs, with regard to social care. Typical of both sectors, the treatment of drug users does not formally represent a special category among the financed forms of care, but drug users are treated as a single target group, together with alcohol addiction and other addictions, sometimes including psychiatric patients. Nevertheless, there are some care centres mainly targeted at the treatment of drug users, though this distinction is not traceable in their financial system.

As regards the operators of care centres, there are treatment centres operated by the state/local governments (providing either only health care or health and social care in combination) and NGOs (NGO organizations, organizations financed by the church) (providing health and social care in combination or just the latter) (Péterfi, 2015). Preventive and awareness service can be provided in any type of care, and a great number of non-governmental market participants provide this type of service.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

The Government declared the principles underlying health political measures in its sectorial strategy “Healthy Hungary 2014-2020”, adopted in Government Resolution No. 1039/2015 (II. 10.).

I. Development and financing of basic care

Measures in 2012

- **Further increase of remuneration under the GPs' indicator system**

After their results in the system, general practice providers got HUF 250 million a month in 2012. Consequently, HUF 3bn was paid at the annual level after the results measured in the indicator system, which granted HUF 900 million extra funds to general practice providers versus the previous year.

- **Reform of the tool grant system**

Over 4,800 general practice providers were subsidized during the year under this title. The amount of the grant exceeded HUF 2.5bn on an annual basis, which means that general practice providers got HUF 2.3bn more grant than in the previous year to recondition, expand and develop their set of tools.

- **Increase in the performance-based remuneration (HUF/point value) of general practice services**

The HUF/point value underlying the settlement of GPs' performance fee has not been increased since 2003, so it has been fluctuating at around HUF 162-166/point for nearly 10 years. Following an increase in the annual budget for general practice services, this value rose to HUF 184-188/point from November 2012. This required a nearly HUF 1bn extra investment for 2012.

- **Reform of the tool grant system**

The ratio of contracted dental services compared with the number of dental services eligible for funding exceeded 80 % during the year, so nearly 1,900 dental services were subsidized under this title. In comparison with the previous year, almost HUF 1.0bn more grant was provided to dentist providers to recondition, expand and develop their set of tools.

- **Increase in the basic fee for dental services and specialist practices**

With regard to dental care, the value of age group-related points underlying fee payment has not changed since 2008. Afterwards, the basic fee was first increased from November 2012: the age group-related points went up to HUF 39.2/month, meaning a 14 % increase for dental services and specialist practices. This resulted in HUF 1.1bn additional payment at the annual level.

- **Increase in the performance-based remuneration (HUF/point) of district nurse services**

The amendment of Government Decree No. 43/1999 (III. 03.) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund determined an incremental financing fee for basic health care in September 2012, with effect from November 2012. As an effect of the Decree, the HUF/point value related to district nurses' financing increased from the former average HUF 279.8 to HUF 315.8. This means an approx. 13 % increase.

Measures in 2013

- **Change in the term of submitting GPs' monthly reports**

After 1 January 2013 general practice providers have had 5 business days to send their monthly reports to the National Health Insurance Fund, through the e-report system. Beforehand, this period was set at 5 calendar days, so the modification helped general practice providers have more time to make and send the reports. This measure is of key importance in certain months when the first days of the month are bank holidays or red-letter days.

- **Repeated increase in the performance-based remuneration (HUF/point value) of general practice services; equation of previous year's increase**

Another increase was carried out from November 2013, with retroactive effect from January 2013. Consequently, the HUF 184-188/point value rose to above HUF 200/point. This required an additional approx. HUF 4bn investment. The equation of the similar performance-based fee increase in the last two months of 2012 required an additional HUF 4.5bn in 2013.

- **Change in the term of submitting dentists' monthly performance reports**

After 1 January 2013 dental providers have had 5 business days to send their monthly reports to the National Health Insurance Fund, through the e-report system. Beforehand, this period was set at 5 calendar days, so the modification helped dental providers have more time to make and send the reports. This measure is of key importance in certain months when the first days of the month are bank holidays or red-letter days.

- **Repeated increase in the basic fee for dental services and specialist practices**

The repeated increase was carried out from November 2013, with retroactive effect as of January 2013. Similar to the previous year, the fee increase was carried out by increasing the age group-related points underlying the basic fee to HUF 44.2/month. Accordingly, dental providers' remuneration increased by 12.7 %. This required an additional approx. HUF 1.1bn investment.

- Increase in the basic amount of remuneration for in-duty care

The basic rate per capita rose from HUF 40/person to HUF 42/person.

The increase was carried out from November 2013, with retroactive effect as of January 2013. This required an additional HUF 500 million investment at an annual level.

- **Amendment of Government Decree No. 43/1999 (III. 03.) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund**

The amendment prescribed additional fee increase in basic health care. The providers were entitled to get the increment from their November 2013 payments, with retroactive effect from January 2013. The Decree also stipulated that the fee increases retroactively due for January-October 2013 should be transferred in one sum, concurrent with payments in early November 2013. In comparison with the November 2012 funding figures, the financial increment in November 2013 meant an average HUF 138,000 surplus in the monthly funding of district nurse services and an average HUF 134,000 increase in the monthly funding of school nurse services.

Measures in 2014

- **Third increase in the performance-based remuneration (HUF/point value) of general practice services in four years**

Concurrently, the digression point limit for general practice services full-time employing specialist interns (after their specialty practice required for the GP's specialty examination), specialists and other professionals went up by 300 points.

As an affect, the approx. HUF 200 point value went up to HUF 206-210. HUF 2.4 bn per annum is required for yet another increase.

- **Third increase of remuneration under the GPs' indicator system**

The budget of the so far HUF 3bn annual remuneration went up by 60 %, so in 2014 as much as HUF 4.8bn (HUF 400 million a month) is available for remunerating the results achieved in the indicator system. This means that HUF 1.8bn more payment is effected to reward professional and high quality work in practice.

- **Introduction of supplementary remuneration for professionals**

This is a new element in the funding scheme of general practice services. Accordingly, the general practice provider is entitled to get a remuneration amounting to a fixed amount after each professional (HUF 10-20,000/month) employed in the service in an at least 20 hours per week working time. The implementation of this measure required an additional approx. HUF 1.8bn investment.

- **Supplementary remuneration for services offering basic dental care and subject to regional healthcare obligation**

Dental services offering basic care in settlements backward in their socio-economic and infrastructure conditions and/or hit with unemployment significantly exceeding the national average have received a monthly HUF 100,000 supplementary remuneration since January 2014. Accordingly, the fixed amount fees paid to the services rose by 9.2 % on the national average. This required an additional HUF 816 million investment at an annual level.

- **Increase in the point value of certain dental preventive and screening-related dental interventions**

In view of improving the screening of buccal cancer and cancer-preventive conditions and for complex childhood preventive activities, the point values of prevention and paediatric, school and youth dental interventions (in the group of dental interventions) went up. The amounts based on the increased point value have had to be settled from the January 2014 payments (i.e. from the performance accounting for November 2013) and the retrospective corrected amounts were paid together with the June 2014 transfers. The point increase, executed for the improvement of priority tasks, helped the providers offering basic and specialized dental care to HUF 684 million extra revenue at the annual level. Accordingly, the average revenue of dental care increased by 8.9 %.

HUF 105,000 one-time supplementary fee per dental practice was equally paid to dental practices funded in basic care, to the debit of the 2014 balance. Accordingly, 2810 dental services got supplementary remuneration in the total sum of HUF 295.1 million in December 2014.

- **Amendment of Government Decree 43/1999 (of 03.03.) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund – February 2014**

As an outcome of the amendment, the 2014 appropriation for district nurse services, mother, children and youth protection was increased by HUF 1.75 bn. This amount shall wholly be spent on increasing the remuneration for providers offering health care by district nurses. The providers have been entitled to get the increment from their March 2014 payments, with retroactive effect from January 2014. The amended Decree also stipulated that the fee increases retroactively due for January-February 2014 should be transferred in one sum, concurrent with payments in early March 2014. The incremental funding scheme results in an average HUF 29,900 increase versus the December 2013 payments to school district nurse services, meaning a 10.4 % revenue increase. For services fulfilling regional district nurses' responsibilities this increment is HUF 28,400 on the average, which leads to 9.6 % revenue increase.

In the range of amendments in the amended legal regulations, the provisions obliging healthcare providers in contractual relation with the National Health Insurance Fund to spend the increased funding fees for increasing the district nurses' benefits have appeared as brand new elements.

- In phase 1 of the development of basic care, each general practitioner's and general paediatric practitioner's practice subject to regional care obligation has received a monthly HUF 130 thousand extra grant from January 2015, which could be spent on the maintenance costs of the consulting rooms.
- In phase 2, in addition to the HUF 10.0bn available under the title '2nd Phase of Renewal of basic Care', HUF 4.1bn extra funds were granted (under the title Provisions for Medical and Preventive Care) for the development of basic care in 2016. The new condition versus phase 1 is that not only GPs but some other basic care providers (district nurses, dental basic care providers, school doctors) may also have a share of the total HUF 14.1bn available.
- GPs who have passed their first specialty examination after 31 August 2015 are also entitled to get a grant for 5 years (provided they perform a healthcare activity in full-time job at a healthcare provider with effective funding contract, or those who get child-care fee or child-care benefit and, at the same time, perform healthcare activity in part-time employment), in the frames of the Aid Scheme for Young Medical Specialists. The amount of the grant has since January 2015 been a monthly gross HUF 151,000 per supported person, which the National Health Insurance Fund transfers to the healthcare providers together with the sum of public dues (27 % social contribution tax) payable by the payer.
- In call for proposals TOP-4.1.1-15 (Infrastructure Development for Basic Health Care) in the Territorial and Settlement Development Operative Programme, and including the funds under call TOP-6.6.1-15 in TOP invited under an identical title on 17 December 2015, total HUF 22.272bn was accessible for supporting the infrastructure-related development of basic care (construction investment, renewal and purchase of instruments) in 2016.

Measures in 2015

- **Act CXXIII of 2015 on Basic Health Care**

The Act sets the statutory conditions of group practice and practice community, so healthcare service may be provided in the frames of this care. A practice community or group practice may primarily be established for the more efficient provision of preventive care accompanying basic health care. The Government stipulates the criteria of establishing practice communities and group practices in a decree.

- practice community: an operational form established for meeting the responsibilities of general practice, general paediatric practice, basic dental and district nurse providers;
- group practice: a form of cooperation wherein, in addition to the basic care responsibilities of GPs and general paediatric practitioners, certain care in the group of outpatient specialty care may also be provided, as stipulated in the law .

The Act stipulates that when the local government is the healthcare provider, i.e. it get the funds, it is obliged to supply the relevant healthcare workers with information about the use thereof on a monthly basis.

If the GP has passed any other specialty examination apart from the GP's specialty examination, he/she may provide special medical service in that specific field, which means that, with regard to specialty care, the conditions of health care could be met close to the inhabitants, in areas where the conditions of institutionalized specialty care are not fulfilled. If the GP, the general paediatric practitioner or the dentist offering basic care has any other professional medical qualification apart from the professional qualification required for the provision of the specific basic health care, then for financing the relevant healthcare profession the health insurance organization concludes a funding contract (under the statutory conditions) with the healthcare provider offering the relevant GP service, if initiated by the healthcare provider.

Some other vital statutory changes apart from the Act on Basic Care are also intended to help and improve the conditions of basic care.

The Act on Local Taxes has also been amended. It is aimed at granting a right to the local government to stipulate, in a decree, exemption or an allowance for the GPs, general paediatric practitioners and dentists who earn 80 % of their revenue from the Health Insurance Fund. The Act permits the local government to stipulate, in a decree, exemption or allowance for GPs or district nurses working as entrepreneurs, provided the local business tax base of their company fails to exceed HUF 20 million in the fiscal year. Tax exemption and tax allowance shall be identical for each GP and district nurse when acting as entrepreneurs.

- **Government Resolution No. 1039/2015 (II. 10.) on the Approval of the Health Sector Strategy “Healthy Hungary 2014-2020”** (hereinafter: Health Sector Strategy)

Pursuant to the aims formulated in the Health Sector Strategy, it is necessary to strengthen the preventive and health educating role of those taking part in basic care, the remodelling of the preventive approach in the GP's healthcare service and the creation of a complex incentive scheme by involving other health professionals. The expansion of preventive activities by district nurses is also related to this.

- **General practitioners' practices**

The aim of Practice Programs 1 and 2 is that medical care should also be provided in GPs' districts caring for adults and mixed age groups and subject to long-term vacant jobs, by employing as public servants some doctors who have not yet passed the GP's specialty examination but can properly fulfil the conditions.

– Target group in Practice Program 1:

- group of local governments with long-term non-served districts,
- group of doctors with no specialty examination in general practical medicine.

98 doctors joined the system and occupied a job in some GP districts that had earlier been permanently non-served, thereby caring for a total 133,000 inhabitants in altogether 86 settlements until late 2015. This included 27 plus 13 plus 27 doctors who commenced their GP activities in prioritised districts, in districts to be developed and in districts to be developed through a complex program, respectively. Among the doctors, 62 passed the specialty examination, including 50 who concluded a performance contract with the relevant local government after their specialty examination.

– Target group in Practice Program 2:

- local governments where the contract for the assumption of a GP's tasks has terminated and there is no second generation with a professional qualification in general practical medicine;
- group of doctors who have a clinical qualification but have not yet passed the specialty examination in general practical medicine.

209 doctors joined the system until late 2015 and acquired thereby the right to practice as general practitioners. This included 46 plus 11 plus 26 doctors who commenced their GP activities in prioritised districts, in districts to be developed and in districts to be developed through a complex program, respectively.

• **Practice shift program, settling grant, tender supporting the acquisition of practice right for GPs**

The objective is to grant a support for GPs who are to acquire the right of having a medical practice. The coverage available for this reached a total HUF 250 million in 2015 and the amount of grant potentially awarded to a GP was HUF 4 million the most, which may only be spent for the acquisition of a right for medical practice. Any doctors acquiring a right for medical practice from their retirement-aged colleagues were given preference in assessing the applications.

The National Health Insurance Fund invited a tender in 2014 and 2015 for supporting the settling of doctors taking a job in GPs' districts unserved for at least 12 months. The winning applicants agreed to perform independent medical activity in the specific GP service for at least 4 years, in an operational form stipulated in the agreement with the competent local government and with their personal participation in every case. The available amount of the grant, subject to vacancy in the medical practice, was between net HUF 6 and 10 million.

• **Swiss-Hungarian Cooperation Program – Priority 8: Model program for public health-focused basic care organization, 2012-16**

In the project funded with CHF 15,294,118, 4 practice communities (centres in Berettyóújfalu, Jászapáti, Borsodnádasd and Heves) have been set up with the participation of 24 basic-care practices in the North Great-Plain and Northern Hungary regions.

The objective of the program is to develop and test a model of basic healthcare provision that focuses on prevention and the care of patients with chronic diseases, is oriented at the community and involves local communities (in particular the Roma population) in close cooperation with local and ethnic local governments, local healthcare and social services and medical workers, and also to formulate recommendations (based on experience) for national healthcare policy.

With regard to the inhabitants (of Roma nationality) living in the territory of the practice community, the priorities include:

- improvement in the equal opportunities in, and the quality of, their access to basic care;
- their development in a way oriented at the community and involving local Roma communities;
- the Roma community is addressed by a person coming from and actually living in the community and not differing from the standards of the community (Roma mother-child health program; training of health assistants of Roma origin; training of responsible Roma health agents).

In the framework of the program approx. 36,000 people, including nearly 10,000 from the Roma minority attended complex screenings (for more than 20 parameters) and related life-style counselling.

Until 31 October 2015, 19,303 adults' health status was examined, including nearly 40 % from the Roma minority.

Overview of special programs in the project targeted at Roma communities:

- *Training Roma health assistants*

The Roma community can be the most effectively reached if the contacting person comes from inside, actually lives in the relevant community and does not differ from the standards thereof. This also means that the scope of the Roma health assistants' competence covers their own small community, hence their employment is linked to practices (and not practice communities). In summer 2013, the program fulfilled its commitment and recruited 48 Roma health assistants. In the course of the selection process the technical management closely cooperated with the local representatives delegated by the National Roma Local Government; the job interviews were held with their personal participation and with the consideration of their recommendations. These workers are responsible for mediating between the basic healthcare personnel and the public (especially those living in unfavourable socio-economic conditions, in particular the Roma population), attending health condition surveys, screenings, prevention services, lifestyle counselling, health promotion-focused presentations, all aimed at the implementation of the program. Additionally, the 2 Roma health assistants per practice are also involved in supplying information to the public and arranging the events organized within the program. For the sake of successful cooperation with the other professionals in the practice community, the recruited health assistants attended an extension training course in August 2013 and there they all underwent the Roma healthcare mediator training. In the

course of additional trainings, 2 of them earned a social worker's qualification and 20 received a medical care assistant's diploma.

– *Roma mother-child health program*

Roma mothers are counselled by district nurses (who also examined their children's health status), as a part of the monthly Roma mother-child club sessions held in the settlements encompassing the 24 practices. The club sessions are organized thematically, each discussing one issue of public interest, with demonstration and direct experiencing.

The estimated rate of Roma persons attending mother-child club sessions in the 13 most disadvantaged settlements is near to 90 %.

• **Development of basic care by district nurses**

The network of district nurses (functioning for 101 years now, intended to protect the health of families and support the families) is a specific “Hungarian product”: this activity can greatly contribute to preserving the health and improving the health condition of the Hungarian population.

District nurses are high qualified experts for public healthcare and prevention. Apart from caring for the women's, mothers', infants', children's, youth's and families' health, they are also involved in public healthcare, epidemiology and health promotion.

The program implemented by November 2015 from European Union funds [Early Childhood (0-7) Program – Social Renewal Operative Programme; TÁMOP-6.1.4] focused on supporting the healthy early childhood and successful school-start of all children between 0-7 years of age (but especially those requiring special support), by way of monitoring the children's development.

The program was aimed at developing and transferring uniform and up-to-date knowledge and methods

- to the professionals in children's basic health care (district nurse, GP, general paediatric practitioner), in order to improve the efficiency of their work;
- at reinforcing the parents' awareness and competence concerning the child's development, care and education;
- at introducing a questionnaire to track the children's development, based on the parents' observations;
- at setting up a Methodological Unit for District Nurses, in order to support the development, arrangement and execution of national professional and methodological programs and activities related to the operation of the district nurses' service and the district nurses' activities/responsibilities, and to initiate interdisciplinary harmonization.

What did the project provide to basic care professionals?

1. *System-level developments*

- Law harmonization – detailed mapping of the responsibilities of basic care professionals, liquidation of parallelisms

- Development of directives based on project results – development and submission of eight directives
 - Development of “Children's Roadmap” – mapping the supply routes
 - Curriculum development with training centres – workshop series with the training centres, integration of development in gradual training
 - Development of quality indicator – development of indices that can objectively assess the effectiveness of supply
2. *Methodological reform*
 - Questionnaires based on parents' observations: 1, 2, 4, 6, 9, 12, 15, 18 months old, 2, 2,5, 3, 4, 5, 6, 7 years old
 - Care plan: description and integration of the process, development of a special care process
 - Support of communication with parents: district nurses' preparation, information materials for parents
 3. *Possibility of professional development*
 - Training development and arrangement of extension trainings: credit-awarding extension trainings for district nurses, general paediatric practitioners/GPs. 5300 persons attended extension trainings and development programs.
 4. *Simpler, electronic documentation*
 - Simple data input and data transfer, with national competence.

- **Breastfeeding grant**

There are a great number of international professional governing bodies emphasizing the importance of breastfeeding. It develops immunity from various diseases both for the child (infectious diseases of the respiratory passages and the digestive system, allergy, obesity, diabetes etc.) and the mother (breast cancer, ovarian cancer etc.), in most of the cases proportionately to the length of breastfeeding. It is also important from the aspect of the mother's and child's psychic health. Successful breastfeeding is built on three pillars: the implementation of the WHO/UNICEF Baby-friendly Hospital Initiative, standardised professional guidelines and approach, and the strict regulation concerning the marketing of breast-milk substitutes.

The promotion of breastfeeding is a fundamental primary preventive activity and one of the most cost-efficient healthcare measures. Healthcare professionals have a unique impact on women's decisions regarding breastfeeding and their breastfeeding capabilities. It is inevitable and necessary to expand their relevant knowledge, so that they could collect thorough information on breastfeeding management. In view of widely disseminating this knowledge, the National Committee for Supporting Breastfeeding held trainings in 2015 in a program bearing the title “Theoretical and practical issues of breastfeeding” (financed from central budgetary funds), held in 10 venues for 493 medical workers, including 215 plus 123 professionals taking part in beneficiary and developing districts and attending the trainings of the Baby Friendly Hospital, respectively.

- **Examination of oral health condition**

Some inevitable tasks in oral medicine are the epidemiological monitoring of dental diseases (considered an endemic) and, in connection therewith, the survey of health behaviour, the definition of risk factors and the identification of correlations affecting these factors. This is

of key importance in the priority target groups of preventive programs, among children and young persons.

The comprehensive objectives of the one-year Hungarian survey starting in May 2013 were as follows:

- present the key epidemiological indices and trends;
- collect relevant Hungarian data on interrelation among health behaviour, dental awareness and oral diseases;
- collect reliable information about the relatedness of disease indices and the specific elements of health behaviour (e.g. dental and buccal diseases and various habits);
- have an accurate knowledge about change trends;
- international comparison and planning.

Relying on the survey of oral health condition and health behaviour in the standard WHO sampling target age groups, i.e. specifically in the 6 to 12 year-old population and aligned to the 2008 survey, 25 boys and 25 girls (and in Budapest 50 boys and girls each) by each age group, i.e. altogether 900 children in each age group were surveyed in all the test points of the 14 settlements with the involvement of total approx. 1,800 persons.

II. Organized public health-focused screening tests

Screening tests can be made in a wide range of the population (split by age groups), in connection with infectious diseases and for certain chronic and non-infectious diseases. As stipulated in the Health Act, the objective of screening tests is to protect the health of the public and improve the individual's quality of life and lifetime through the active localization and identification of hidden diseases, some health conditions preceding certain diseases and the disposing risk factors in an early stage possibly with no complaints. In the group of age-related screening tests, the screening of new-borns and children of compulsory school age is obligatory. [Section 81 (3) of the Health Act]

The screening tests available free of charge in certain age groups and targeted at the prevention and early identification of diseases linked with age-specific characteristics, as well as the health providers performing the screening tests and the procedural order concerning their employment are all regulated in Decree of the Minister of Welfare No. 51/1997 (XII. 18.): this describes the screening tests made in the various age groups in basic health care or specialty care, and the targeted screening tests aimed at public health.

- **Reduction and early identification of the risk of tumour diseases – organized, public health-focused screening tests**

The burdens generated by chronic non-infectious diseases, in particular malignant tumour diseases (alongside jugulating the epidemics caused by infectious diseases) pose the biggest challenge for the healthcare systems of our age in a great number of countries in the world. In addition to the patients, these burdens affect the relatives and pose a serious challenge for the entire society. Mortality caused by tumour diseases is also a priority public health and health political issue in Hungary. In the group of EU Member States, Hungary has the highest mortality rate per 100,000 inhabitants caused by tumour diseases. Analyzing the development of tumour death, an annual 33,000 deaths caused by malignant cancer have been recorded in Hungary with some fluctuations since 2000 (which was all in all rather unfavourable),

representing over a quarter of total mortality. This ratio is more unfavourable (40 %) in deaths before the age of 65.

Mortality due to malignant tumour diseases varies by sexes both in number and types. With reference to the 2013 data, over half the tumour deaths hit men (55 %). Nearly a third of them had a malignant tumour in the throat-pipe, the bronchus or the lungs, followed by the malignant tumour of the large intestine and the rectum (16 %). The ratio of mortality caused by a malignant tumour in the prostate (7 %), the lip, the buccal cavity and the pharynx (6 %) was also outstanding. In women's tumour cases, similar to men, the malignant tumour of the throat-pipe, bronchus and lungs was the most frequent lethal tumour type (21 %), followed by malignant tumour in the large intestine and rectum (15 %) and in the breast (14.5 %).

Most frequent malignant tumour deaths in 1990-2014, by sex

Year	Malignant tumour death			Throat-pipe, bronchus, lungs		Large intestine, rectum		Lip, buccal cavity		Breast	Uterus Neck
	total	men	women	men	women	men	women	men	women	women	women
1990	30,871	17,497	13,374	5,416	1,492	2,146	2,090	945	175	2,097	602
2000	33,280	18,732	14,548	5,727	2,097	2,514	2,372	1,413	275	2,316	481
2010	32,460	18,032	14,428	5,741	2,907	2,704	2,261	1,232	292	2,011	379
2011	32,670	17,990	14,680	5,558	2,975	2,835	2,219	1,213	281	2,138	414
2012	33,224	18,279	14,945	5,763	3,133	2,810	2,274	1,225	311	2,096	426
2013	32,748	17,815	14,933	5,418	3,173	2,865	2,242	1,146	285	2,167	405
2014	32,748	17,763	14,985	5,456	3,277	2,848	2,202	1,157	303	2,107	420

Source: Central Statistical Office

Based on the data in the National Cancer Register of the National Institute of Oncology, the annual number of patients newly diagnosed with a malignant tumour disease has taken an ascending trend. When focusing on the time period between 2003 and 2013, the number of malignant tumour diseases is stated to have increased by nearly 10 %. The number of new cases stagnated at around 75,000 between 2011 and 2013.

Most frequent reported new malignant tumour diseases in 2001-2014, by sex

Year	Total reported new malignant tumour disease	C34 Malignant tumour of bronchus and lungs		C18-C20 Malignant tumour of large intestine, intestine and anus		C00-C14 Malignant tumour of lip, buccal cavity and pharynx		C50 Malignant tumour of breast	C53 Malignant tumour of cervix
		men	women	men	women	men	women	women	women
2001	62,931	7,746	3,638	4,606	4,311	3,028	842	6,196	1,355
2003	70,197	7,840	3,886	5,006	4,519	3,265	991	8,032	1,332
2008	70,527	6,983	4,006	5,134	4,463	2,737	935	7,133	1,094
2009	69,662	6,885	4,014	5,058	4,496	2,664	904	7,276	1,040
2010	67,398	6,583	3,917	5,187	4,405	2,688	889	6,810	950
2011	75,581	7,229	4,492	5,734	4,929	2,895	1,032	7,333	1,159

2012	74848	6,896	4,382	5,611	4,785	2,767	977	7,720	1,069
2013	75458	6,726	4,569	5,736	4,650	2,699	1,062	7,781	1,120
2014*	76996	6,916	4,651	5,701	4,789	2,689	1,084	7,934	1,159

Source: National Cancer Register

* Preliminary data

The high ratio of tumour diseases and mortality concludes that most tumour patients are diagnosed and treated in an advanced state when the chances of curing the patient effectively are limited. Based on the present state of medicine, a considerable proportion of mortality due to tumour diseases could be avoidable.

Measures for efficient prevention and fight:

The European Partnership for Action against Cancer initiative mediates two main messages for the more efficient prevention and fight of tumour diseases at both the national and EU level:

- cancer disease if diagnosed in the early stage can be cured or the chances of recovery can be considerably improved;
- and healthier lifestyle can contribute to reducing the risk of certain cancer diseases to develop.

The Health Sector Strategy identified the reduction of malignant tumour deaths and the mitigation of personal and social burdens caused by the disease as a public health priority.

The key task is the early diagnosis and treatment of the disease, linked with among others the creation of infrastructure suitable for health promotion, risk reduction, tumour screening and diagnosis and with meeting and improving the conditions of training professionals.

The long-term objective of organized public health-focused screening tests is to halt and then mitigate the currently ascending trend in tumour diseases, whereas the short-term objective is to integrate the target population (through the highest possible number of individuals) categorized by age as vulnerable in the organized screening system.

Any procedures the effectiveness whereof in decreasing the disease-caused mortality is justified by measurements can be integrated in the range of organized targeted public health-focused screening tests. Currently: two-yearly breast screening among women between 45-65 years of age (mammography) – since 2002; after a single negative screening test, three-yearly cervical screening test among women between 25-65 years of age (cytology) – since 2004; and two-yearly large intestine and rectum screening test, based on fecal occult blood test, among men and women between 50-70 years of age (currently a pilot scheme).

Organized breast screening

It was launched in 2002. 5,000 malignant tumours have been diagnosed since. Relying on the 3 new capacities integrated in 2014, organized breast screening for women is currently provided at 40 so-called “complex screening centres” equipped to conduct mammography screenings and clinical patient monitoring and in 7 mammography screening stations only suited to perform screenings, thereby covering the country and having sufficient capacity to examine the entire vulnerable population.

The ratio of undergoing organized breast screening approximates 45 % (500,000 invitations are delivered each year) and the goal is to reach a higher participation ratio.

In view of increasing public attendance and improving accessibility and availability, three breast screening mobile units are currently in function in the country to provide breast screening as a “public-oriented solution”.

Decrease in deaths due to cervical cancer

Organized cervical screening

Approx. 400 women per annum die in malignant cervical cancer in Hungary. Based on the data supply of the National Health Insurance Fund, each year approx. 30 % of women between 25-65 years of age (i.e. vulnerable age group) undergo organized cervical screening and diagnostic examinations available since 2004. This is mainly attributable to the rather rare or non-attendance of some of the invited target population in this screening type, and ad hoc screening is not typical in their case, either. The majority of fatal cases is linked with this population.

The objective is to achieve a higher rate of completed screenings, especially by way of undergoing well-developed, free-of-charge, invitation-based and organized cervical screening.

With the aim of decreasing mortality due to cervical cancer and increasing attendance in public health-oriented cervical screening, district nurses have recently been involved (as new players) in the organization and arrangement of public health-aimed cervical screening: they “bring” the screenings closer to women who live in small settlements; and can even convince women who have not been at a gynaecologist for 10 or more years. to undergo screening.

The program for the national expansion of cervical screening by district nurses was implemented with EU support. Therein, district nurses mainly working in settlements with less than 5,000 inhabitants got a licence to do the cervical screening/take samples (1,148 persons). Adding the 285 district nurses who got their competence in pilot programs held in preceding years and financed from Hungarian funds, now altogether 1,433 district nurses are authorized to do cervical screening.

The project supported cervical screening not only by holding trainings for district nurses but also by providing the necessary infrastructure. In that framework 436 gynaecological chairs, 375 draught-screens, 1,300 screening and another 1,300 sampling packs were collected. The district nurses used the sampling pack and the screening pack in their practical sampling sessions and in the course of cervical screening by district nurses, respectively.

Findings of cervical screenings by district nurses (2012-2015)

Year	Number of district nurses doing the screening (persons)	Settlements with screenings by district nurses (number)	Persons to be screened and accessed by district nurses (persons)	Persons screened by district nurses (persons)	Screened with the suspicion of tumour (persons)	Screened with the suspicion of inflammation (persons)

2012	218	292	17,377	4,997	27	348
2013	211	349	11,101	3,908	35	200
2014	197	301	33,825	2,841	53	141
2015	686	884	88,913	14,212	963	214

The introduction and national expansion of cervical screening by district nurses can help raise the ratio of women undergoing cervical screening, so the timely detected deformations can greatly improve the chances of recovery. Consequently, the number of women's deaths caused by cervical cancer can decrease.

Introduction of vaccination against Human Papillomavirus (hereinafter: HPV)

While the deformation preceding cancer and leading to tumours can be detected at an early stage with screening, vaccination against cervical cancer can even prevent infections of HPV, the most common source of the disease. As well known, the results of the Hungarian compulsory vaccination system are outstanding in global terms. Owing to extraordinarily high re-vaccination, the system helps protect against infectious diseases and maintain national epidemiological safety. Additionally, for the sake of reinforcing the national vaccination scheme, the Government launched the vaccination against HPV as a free-of-charge vaccination recommended with compulsory effect as of September 2014. The aim of the measure is that more and more young people should get the vaccination with their parents' consent and, consequently, the national development of and mortality due to cervical cancer could significantly decrease in years and decades.

In accordance with Section 7 of Decree of the Minister of Welfare No. 18/1998 (VI. 03.) on Epidemiological Measures for the Prevention of Infectious Diseases and Epidemics, girls who have reached their age of 12 and are in the 7th year of the elementary school can get the vaccination against HPV in the school campaign for vaccinations, free of charge.

The first experience in the national introduction of the vaccination was already especially favourable. The parents could be accessed almost without any exceptions with the help of the school-based health care service, and 99.3 % of the parents' declarations were returned to the district nurses. From among the parents of 46,000 eligible children, nearly 35,000 asked for the vaccination in the first phase of launching the national program, meaning that the majority (77.5 %) of the target group intended to seize the opportunity of free-of-charge vaccination, and another 5.6 % of the eligible children had already got the vaccination beforehand.

The Hungarian figures were outstanding in the group of European countries that had earlier launched campaigns for vaccination against HPV. Based on the currently available data of the European Centre for Disease Prevention and Control, only Portugal and the United Kingdom have reached similarly good ratios in the whole of Europe.

With regard to the new campaign vaccination in 2015, the parents had to submit a declaration until 11 September 2015 and state therein if they applied for the voluntary, free-of-charge vaccination against cervical cancer for their daughters in the 7th year of the school. Similar to the previous year, there was substantial interest in the vaccination. The assessed data conclude that from among the parents of the 44,000 eligible children nearly 34,000 applied for the free-of-charge vaccination, which means a stagnation at an almost 80 % ratio on the national average.

The introduction of the vaccination against HPV as a vaccination recommended with compulsory effect can help implement equal opportunities because, with the help of the vaccination, disadvantaged children can get the same protection as those in better financial conditions, which can contribute to lowering the health-related inequalities among the individual regions of the country, which in turn is welcome from epidemiological and social aspects.

Alongside the organized public health-focused cervical screening program, the introduction of vaccination against HPV as a primary preventive procedure means a major step for driving back a disease that causes nearly 400 women's death in Hungary each year.

All these measures (i.e. active participation in organized screening and the vaccination) can jointly help and reduce national mortality caused by cervical cancer.

Large intestine and rectum screening with the GPs' involvement

The tumour disease of the large intestine and the rectum is the second most frequent tumour in Hungary after lung cancer, considering the number of newly diagnosed tumours (8,500 persons) and the resulting deaths (nearly 5,000 persons).

In the frames of the project financed from European Union funds in 2014-2015 (Social Renewal OP, TÁMOP-6.1.3.A-13/1-2013-0001 Pilot Screening Programs – Supporting the Expansion of Cervical Screening Tests by District Nurses and Large Intestine Screenings) the screening program was launched in Csongrád county in the 50-70 year-old male and female target population, with the involvement of altogether 226 GPs and assistants. The experts of the medical practices attended an accredited training in the township centres of the county before commencing the screening project. The approx. 11,000 screenings (50 % coverage) resulted in diagnosing 26 malignant tumours in the form of in situ carcinoma or in stage 1.

Large intestine screenings were carried out in an additional three counties (Győr-Moson-Sopron, Nógrád, Heves) from budgetary funds.

The large intestine screenings will be subject to national expansion based on the findings of the pilot large intestine screening programs which rely on the examination of the fecal occult blood among 50-70-year-old women and men.

National Anti-cancer Program

For the soonest possible and permanent improvement of the unfavourable national conditions, the National Anti-cancer Program (launched in 2006 and reformed in 2014) set the target of decreasing the burdens caused by tumour diseases, lowering the disease and mortality indices and improving the patients' and their relatives' quality of life. It comprises an analysis of the epidemiological data of tumour diseases, a primary and secondary prevention strategy founded on these data; it gives an overview of the problems of national oncological care and makes a proposal for the necessary structural changes.

National Cancer Register

The regulatory framework of the National Cancer Register managed by the National Institute of Oncology rests on Act XLVII of 1997 on the Management and Protection of Healthcare

and Related Personal Data (hereinafter: Health Data Act) which stipulates that, in case a tumour disease is diagnosed, the patient caretaker supplies the patient's health and personal identification data to the National Cancer Register (kept in accordance with a special legal regulation).

The National Cancer Register manages a tripartite database (epidemiological, care-tumour and individual-specific) which:

- is expected to register new tumour patients (*incidence*) and the survivors once diagnosed with cancer (*prevalence*) (epidemiological);
- supplies information from a medico-technical aspect, concerning the quality of the individual therapies, their compliance with the technical protocols and the related survival (care-tumour-specific);
- permits the tracking of the individual's health condition (individual-specific).

National Screening Register

The National Screening Register, managed by the Office of the Chief Medical Officer of State, is in charge of monitoring each of the three modes of public health-focused organized public screenings (breast, large intestine and cervical screening), and assessing their performance and quality. The statutory connection of the national databases (National Health Insurance Fund, National Screening Register, National Cancer Register, Central Statistical Office) helps assess the effectiveness of screenings and have an accurate follow-up of client paths.

Information System of Mortality and Disease Indices(hereinafter: ISMDI)

Relying on the mortality and tumour disease indices and maps available in ISMDI, a detailed health picture can be drawn for each county, microregion and township. Moreover, the downloadable maps with a resolution down to settlements and (for tumour diseases) postal code facilitate an accurate analysis of the regional breakdown of diseases and deaths, as well as inequalities. ISMDI is unique and unprecedented in this regard. The epidemiological indices depicted in the maps can help make assumptions and raise questions that can underlie additional tests and targeted interventions. ISMDI is a tool promoting the targeted shrinkage of regional inequalities in health care. The primary users of ISMDI are the public health professionals working in the relevant fields.

The county and township offices made altogether 39 regional analyses on the health condition of the public until 2015. Based on the ISMDI indicators, the experts working in public healthcare management could get an overview of the inequalities in their competence area. The list of mortality indicators in ISMDI was extended with a new indicator by 2015, the death caused by Mesothelioma, moreover, the most recent subsystem of ISMDI was launched in the same year. This comprises the 3 key indicators in the data of the National Register of Congenital Abnormalities (hereinafter: NRCA). NRCA within ISMDI was accessible to users only as a pilot program in 2015.

III. Rescue

- **Purchase of ambulance cars and tools**

For the sake of solving the issue of the aged motor car park, nearly HUF 3bn funds were granted, which facilitated the purchase of 120 new ambulance cars (60 emergency ambulances/response units and 60 ambulance cars). The HUF 11.5bn funds granted in scheme 2.2.1. in the Social Infrastructure OP contribute to the purchase of 200 ambulance cars, alongside some other developments (construction of 22 new ambulance stations, launch of rescue service, renovation of 60 ambulance stations of poor technical condition). The HUF 175.5 million grant was used for the purchase of tools and instruments inevitable for the emergency service.

- **Construction and renovation of ambulance stations**

New ambulance stations were built in Pesthidegkút, BÉlapátfalva and Recsk. The local government supported the construction of new stations in Százhalombatta, Mór, Velence and Rákospalota. 14 ambulance stations were partly renovated from HUF 225 million in the Central Hungary region. Some emergency ambulances were reconditioned in Törökszentmiklós. HUF 167 million extra funds were appropriated in the 2013 budget of the National Ambulance Service for the capacity development of ambulance stations subject to structural change.

- **Other results in rescue**

HUF 15 million grant was offered both in 2012 and 2013 for the continuous provision of water rescue at lake Balaton in the summer high period.

With regard to air rescue, some high-value instruments were modernized and an ultrasound equipment (also available for pre-hospital purposes) was acquired from their own budget, from revenues in the foundation and from external sponsorship (MOL, Szerencsejáték Zrt.).

IV. Home nursing for disabled persons

The following are defined in Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (X. 20.): personal and objective conditions for disabled persons' dental care in anaesthesia; personal and objective conditions of parenteral nutrition at home; minimum conditions of institutional hospice-palliative outpatient care. The statutory conditions of funding are provided in Decree of the Minister of Human Capacities 55/2012 (XII. 28.).

The order and documentation of home nursing and hospice has become simpler and more transparent. According to the Decree of the Minister of Welfare No. 20/1996 (VII. 26.) on Home Nursing Activity, as well as the amendment of Government Decree No. 43 /1999 (III. 03.) and Government Decree No. 217/1997 (XII. 01.).

As an outcome of the cooperation with the social sector, the assessment of eligibility for higher family allowance has been simplified through the amendment of Decree of the Minister of Health, Social and Family Affairs No. 5/2003 (II. 19.). Appendix 1 of the Decree, in effect since April 2015, comprises a list of BNO codes which provides an obvious guideline for the specialists assessing eligibility.

The amendment of Decree of the Minister of Welfare No. 12/1991 (V. 18.) on the Health Conditions of the Holidaymaking and Camping of the Learning Youth simplified the issuance of a health certificate before the children's organized camping: a declaration completed by the parent or guardian shall be satisfactory.

V. Specialty care

A multi-stage codification and execution process (carried out in 2011-2013) led to strengthening state commitment. The first step therein comprised the review of the responsibilities of specialty care and the re-regulation of the healthcare responsibilities of the state, the county, the metropolitan and settlement-based local governments. Owing to the change of the Act on the Local Governments of Hungary only basic health care fell in the compulsory responsibilities of local governments as of 1 January 2012, considering that the Act permitted the option of stipulating the compulsory responsibilities of local governments in some other act. This led to the amendment of the Health Act which at present stipulates the responsibility for specialty care according to the following.

The responsibility of the owner or operator of the health care provider not owned or operated by the state or the local government (inc. e.g. parish operators) covers arrangements for performing the duty of public financed specialty care designated for the health care provider.

Concurrent with the transformation of the responsibility system, the take-over by the state of local government institutions offering inpatient specialty care was carried out continuously, in several stages between 1 January 2012 and 1 May 2012.

The process regulated in three acts led to the transfer of altogether 98 inpatient specialty care institutions to the ownership and operation of the state. Additionally, the property assets that had been owned by the local government before the take-over and had not been used by health care providers owned or operated by the local government to provide inpatient specialty care (taken over by the state) were transferred to state ownership on 1 May 2012. Similarly on 1 May 2012, the assets owned by the settlement-based local government and belonging to the health care institutions transferred to state ownership on 1 January 2012 were transferred to state ownership.

The assumption by the state of the debt and charges thereof of the county governments as of 30 December 2011 and of the debts and charges thereof incurred at the Metropolitan Municipality in connection with the institutions taken over and their responsibilities and effective as of 30 December 2011 was linked with the take-over of county hospitals by the state.

The take-over of hospitals by the state was followed by the transformation of hospitals (once functioning as business associations) into budgetary organizations, which resulted in 20 new budgetary organizations taking over the responsibilities of the 28 state-owned business associations as of 1 April 2013. The debts and debt-generating transactions of the business associations that could not be transferred to the new budgetary organizations along with the duty were compensated and terminated by the state in the course of the transformation process.

All this leads to conclude that the compulsory responsibilities of the county and settlement-based local governments concerning inpatient specialty care were discontinued. Still, both Act CLXXXIX of 2011 on Local Governments in Hungary and Act CXXXII of 2006 on the Development of the Healthcare System permit local governments to take over inpatient specialty care from the state, based on an agreement.

As concerns outpatient specialty care, Semmelweis Plan did not set any objectives for the reinforcement of public commitment. However, outpatient specialty care providers were transferred into state ownership and operation together with the inpatient institutions during state take-over.

Still, the state did not take over the independent outpatient clinics, so their operation and management still belongs to the responsibilities of the local governments acting as owner/operator, as part of their obligation to operate specialty healthcare institutions. However, if the local government fails to fulfil its obligation to operate specialty healthcare institutions, the specialty care duty becomes the specialty care-related obligation of the state after a two-stage process.

Definition of specialty care duty – progressivity levels, personal and objective minimum conditions

The Semmelweis Plan set the target of re-assessing the technical minimum conditions, the reorganization of the progressive and hierarchic system of inpatient specialty care and the full-scale enforcement of the principal of technical progressivity in the course of transforming the hospital system. Conformant with the Semmelweis Plan, yet another objective was the implementation of the principle of progressivity also in outpatient specialty care.

The technical minimum conditions underlying the provision of healthcare services were reviewed and updated for each profession with the involvement of the technical departments and councils of the new college system set up in May 2011, prior to the issuance of the new operating permits required on account of the re-allocation of the capacities and competence areas of inpatient institutions.

Health care providers offering inpatient specialty care and healthcare providers providing publicly financed outpatient specialty care and diagnostic services had to report their fulfilment of the pre-set new minimum conditions until July 2012 and late December 2012, respectively.

The capacities split up and healthcare areas designated for inpatient specialty care (as of 1 July 2012) were all defined in accordance with the statutory progressivity levels.

Definition of specialty care duty – specialty care capacities and healthcare areas

The Semmelweis Plan set the target of implementing needs-based capacity planning and correcting regional disproportions, by way of the gradual and local needs-conformant transformation and reform of the healthcare system.

In view of achieving the objective set out in the Semmelweis Plan and considering the take-over by the state of the specialty healthcare obligation, the inpatient specialty care capacities and related healthcare areas were reallocated under the law as of 1 July 2012.

Following the efficient conduct of procedures for capacity allocation and the designation of healthcare areas, the capacities in the various inpatient specialty care facilities are currently allocated as follows:

The specialty care institutional system – upkeep of specialty care providers

The take-over by the state of institutions providing inpatient specialty care called for reviewing the totality of the operator's responsibilities, given that the fulfilment of this responsibility was significantly heterogeneous in the previous system which was focused on maintenance by the local government. Due to the commitment of the state, the operator's rights had to be reasonably shared between the National Institute for Quality and Organizational Development in Healthcare and Medicine and the minister in charge of sectorial governance, moreover, with regard to tertiary level healthcare institutions, these providers' approximation to the care system required an expansion in the minister's power. These rules were approved after significant changes in the relevant part of the Health Act.

The specialty care institutional system – operating form and economic management of specialty care providers

Some of the hospitals that had been transferred to state property or operation in 2012 functioned as business associations at the time of the take-over. The inpatient specialty care providers operated by the state are expected to function under identical rules and in an identical organizational form, which serves the highly efficient exercise of operator's rights.

Patients in the specialty care system: managing patients' complaints

The National Centre for Patients' Rights and Documentation (hereinafter: OBDK) was established as of 1 September 2012. Its foundation was similarly a key pre-set objective in the Semmelweis Plan. Legal protection used to apply also in the frames of several organizations. Later, the integrated organization which retained the integration of legal protection duties in healthcare, social, child protection and child welfare issues and thereby preserved the benefits of this organizational form was established as an outcome of the administrative reorganization. Still, the patients' rights prioritized with regard to the operation of OBDK can be enforced even more efficiently in this organizational form.

The Semmelweis Plan described a principle (concerning patients' rights and built not essentially on the normative scheme) which primarily prefers the removal of communication borders, the mediatory activity and a solution using the available resources.

Heart transplantation on GUCH patients: Decree of the Minister of Welfare No. 9/1993 (IV. 02.), Act CLIV of 1997 and the amendment of Decree of the Minister of Health No. 18/1998 (XII. 27.) led to ensuring the statutory background for executing the heart transplantation of Grown-Ups with Congenital Heart defects (GUCH) also in Gottsegen György Hungarian Institute of Cardiology.

Contracting with Eurotransplant

The Hungarian National Blood Transfusion Service reached a preliminary cooperation agreement with Eurotransplant on 3 November 2011. Later, from 1 July 2013 we joined the international organization as a full-fledged member. There was a considerable increase in the number of organ transplantations, which facilitated greater access for patients in need of transplantation.

Mutual donation has been identified in the law since 2014, which helped increase the number of live donor organ transplantations, based on “mutual” organ donation.

VI. Protection of pregnant women, children and adolescents: general introduction on district nurses, National Strategies and action plans

As regards the protection of pregnant women, children and adolescents, see also the above information about the district nurse system as a special Hungarian phenomenon.

Decree of the Minister of Human Capacities No. 26/2014 (IV. 08.) on Prenatal Care entered into force in Hungary in 2014. In purview of this Decree, prenatal care means a complex service rested on cooperation among the district nurse, the GP, the obstetrician and gynaecologist, the MIDWIFE if chosen by the pregnant woman (new element!) and the pregnant woman. A midwife may provide prenatal care only in the case of low-risk pregnancy (diagnosed by the specialist for obstetrics and gynaecology), upon the concurrent fulfilment of the conditions under the Decree.

- **Periconceptional care – positive (conscious family planning)**

A program managed by the National Institute of Pharmacy and Nutrition (hereinafter: NIPN) and presently the National Institute for Health Promotion (hereinafter: NIHP) (a successor of NIPN) since 1995.

The population in Hungary has seen a distressing decrease (the so-called total fertility rate is 1.4 in Hungary). High quality “positive family planning” (aimed at ensuring the most healthy years of age, protecting the desired pregnancy and preventing premature delivery and congenital disorders) is especially revalorized in such circumstances.

Congenital disorders cause 25 % of infant mortality in developed countries. They make up 3-6 % and premature delivery 9 % in Hungary, which is by far above the European average. These children's and their families' chance for a healthy, full, socially equivalent life is rather rare. The treatment of these children who start their life with such a handicap takes a lengthy time and puts major burden on their families and the patients alike. Consequently, further negative sequels and mental disorders (depression, anguish etc.) may develop. Quite often they need lifelong health care, still, full recovery cannot be achieved in most of the cases because, despite the highly costly treatments accompanied by suffering, the clinical pictures generally refer to a defect condition. The creation of equal opportunities at the start of life poses key responsibility on health care (it is of public health importance). The efficient primary prevention of later-manifesting diseases that call for a frequent and major cause of death can also be carried out only with care at around but mainly preceding the time of conception.

This means that so-called conscious, positive family planning is an efficient tool for the prevention of premature delivery and congenital disorders. Their risk can be lowered by 40-50 % with the above method.

The positive family planning model offers a chance for healthy condition before having children. This similarly applies in the case of the mother's diseases that escalate the specific risk (obesity, diabetes, depression, anguish) and affect 20-25 % of those planning to have a

family. The individual-tailored family planning model presents a good chance for the families to give birth to a healthy baby and not to hand down the weighty burdens, thereby achieving the harmonic life and mental health of the entire family.

The family planning program is based on a standard procedure. It is managed as a model program and a draft guideline has already been made for its dissemination as a national network(*Technical draft guideline on pre and periconceptual care, 2011*).

- **Multidisciplinary teenager ambulance**

A model program run by the National Institute of Pharmacy and Nutrition and then the National Institute for Health Promotion. The objective of the multidisciplinary teenager ambulance is to mitigate the risks of adolescence as a vulnerable life cycle. Considering conventional disease indices adolescents are the “healthiest”, however, mortality figures reveal that accidents, intoxications and suicides reach an outstandingly high ratio in their case. The adolescents' lifestyle-related problems and the key causes of death in their age especially raise the importance of prevention and psycho-education, which is faintly or hardly available in the current care system.

The multidisciplinary teenager ambulance is fit to the teenagers' special needs: among others, preventive consultations and education considering the individual needs can be held for the adolescents.

As a part of education for family and sexual life, developing the understanding of positive and conscious family planning can lay the foundations for the future families' and their children's welfare and health. A supporting tool can be the training of experts specialized in this age group (train the trainers).

- **tinivagyok.hu website**

Daily updated website for teenagers and those dealing with teenagers, mainly focusing on topics related to health, health care and lifestyle. Its popularity ratings have been increasing since its foundation (in 2011), now it needs a reform.

National Strategies and action plans:

- **“Child is Our Common Treasure” National Infant and Juvenile Healthcare Program**

For the lack of continued financing, the program died away. Some parts have not yet been implemented.

- **Data collection in Neonatal Intensive Centres (hereinafter: NIC)**

Data collection, now in its 11th year, is aimed at offering an objective background to the objective and personal development of professional work, in order to improve the life chances of premature babies and new-borns in need of intensive care. The up-to-date findings of the database highlight that massively different medication methods, habits and practices are used in Neonatal Intensive Centres, and considerable differences are found in the data referring to mortality and complications. The key objective in the short and medium run is that the

difference in medication methods and results achieved should be narrowed among Hungarian Neonatal Intensive Centres.

VII. Nutrition policy

National Survey on Nutrition and Nourishment Conditions 2014 (OTÁP2014) by the National Institute for Food and Nutrition Science

The objective of the OTÁP2014 survey is to get an insight into the nutritional habits of the grown-up population, define the occurrence in Hungary of overweight, under-nutrition and abdominal obesity from a nationally representative sample and through repeated measurements, and track changes in time, based on a comparison with the results of the 2009 OTÁP survey. As proven after the 2009 survey, all this information can contribute to taking the necessary measures and interventions and thereby to improving the health condition of the public.

Nutrition

Based on a flash report of the survey, two thirds (66.8 %) of the Hungarian population above the age of 15 ate some vegetable or fruit on a daily basis, which means a noteworthy decrease versus 75.5 % in 2009. The daily intake of vegetables or fruits got more and more frequent with age. A bigger proportion of young and middle-aged women than men of the corresponding age eat vegetable or fruit every day, but this difference vanishes by the elderly age when almost 80% of both men and women eat vegetable or fruit daily.

Distribution of vegetable and fruit intake by age groups and sexes

<i>Fruit and vegetable consumption (%)</i>	<i>Women</i>			<i>Men</i>			<i>Total</i>		
	18-34	35-64	65+	18-34	35-64	65+	18-34	35-64	65+
<i>Daily</i>	62.9	72.2	79.7	57.1	59.0	77.9	59.9	65.8	79.0
<i>Weekly</i>	33.6	24.8	18.0	36.1	35.2	18.5	34.9	29.8	18.2
<i>More rarely or never</i>	3.5	3.0	2.2	6.8	5.8	3.6	5.2	4.3	2.7

Health and health behaviour in school age – 2014

National report on the 2014 survey of The Health Behaviour of School-aged Children, an international research in collaboration with the World Health Organization

Okostányér (*Clever plate*)

New Hungarian nutritional recommendation. Hungarian National Dietetic Association, Scientific Committee for Food Science of the Hungarian Academy of Sciences, 2016

Tétplatform újakezdés *Bet platform restart 2016.*

- Expanding information about healthy nutrition.
- Fighting against disbeliefs related to nutrition and food products.
- Providing an authentic, reliable and authoritative source with regard to healthy lifestyle.
- Assisting the media in the fields of healthy nutrition and lifestyle.
- Supporting everyday (inc. workplace) physical activity.
- Assisting the development of food products in support of health-conscious nutrition.
- Facilitating self-control in the promotion and distribution of food products.

Children's Health Program (GYERE)

The Hungarian National Dietetic Association launched its three-year project aimed at the prevention of childhood obesity under the title GYERE Children's Health Program in Dunaharaszti in autumn 2014 and in Szerencs from September 2015, in the framework of the national program of EPODE⁹, the world's biggest network for the prevention of obesity.

Food industry for consumers' health – let's act for it together

Resorting to the tools of self-control, the National Society of Food Processors (hereinafter: NSFP) defined commitments that can contribute to the Hungarian consumers' multifarious and balanced nutrition, the improvement of their health condition, can encourage them to live an active life and can also help improve the public health indices.

The joining companies make a report on the progress of their commitment to NSFP once a year, until 15 September. NSFP reports on the fulfilment of the preceding year's commitments for its members and the public at least once a year, in the spring general assembly or any other public event. NSFP makes a written report for the competent ministries, institutes and other sponsors at least once a year.

Social Renewal Operative Programs JANPA – Joint Action on Nutrition and Physical Activity, JANPA

The overall aim of the EU project is to contribute to halting the rise of overweight and obesity in children and adolescents in EU Member States by 2020. Altogether 26 countries joined JANPA as partners: 25 of the 28 EU Member States and Norway. The National Institute of Pharmacy and Nutrition is the leader of Work Package 6 in the project, aimed at creating healthier environments in kindergartens and schools, primarily through nutritional and physical activity policies targeted at children and teenagers.

“My healthy family” program

“My healthy family” is an EU pilot project to propagate and increase fruit and vegetable intake from pregnancy to retirement. The project was implemented in two regions in Hungary in 2014-2015.

The pilot project is an initiative of an experimental nature designed to test the feasibility and usefulness of action. It is meant to try different approaches to address a problem and to identify the procedures that can be for the benefit of possible future initiatives, in the area of nutrition and physical activity in this case.

The contract between the European Commission and ProPager rests on this approach, it provides the necessary competence for implementation for the constructors and local sponsor organizations. A board of scientific experts has been set up from a variety of disciplines to provide robust guidelines for the project intervention and validate its methodological tools.

VIII. Prevention of accidents to children

Some external cause of death was the leading cause of death in the 10-14 and 15-19-year-old age groups in Hungary in 2013. 132 young people died in an accident in 2013. It is a fact,

⁹ Preventing childhood obesity

nonetheless, that mortality and injury due to traffic accidents decreased in both the 0-17 and 18-24-year-old age groups between 2006 and 2013. The number of intoxication cases rose between 2008 and 2013.

As regards non-fatal accidents, 59.4 % of students declared in the most recent (2014) data collection for the Health Behaviour in School-aged Children (HBSC) survey that they had not been injured so much as to need medical treatment in the past 12 months. Data collection in 2010 recorded a mere 32.3 % of those injured at least once, whereas the current figure reflects a 40.6 % increase. Nevertheless, as regards the frequency of accidents, Hungary is in the bottom third in each age group from among the 42 countries joining the HBSC survey.

IX. Prevention of child abuse

Continuous operation of a website focusing on child abuse.

The technical guideline (“On healthcare providers' responsibilities upon the suspicion of child abuse and neglect”) was made with our experts' coordination and cooperation.

X. Competence of Drug Focus Point

Key treatment priorities in the national drug strategy

As regards drug users' care, the establishment of a generally accessible institutional system that can support the children's and young persons' care, meet the actual needs and have a national coverage was identified among the specific objectives of the National Anti-drug Strategy 2013-2020 (hereinafter: Strategy). The Strategy sets the target of having at least 20 % of problematic drug users and drug addicts in care and, in general, improving the accessibility and national coverage of the institutional system (which facilitates the addicts' health and social care) and having by 2020 a coordinated, complex care system in each township that can use common operating indicators, active search and take-in-care techniques. Yet another priority in treatment and care is that minimum 80 % of healthcare and social service providers shall perform their activities according to the relevant professional guidelines and every provider shall be subject to regular clinical or social institutional quality assurance audit.

The Strategy formulates so-called care-organizational principles comprising the interdependence of care through services in various specialty fields, coordination between the technical content and regional coverage of services, transparent patient paths among the individual care types that cross institutional borders and the prevention, management and follow-up of clients' mistaken path.

In treatment and care, the Strategy similarly identifies the recovery-focused approach as a baseline: this is aimed at improving and recovering the client's health condition, as well as promoting reintegration in society. The Strategy takes low-threshold care as the first station in the care chain as, together with the search activity, it can help to find the lurking drug users and take them in treatment and care, and can also help in the prevention, screening and mitigated spread of infectious diseases.

XI. Effective prevention of injuries

According to the 2014 mortality data of the Central Statistical Office the external reasons for morbidity and mortality cause 5 % of total mortality among men and, as such, are the third most frequent causes of death after circulatory diseases and tumours. Among women, injuries made up 3 % of total mortality in 2014 and were the fifth most frequent causes of women's death. In international comparison the Hungarian mortality rates due to injuries are 1.5-fold higher than in the EU Member States.

Injuries (accident and violence) are the most frequent causes of death among the 10-19-year-old persons. 132 children lost their lives due to some injury in Hungary in 2013. The most frequent types of fatal injuries are mis-swallowing and choking for the less than 5-year-old and traffic accidents for those above 5 years of age (Office of the Chief Medical Officer of State, 2015).

The chapter “Life and practice” in the National Core Curriculum developed in 2012 describes the elements of safety education by age groups and particularizes the prevention of domestic and traffic accidents, hazard recognition and first aid.

The study made by the National Institute for Health Promotion in 2013 (“Interventions for the community-level prevention of injuries and accidents”) was aimed at collecting and assessing efficient (by international experience) experience, descriptions and interventions for the prevention of injuries and accidents, based on the transformation of the artificial and social environment and, on that basis, formulating recommendations for accident prevention.

With regard to serious road accidents, several international surveys were made in the frames of FERSI¹⁰ and the Safety Cube project in 2015. Hungary was represented there by the Institute for Transport Sciences.

The Global Status Report on Road Safety by WHO, which gives an overall picture of traffic safety and the legal background in Hungary, was published in autumn 2015. The experts of the World Health Organization (WHO), the Ministry of Human Capacities, the National Institute for Health Promotion, the National Police Headquarters in Budapest, the Central Statistical Office, the Institute for Transport Services and the Hungarian Association of GRSP¹¹ were involved in making the Report.

WHO experts held a TEACH-VIP (Capacity development for the prevention of childhood injuries) training in Budapest on 12-13 October 2015, in a 1.5-day training on “*Capacity development for the prevention of childhood injuries and battery – train the trainers*”, which was held for experts in injury and battery prevention jointly by the European Regional Office and the Hungarian Office of WHO. The aim of the training session was to support national efforts for capacity development in injury prevention, with special regard to the prevention of childhood injuries and childhood maltreatment.

The WHO Eighth network meeting of national technical focal points on violence and injury prevention was held in Moldova in autumn 2015. There Hungary was represented by an

¹⁰ The Forum of European Road Safety Research Institutes

¹¹ global road safety partnership

expert from the National Institute for Health Promotion. The Hungarian participant presented the Hungarian experience in making the Global Status Report on Road Safety in the meeting.

XII. Field of health promotion

1. Development of the prevention capacity of the healthcare system – Establishment of health promotion offices

61 health promotion offices (hereinafter: HPO) were established and commenced their activity in Hungary in 2013 and during 2014 for supporting the prevention capacity of the healthcare system, in the frames of EU development. From among the offices established, 20 are in most disadvantaged and 18 in disadvantaged townships.

The fundamental objective of the setting up of such offices constituting one of the bases of the public health organisational structure is to contribute to decreasing the number of cardiovascular and tumour diseases, reducing early and avoidable mortality and to improve the ways of life that determine health quality, as well as the attitudes and habits having an impact on health behaviour. Increasing health awareness in the public.

The HPOs coordinate the health promotion programs of the township, function as a liaison between basic health care, out-patient specialty care (independent or integrated with in-patient care) and the entities implementing health promotion programs. The persons transferred from the GP's service, the outpatient clinic or after inpatient specialty care to the health promotion offices and requiring a change in their lifestyle or the persons initiating to change their lifestyle on their own are enrolled primarily in screenings for the prevention of the risk of circulatory diseases and, based on risk assessment, in lifestyle changing programs, and their participation in the programs is followed up.

In summary, the activities of HPOs cover 3 main areas:

- Individual client status examination and risk assessment, and related individual counselling;
- Implementation of lifestyle changing programs and community-level health education and health promotion programs in various stages (settlement, workplace and school sites);
- Follow-up of health promotion activities in the HPO township, improvement of cooperation among organizations specialized in health promotion, networking of organizations.

Their operation resulted in the establishment of a network of efficient organizations that can meet the requirements of health promotion, are flexible in partnership cooperation and follow an up-to-date approach.

170,927 clients' health status was examined in the 61 HPOs since September 2013, including 46,569 clients in the 20 most disadvantaged HPOs. The HPOs implemented altogether 2,865 community-based health education and health promotion programs, and accessed 87,215 persons with their physical activity programs in the project period. The HPOs accessed 87,215 persons with their physical activity programs in the project period. These programs proved to be the most popular and helped access the most clients. 73,037 persons filled in the AUDIT

10 questionnaire (estimating alcohol drinking habits) in the project period and 1,192 destructive drinkers were filtered out.

2. Suppression of smoking

Smoking is a serious issue in relation to public health and national economy in Hungary. Over twenty thousand die in smoking every year. Smoking is the most important behaviour-related cause of death in Hungary in the beginning of the 21st century. Smoking causes nearly one third of early mortality (below the age of 65). Over one third of this is attributable to lung cancer and nearly a quarter to cardiovascular diseases. A smoker's risk of death is three times bigger than a non-smoker's

The rate of adult smokers decreased in most OECD countries in the past two decades. The rate of daily smoking adults also decreased in Hungary, from 30.2 % in 2000 to 26.5 % in 2012, which still exceeds the OECD average (20.7 % in 2012).

According to the 2014 data of the European Health Interview Survey¹² (EHIS) 29 % of the adult population smokes, versus the 31 % ratio in 2009. There is major difference between the smoking habits of the two sexes, and it has slightly increased versus 2009: less than a quarter of women but one third of men belong to the group of frequent smokers.

In the 15-17-year-old age group 14 % of girls, but almost a quarter of boys in this age group were smokers.

Electronic cigarettes and electronic smoking-imitation devices are gaining popularity, still, these products are dangerous to health and their consumption is proven to pose a high risk. The suppression of smoking is one of the most efficient public health interventions wherein the prevention of habituation and the support of cessation both play a role.

Measures in 2012

Believed to be a milestone in Hungary, the Parliament decided for the amendment of Act XLII of 1999 on the Protection of Non-smokers and Certain Regulations on the Consumption and Distribution of Tobacco Products with an outstandingly high (84 %) majority on 26 April 2011. Accordingly, smoking is as a general rule prohibited in enclosed public areas and community areas from 1 January 2012. The public opinion polls and audits lead to conclude that the social acceptance of the amendment of the law is high (85 %) and is acceptably obeyed.

Owing to the amendment of the law Hungary joined the countries executing one of the most up-to-date anti-smoking regulations in Europe, and with that they meet the health political and technical expectations and recommendations of the EU and WHO.

Following the amendment of the Non-smoking Act the average concentration of indoor air pollution (mainly attributable to tobacco smoke) dropped by 90 % in entertainment venues and catering facilities. Based on the findings of the European public health survey in 2014, further major improvement is seen in exposure to passive smoking, versus the 2009 figures.

¹²<http://www.ksh.hu/docs/hun/xftp/stattukor/elef14.pdf>

In October 2012 the National Methodological Centre for Smoking Cessation Aid was set up within the Korányi National Institute for Tuberculosis and Pulmonology. The project was launched on 1 October 2012 and lasted 18 months; the upkeep period is still ongoing.

Key tasks:

- tasks related to the process, characteristics and methodology of smoking cessation;
- organizing extension trainings for experts who work in pulmonary centres and for GPs;
- in the frames of a call centre for supporting cessation, accessible on a toll-free number (06-80-44-20-44), trained psychologists and physicians supply information and give advice to questions concerning smoking and abandonment. Using the green number, the physicians and psychologists also hold abandonment support programs;
- internet website (www.leszokaspont.hu) facilitating wide-ranging public communication;
- continuous contact with pulmonary centres. The regular data supply from these centres helps keep track of smoking cessation.

Focal Point for Tobacco Control

Through the ratification of the WHO Framework Convention on Tobacco Control, Hungary agreed among others to establish and operate a Focal Point for Tobacco Control which was actually established in 2005. The Focal Point for Tobacco Control was continuously in function in this reporting period.

Smoking surveys

The Global Youth Tobacco Survey (GYTS) was completed under the coordination of the Focal Point for Tobacco Control.

A smoking survey was carried out with the technical management of the Focal Point for Tobacco Control of the National Institute for Health Promotion, to survey actual smoking prevalence in 2012¹³. It was made with the representative sample of the Hungarian population (above 18 years of age), based on a methodology and questionnaire prepared by WHO and the American CDC (GATS = Global Adult Tobacco Survey). The primary objective of the survey was to assess the frequency and characteristics of smoking among the adult population.

Measures in 2013

The majority of tobacco products¹⁴ may only be marketed in a packaging holding photos, illustrations and health protection warnings as of 1 January 2013.

Tobacco products may only be sold in special controlled shops, national tobacco shops as of 1 July 2013.

86 pulmonary centres held group consulting sessions for smoking cessation from December 2013 to 2015, similarly with EU support. Pulmonary centres are obliged to manage the support of individual cessation (to the debit of the central budget), and they also hold local professional and public communication.

Both the local-tariff blue number 06-40-200-493 and the website leteszemacigit.hu are visible

¹³ Adult Tobacco Survey, 2012

http://www.fokuszpont.dohanyzasviszszaszoritasa.hu/sites/default/files/17_evnel_idosebb_lakossag_dohanyzas_felmeres_honlapra_20131009.pdf

¹⁴exc. tobacco products for sneezing, “snuff”

on the packaging of tobacco products, in 6 of the 42 warning notices with pictures, as well as in the text of the notices and signs designating the places subject to smoking restrictions (under the law) or designated for smoking. The service has two functions on the phone: it supplies information to support cessation and is intended to record any observations regarding compliance with the law. The website leteszemacigit.hu gives information in the field of cessation.

The Global Youth Tobacco Survey was also held in 2013¹⁵ under the coordination of the Focal Point for Tobacco Control, and a smoking survey among adults (above 18 years of age) was also held with their professional management¹⁶. The primary objective of the survey was to assess the frequency and characteristics of smoking in the adult population.

Measures in 2014

The places, premises and public areas subject to smoking restrictions and designated for smoking must be labelled with an eye-catching method, using a uniform notice and sign of pre-defined content and form as of 1 March 2014.

The European Parliament and the Council issued their Directive 2014/40/EU Concerning the Manufacture, Presentation and Sale of Tobacco and Related Products on 3 April 2014.

Hungary sits in each of the European Union Committees and Subcommittees set up for the suppression of smoking and is a member of the task forces and expert groups. The Hungarian experts had an active role in the development and agreement of the new Tobacco Directive (2014/40/EU) and in the preparation of committee decisions for its implementation.

Tobacco Smoke-free Hungary Case Study¹⁷

The Focal Point for Tobacco Control of the National Institute for Health Promotion made a case study with WHO support on the impact assessment of the amendment of the act on the protection of non-smokers, under the title “Tobacco Smoke-free Hungary”¹⁸.

The objective of the case study is to present the measures that can effectively promote the suppression of smoking and have been introduced in recent years. The introduction of this many measures in such a short time is unique even among the State Parties in WHO FCTC and the Member States of the European Union.

Measures in 2015

The relevant legal regulations have been amended for meeting the obligation of law approximation.

The definitions of tobacco product, smoking, combined health protection warning and collective package have been clarified in the law approximation process. In view of the non-smokers' protection, it is stipulated now that the labelling of the packaging unit and the collective packages shall not include any deceiving information, and the health protection

¹⁵ Focal Point for Tobacco Control in the National Institute for Health Promotion Global Youth Tobacco Survey, 2013

<http://www.fokuszpont.dohanyzasvisszaszoritasa.hu/hu/content/hazai-es-kulfoldi-adatok-tanulmanyok>

¹⁶ Adult Tobacco Survey, 2013

http://www.fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/17_evnel_idosebb_lakossag_dohanyzas_f_elmeres_II_honlapra_20140128_v2.pdf

¹⁷ <http://www.euro.who.int/en/countries/france/publications3/tobacco-control-in-practice/Section-8-protection-from-exposure-to-tobacco-smoke-the-story-of-hungary>

¹⁸ <http://www.fokuszpont.dohanyzasvisszaszoritasa.hu/hu/content/hazai-es-kulfoldi-adatok-tanulmanyok>

warnings have been enlarged. Moreover, the prohibition of the distance selling of tobacco products has been laid down.

The amendment of the implementing decree to the act on the protection of non-smokers led to introducing the standard packaging in Hungary, moreover, the consumption, distribution and use of electronic cigarette, refill container and electronic smoking-imitation device has also been built in the regulations.

The law approximation of the directive and its implementing decisions is ongoing through the amendment of the relevant legal regulations. This process is expected to last until 20 May 2020, however, most of the amendments to the legal regulations entered into legal force on 20 May 2016.

The measures introduced in the frames of law approximation are expected to further prompt cessation and help prevent smoking habituation.

Communication activities completed in recent years: annually regular communication in the form of press conference and press review on the occasion of the Don't Smoke World Day or World No Tobacco Day.

Price and tax measures: tobacco products have in recent years been subject to multiple tax increase. The most recent measure was taken in April 2015. The Office of the Chief Medical Officer of State is continually controlling the observation of smoking restrictions and prohibitions.

Additionally, smoking prevention programs have been continually running in kindergartens and schools in the relevant period (Kindergarten Program for Smoking Prevention by the Focal Point for Tobacco Control, "Uncool cig" school program).

3. Suppression of excess alcohol consumption

Alcohol consumption in Hungary has been high on the global scale for decades now. The consumption figures in the 80s (over 13 litres of clean alcohol/person/year) somewhat dropped in the 90s and stabilized at around 11-12 litres after 2000, but then began to increase again.

Considering EU Member States only, Hungary takes the 5th place in alcohol consumption (total consumption) with its volume of 14.15 litres/person (OEFI-OAC, 2013). According to the data base of WHO HFA the consumption of clean alcohol was 10.88 litre per capita in 2013, and with this figure Hungary is ranked to the 8th place among the EU Member States.

Measures in 2012

The prevention of drug and excess alcohol consumption ranked among the main supported activities of the call for tenders ("Health education and awareness raising lifestyle programs – local scenes") (Social Renewal OP, TÁMOP-6.1.2./11/1) in support of programs in local scenes.

Measures in 2012-2015

A technical methodological document (“Alcohol mini protocol for health promotion offices”) was made in the Public Healthcare subproject of the TÁMOP 6.1.1 – 12/1-2013-0001 project (Social Renewal OP) (Establishment of a Professional Network for Health Promotion) implemented in the Institute for Health Promotion. Some scene-specific model programs for the prevention of alcohol consumption (designed for school, community and workplace scenes) were similarly developed within the above project. These are aimed at promoting the local implementation of health promotion programs for the prevention of alcohol consumption, in the individual scenes. The final documents delivered to the health promotion offices are accessible on <http://szh.egeszseg.hu/#efiwelcome> website.

Measures in 2014-2015

On behalf of Hungary, the National Centre for Addictology in the National Institute for Health Promotion takes part in the international project RARHA (Joint Action for Reducing Alcohol Related Harm). Its main target is to reduce alcohol-related harms, in conformity with the EU strategy. The results are expected to be available by late 2016.

4. Extending physical activity in the public

Scientific researches have proven that a physically active lifestyle can help preserve health, prevent diseases and mitigate their risk in non-infectious chronic diseases.¹⁹ According to WHO the lack of physical activity is the 4th leading risk factor in global mortality (6 %). Regular physical activity cuts back the occurrence of depression and anxiety symptoms and is an effective tool in preventing the development of mood disorders.²⁰

Measures in 2012

Providing a complete regulation on health promotion in schools, through the approval of Decree of the Minister of Human Capacities No. 20/2012 (of 31.08.) on the Operation of Educational Institutions and the Use of Names in Public Educational Institutions.

The amendment in 2011 of the Health Act stipulates the introduction of full-scale health promotion in schools. The tasks linked with the protection of the child's and student's health and safety, and the rules pertaining to those participating in the tasks in the educational institution were all stipulated in Chapter X of the Decree, based on the statutory authorization. In purview of Section 128 (3) of the Decree and with reference to the child's and student's right to health and safety, special attention shall be paid to the tasks related to comprehensive health promotion (covering among others the fields of everyday physical education and physical activity) in the everyday operation of the educational institution.

Measures in 2013

The Hungarian School Sport Federation launched its key project T.E.S.I.²¹ (Social Renewal OP, TÁMOP-3.1.13-12-2013-0001) in May 2013. One of the research and development-oriented tasks of the project was to set up a health-focused fitness measurement and assessment system that can be coherently used in the Hungarian school system. The new physical fitness measurement system taking effect from the 2014/2015 school year is the National Uniform Student Fitness Test (NUSFIT).

¹⁹ Kruk, J. [2007]: Physical activity in the prevention of the most frequent chronic diseases: an analysis of the recent evidence. Asian Pacific Journal of Cancer Prevention, Vol. 8. No. 3. pp. 325-338

²⁰ https://dea.lib.unideb.hu/dea/bitstream/handle/2437/132063/Petrika_Erzsebet_Ertekeztes-t.pdf?sequence=5

²¹ “Establishing the new strategy for physical education and a new system for measuring physical condition, and encouraging voluntary participation in the organisation of complex physical activity programs in schools”

The school teacher for physical education fulfils the tasks related to measuring the students' physical condition and fitness. The aim of measuring the students' physical fitness is to promote the preservation, betterment and maintenance of the students' health and to track the students' health condition by showing the students' physical fitness level.

An additional purpose of the project is to develop a physical education strategy for schools until 2020 and to render practical and methodological support to teachers (in the form of printed and audiovisual publications) in order to offer high quality physical education.

The compulsory responsibilities of the Health Promotion Offices include the organization and arrangement of programs prompting the adult population to do regular physical activity.

Measures in 2014

An intersectorial HEPA²² task force has been in function since the end of 2014 in cooperation with the Secretariat of State for Sport and with the involvement of the competent sectors and experts, to coordinate the national and international tasks related to physical activities for health protection.

Measures in 2015

The objective of the Social Renewal OP project (TÁMOP-6.1.2.A-14/1) implemented with HUF 3.59 bn support from European Union funds in 2015 was to develop the competences of elementary school students for living a health-conscious life, by way of implementing community building, health promotion and physical activity programs, as well as to expand the knowledge and proficiency and shape the attitude of the professionals taking part in the implementation of the programs, on a methodological basis elaborated in the framework of the program. The program incorporated the implementation of county-level leisure time community programs built on cooperation among schools (“Heptathlons”) and complex physical activity and health promotion programs. 30,903 students (inc. at least 9,271 disadvantaged students) were enrolled in 288 public education institutions, with the participation of 1,061 assisting professionals (926 teachers, 73 district nurses, 55 county coordinators, 7 regional coordinators). The head of each institution declared that at least 30 % of the enrolled students belong to the category of either disadvantaged or multiple disadvantaged.

A full-scale concept on health promotion in schools was made for the decision-makers; a recommendation (to assist the teachers in their work) and EPSZA^[3] booklets were made for teachers.

In addition to the above, the importance of regular physical activity was emphasized in a number of events (e.g. Lifestyle campaign for pensioners – Move, Granny (2012); “Stairs are an option. Take the first step”, “Heart-shaped walking and jogging for health, because health matters” (2013); Night of physical activities (2014, 2015); “To your health. Instead of rat race” workplace campaign; Follow the track of health).

²² Health enhancing physical activity.

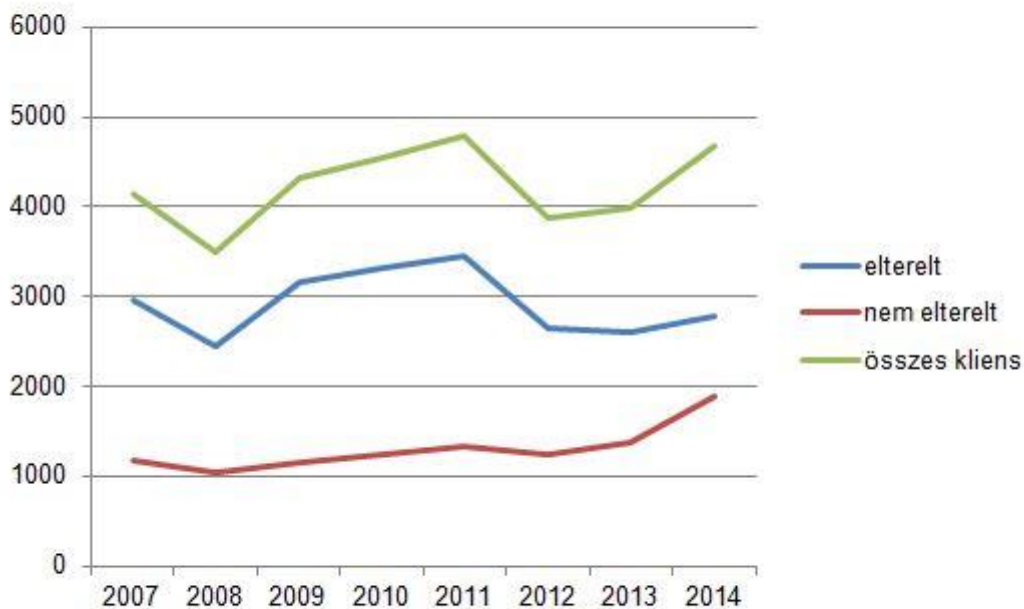
^[3] 10 technical recommendations linked to the program elements for health promotion.

3) KEY DATA AND STATISTICS

I. Competence of Drug Focus Point

The drug users' main reason for being subjected to treatment is the elusion of criminal proceedings (distraction). Any change in the conditions of and accessibility to distraction and the activities of the drug policing units all influence the annual trend in the total number of treatment starters. Regarding all the clients (4,688 persons) 60 % (2,788 persons) was the ratio of those being subjected to treatment through distraction in 2014.

Az elterelt, nem elterelt, valamint az összes kezelésbe lépő kliens számának alakulása, 2007-2014 (fő)



**Forrás: TDI adatgyűjtés 2015
Nemzeti Drog Fókuszpont – Éves Jelentés 2015**

Outpatient service providers

Funding categories relevant to the drug users' outpatient care:

- health care:
 - outpatient care in addictology
 - paediatric and youth care in addictology
 - outpatient care in psychiatry
 - paediatric and youth care in psychiatry
- social care – based on Act III of 1993 on Social Governance and Social Benefits (hereinafter: Social Act):
 - low-threshold care for addicts

- care for community addicts
- day care for addicts

Additionally, the service for prevention and awareness raising as an alternative of criminal proceedings is financed from special (similarly social) resources.

This means that there are some care facilities mainly with healthcare profile. Such are the addictology centres in hospitals and addictology clinics, the psychiatric centres and clinics, and some of the drug ambulances which typically function as a part of an institution supported by the state/local government. There are also care facilities with social profile. They are financed from the social budget only, and the operator is typically a non-governmental or ecclesiastic organization in their case. The care facilities with mixed profile are financed from both budgets. Such are the drug ambulances typically run by NGOs (Péterfi 2015).

No accurate figures are available on the number of care facilities actually caring for drug users, as the drug users' health care is split into major groups. Some data are available from the TDI data collection which has a good coverage in outpatient care, based on the professionals' estimations. These data are presented in the tables below.

Outpatient care providers (number of treatment units in 2014)

	number of treatment units	definition (types of treatment units)
drug ambulances, other specialized drug patient clinics	41	Service providers that identify themselves as outpatient treatment units (inc. drug ambulance, addictology centre or other care facility) in the TDI data collection (typically, drug ambulances, addictology centres and clinics, and other treatment units targeted at drug patients and offering health care or preventive and awareness raising services). Approximately 20 % of these providers offer opioid substitution therapy.
low-threshold providers ²³	22	Service providers that identify themselves as low-threshold/drop-in/search treatment units in the TDI data collection (typically, providers offering psychosocial care).
general / mental healthcare providers	6	Service providers that identify themselves as outpatient treatment units (and therein as psychiatric units) in the TDI data collection (psychiatric centres and clinics in hospitals and polyclinics).
treatment units in law enforcement	7	Institutions also reporting on care for detainees in the TDI data collection (penal institutes and third party service providers caring for detainees). The units offering outpatient and hospitalized care are shown in a cumulated form in this table.

Source: TDI data collection 2015

²³ and other treatment units basically with a social profile

Additional aspects of outpatient care – distraction

In the case of certain criminal offences related with drugs the perpetrator has the possibility to avoid the normal criminal proceedings, the prosecution as well as the judicial proceedings if he takes part in treatment/preventive interventions lasting for definite duration, provided he meets the below conditions:

- he grows, produces, obtains, keeps or consumes a minor volume of drugs for his own use;
- he admits to have committed the criminal act;
- his criminal liability was not stated in connection with the possession of or trade in drugs in the two preceding years;
- he was not involved in distraction in the two preceding years. (Section 180 of Act C of 2012 on the Criminal Code)

Pursuant to the Section 180 (1) of the Criminal Code, if the conjunctive criteria are met, the investigative authority, the prosecutor or the court of justice terminates the ongoing proceeding with its decision.

On the basis of the provisions of the act it can be concluded that the termination of criminality of the offender can occur if all conjunctive criteria are met, what however does not affect the prosecution thus the offender cannot avoid proceedings. The prosecution starts against the offender but if the criteria set in Section 180 of the Criminal Code are met he/she cannot be punished for the alleged plot. On the other hand, for avoiding the punishment the offender has to prove with documentary evidence that he/she has been subject to drug addictology treatment, drug users' outpatient care or took part in preventive-informative service for at least 6 months.

Those opting for distraction are referred to preventive and awareness raising service (hereinafter: PAS) (which is rather considered a recommended preventive intervention) or care²⁴ on the basis of a preliminary status test made by the psychiatric specialist or the clinical psychologist. The duration of treatment interventions is not fixed, providers offer them in the frames of drug management programs for classical outpatients and inpatients. The perpetrator needs to attend the prevention or treatment program for at least 1.5 hours every two weeks, for 6 months, before the certificate of fulfilment may be issued. (For the criminal proceedings closed on account of distraction see sub-chapter T1.2.1. in the chapter “Drug Market and Drug Criminality”).

Utilization of the outpatient care system in 2014

69 providers (of the 90 treatment units sending some report) reported on enrolling new drug-user clients in outpatient care in 2014 (exc. care for detainees). 85 % of all the clients (4,003 persons out of 4,688 persons) started a treatment at a specialized outpatient care provider, a low-threshold provider or a general/mental healthcare provider.

²⁴ which the legal regulation groups in the types “treatment curing drug addiction” and “other care for the treatment of drug use”.

Outpatient care (number of clients starting the treatment, in 2014)

	total clients (treatment starters)	characteristics of treated clients
drug ambulances, other specialized drug patient clinics	3079	inc. 1980 persons starting their treatment in the frames of distraction.
low-threshold providers ²⁵	775	inc. 539 persons starting their treatment in the frames of distraction.
general / mental healthcare providers	149	inc. 117 persons starting their treatment in the frames of distraction.
treatment units in law enforcement	146	inc. 144 persons starting their treatment in the frames of distraction.

Source: TDI data collection 2015

Inpatient service providers

Relevant financing categories with regard to inpatient treatment programs targeted at drug users:

- health care:
 - active, chronic and rehabilitation-focused inpatient care in addictology
 - rehabilitation care in paediatric and youth addictology
 - psychiatric, chronic and rehabilitation-focused inpatient care
 - rehabilitation care in paediatric and youth psychiatry
- social care – based on the Social Act:
 - institutions offering nursing and care for psychiatric or addicted patients
 - rehabilitation institutions for psychiatric or addicted patients
 - institutions offering temporary accommodation for psychiatric or addicted patients
 - hostel for psychiatric or addicted patients
 - subsidized housing.

There are again care facilities mainly with healthcare profile among inpatient care providers: such are the addictology or psychiatry departments in hospitals. Here care is typically provided by psychiatrists, addictologists, clinical specialized psychologists and specialized nurses. The programs arranged by hospital departments are traditionally and typically focused at offering care for psychiatric patients and those having alcohol problems; drug users are offered care in these institutions to a lesser extent only. No correct data are available to describe this residential care form, which is partly due to the difficulties of definition and partly to the low level of care monitoring. Alongside non-hospitalized care, the other option are the mixed-profile providers who get funds from both budgets. Therapy communities are organizational units that do not function in the conventional hospital-health care institutional system, can give a long-term therapy-focused answer to the multiple treatment needs of

²⁵ and other treatment units basically with a social profile

psychoactive drug users and those suffering of behavioural addictions through community cohabitation and are typically run by the church, an NGO or the local government. Recovered drug users are frequently employed in these care facilities, alongside the multidisciplinary team.

Inpatient care providers (number of treatment units in 2014)

	number of treatment units	definition (types of treatment units)
inpatient departments in hospitals	8	Treatment units identifying themselves in the TDI data collection as inpatient addictology and psychiatry departments in hospitals.
residential care for drug users (not hospital)	0	
therapy communities	6	Therapy communities (drug therapy/drug rehabilitation institutions/homes) in non-hospital environment, identifying themselves in the TDI data collection as inpatient care providers:
treatment units in law enforcement	0	The units offering outpatient and residential care for detainees are shown in a cumulated form in table 4.

Source: TDI data collection 2015

Utilization of the inpatient care system in 2014

Approx. half of the new drug-user clients starting their inpatient care were enrolled in treatment in mixed-profile therapy communities, whereas their other part were treated in hospital departments. This means that 11.5 % of all clients (539 persons of 4,688) started their treatment in the frames of inpatient care in 2014.

Inpatient care (number of clients starting the treatment, in 2014)

	total clients (treatment starters)	characteristics of treated clients
inpatient departments in hospitals	266	inc. 7 persons starting their treatment in the frames of distraction.
residential care for drug users (not hospital)	0	
therapy communities	273	inc. 1 person starting his treatment in the frames of distraction.
treatment units in law enforcement	0	For a summary of detained clients see table 5.

Number of clients receiving opioid-substitution treatment

Two types of substitution drugs are used in opioid-substitution programs in Hungary: methadone and buprenorphine/naloxone. The use of methadone is more prevailing for historical and financial reasons. Typically, three quarters of the annual number of cases are treated with this substitution drug (576 persons in 2014, 77 %), whereas buprenorphine/naloxone mixtures are the selected substitution drugs for about a quarter of the clients (169 persons in 2014, 23 %). Yet another difference between the two drugs is that in the case of buprenorphine/naloxone the drug may be prescribed if financed by the patient, so the costs can be borne for the treatment of available clients, in addition to the supply capacities restricted on account of the performance ceiling.

The service providers participating in the national substitution report reported on a total 745 clients in 2014. According to the experts' estimations this covers approx. 75 % of all the cases.

4) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR requests information on the government measures taken to reduce infant mortality.**

Detailed information on infant mortality is included in the **I. The general condition of the Hungarian population** subpoint of **1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS** point.

- **The ECSR requests information on the process of the healthcare reform described in the previous report, on how it adapts to the population needs, what effects it has on healthcare expenditures, and whether it contributes to the reduction of avoidable deaths.**

Hungary has widespread healthcare coverage, and state-of-the-art technologies are available for everyone within the service package, regardless of their income levels.

Between 2010 and 2012 20 out-patient centres were established from EU funds, thereby reducing the inequalities in availability. Developments are continuously carried out from EU funds to reduce territorial disparities, below we highlight the oncological developments as an example (however, further out-patient developments were also made):

- Component “A” of the TIOP-2.2.5 tender promotes the establishment and development (development of radiotherapy) of a complex regional oncological centre reserved for the Central Transdanubian region, as well as the realisation of an onco-pulmonological development.
- Component “B” of the TIOP 2.2.5 tender was reserved to promote the development of oncological modalities in the rest of the convergence regions.
- Under the TIOP 2.2.6/12/1/A “Promoting structure change with the development of oncological centres” tender HUF 10 bn support was made available, tenders could be submitted between 15 January 2013 and 18 March 2013. Thanks to the developments,

a system was established of regional oncological centres and territorial (county) oncological and radiotherapical centres, which have the competences corresponding to the given progressivity level, and they operate under professional conditions and frameworks adequate for the given level.

Significant public health measures were carried out in the previous government period (their positive impact is obviously expected to be felt later). With regard to the fact that the most significant risks of disability-adjusted life year include unhealthy diet, high blood pressure, smoking, high body mass index and excessive alcohol consumption, it is of utmost importance to emphasise the expected effects of the following measures:

Primary prevention:

- The amendment of the Act on National Assets in force as of 1 January 2012, which in principle prohibited smoking in closed areas. Support centres were established to quit smoking at the sites of pulmonology departments: 86 sites of altogether 74 institutes participate in it. Up until the end of September 2014, 2,950 patients were incorporated by the pulmonology departments to group counselling to quit smoking,
- Introduction of Act CIII of 2011 on Public Health Product Tax as of 1 September 2011. The primary objective of the Act was to reduce the consumption of food that is undesirable from nutrition and health aspects by levying a tax on foods with high sugar or salt content and certain caffeinated products that are proven to carry health risks, to promote food reformulation and to improve the financing of healthcare services and public health programmes.
- New mass catering norms have been introduced, and the transfat content of foodstuffs was also regulated.

Secondary prevention:

- In order to increase the rate of participation at the organised cervix screening, a programme for cervix screening to be performed by district nurses has been launched. The district nurses convinced even such women to participate in the screening, who had not visited a gynaecologist for 10 or more years.
 - Since September 2014, the vaccination of girls between 12 and 13 years of age against Human papilloma virus is taking place in schools (with parental consent). Their vaccination rate is currently at 80 %.
 - Large intestine screening based on fecal blood sampling is currently in progress in three counties (Győr-Moson-Sopron, Nógrád, Heves counties) among man and women between the age of 50 and 70 with the participation of 104 voluntary general practitioners with around 20000 patients.
- **The ECSR requests information concerning the waiting lists for hospital treatment and for consultations on primary healthcare services (doctor and patient consultation).**

Out-patient care

Healthcare providers obliged to provide services under the financing contract perform out-patient care on the basis of the out-patient waiting lists, which are kept separately for each specialist clinic. The person in charge of keeping the out-patient waiting list is designated in the organisational and operational regulations of the healthcare provider.

Out-patient waiting list shall mean the list under Act LXXXIII of 1997 on the benefits of compulsory health insurance (hereinafter “Health Insurance Act”) that determines the order of attending patients for each specialist clinic in out-patient care institutions by the date and time of the care to be received, where the health conditions of the insured does not require their immediate care.

It is important to mention that the law allows for the derogation from this order. Any derogation from the order established on the basis of the date of placement on the out-patient waiting list is professionally sustained if the delay to attend the given patient placed on the out-patient waiting list bears a greater risk than the delay in attending the patients rated lower on the list due to the change of order. In case the patient receives care in an order that is different from the out-patient waiting list, the data on the basis of which the fulfilment of the conditions for derogation from the order are established must be recorded in the healthcare documentation of the patient.

In-patient care

OEP keeps a uniform, national and public register that establishes equal conditions for all providers and – what is most important – is clear and transparent for all patients and interested individuals as of 1 July 2012. The updated national waiting list register gives immediate and public information concerning the national status of waiting lists broken down by region, institute or waiting list at the www.oep.hu website according to the actual situation. We do not have checked data on waiting list registers for the period prior to 2011. Even though the recording of waiting lists were regulate at statutory level since 2007, the Health Insurance Supervisory Authority performing their registration only collected data concerning the length of waiting lists, which were based on self-declarations of the institutions.

Waiting lists only describe a problem map which promotes correct sectoral policy decision-making. However, this is only possible if we can build on controlled data that is managed uniformly over the country. Accordingly, the register is available for the patients from the very first moment, and their interest, feedback and constant control provided great help for the development of the system. OEP compares the data of the waiting list register with the hospital performance reports. In the register we manage separately patients waiting due to lack of capacity or other reasons from patients who scheduled their operation for a later date than the earliest date that could be provided by the institution (these patients are excluded from the normal waiting lists and are transferred to the pre-booking list). Our aim is to present information on waiting lists in a transparent manner that can be followed by everyone.

To reach the above mentioned goals, the sector handles as a priority the programme targeted at reducing waiting lists. In previous years the government provided HUF 7.2 billion in funds until the end of 2015 (end of 2013: HUF 786.5 million, August 2014: HUF 431.8 million, end of 2014: HUF 1 004.60 million, 2015: HUF 5bn).

The proclaimed aim of the programme was to realise by the end of the programme that patients do not have to wait for operations longer in case of illnesses that significantly deteriorate their quality of life and life expectancy than the average waiting time of the rest of the EU Member States. The professional goal wished to be reached in practice was to realise that patients do not have to wait more than 2 to 3 months for smaller operations and 6 months for larger – prosthetic or spinal – operations. The healthcare providers concerned performed

cataract surgeries (ratio around 50 %) and hip and knee replacement operations (together almost 40 %) with the highest case number ratio.

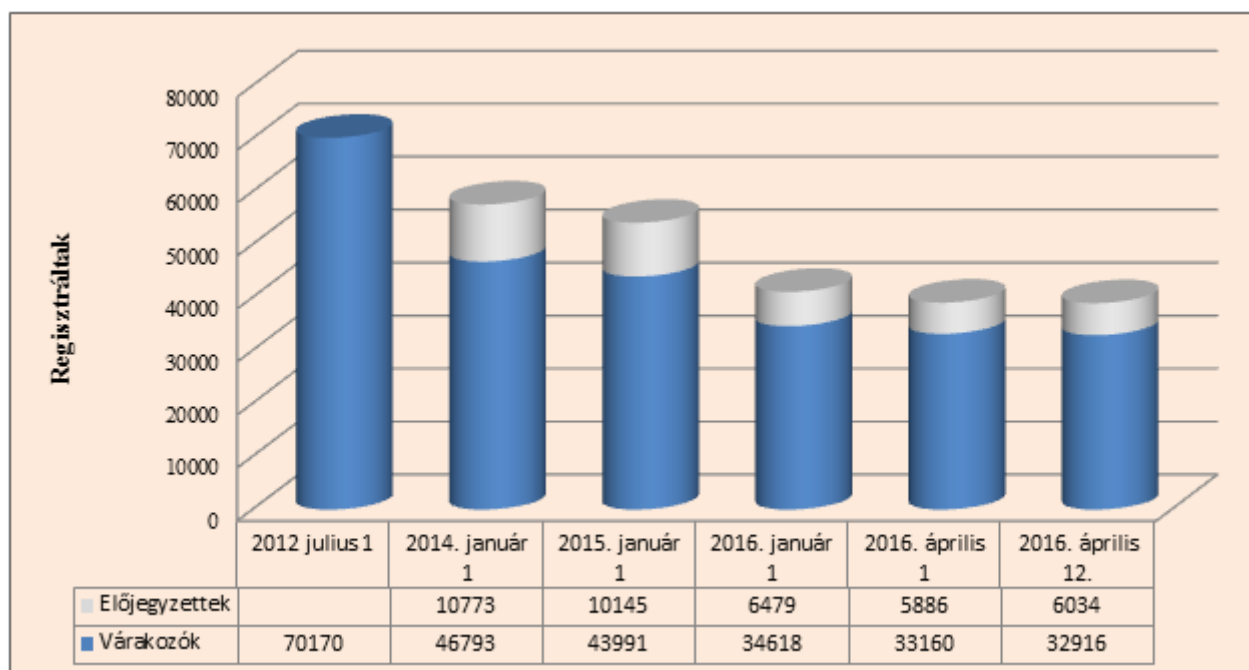
Compulsory institutional waiting lists are the following:

Waiting lists
Cataract surgery
Tonsillectomy, adenoidectomy
Surgery of sinuses, proc. mastoideus
Spine stabilisation surgery
Spinal disc herniation surgery
Intervention due to gallstones – exploration
Intervention due to gallstones – laparoscopy
Ventral hernia and hernia inguinalis surgery with implant
Hernia surgeries (hernia parietis abdominis, inguinalis, umbilicalis, femoralis) without implant
Benign prostate enlargement surgeries I (Prostatectomia)
Benign prostate enlargement surgeries II (Transurethralis prostate surgery)
Gynaecological surgeries in non-malignus processes
Knee replacement surgery
Hip replacement surgery
Coronary interventions
Cardiac electrophysiology study, large and radiofrequency ablations
Serious extended spinal surgeries

It must be noted that gallstone and hernia surgeries are not included in the compulsory waiting lists as of 1 January 2016 based on professional recommendations, with regard to the fact that the waiting time for such surgeries nation-wide was below 60 days for a long period of time. Currently only those institutes keep these waiting lists under the classification of waiting list due to “lack of capacity” as specified in law, where waiting time is still above 60 days.

As a result of targeted measures to reduce waiting lists, it can be said that the number of patients waiting halved between 2012 and the end of 2015. Based on the data of the waiting list register, on 31 December 2015 around 35,000 patients were awaiting surgical treatment pursuant to the waiting lists to be kept compulsorily by the institutions compared to the 68,000 patients waiting in 2012 according to the waiting lists.

Changes in the number of cases registered on the waiting lists under compulsory registration from 2012



Source: OEP.

Already based on the first analyses after the introduction of the national waiting list registration system a clear difference could be seen between the planned average waiting times calculated on the basis of the surgery dates set at the inclusion of patients in the waiting lists and the actual waiting times determined on the basis of performed surgeries. Actual waiting times were shorter than planned waiting times, and the decrease in waiting times – with the exception of knee replacements – practically reached the reduction rate set as the first step (for knee and hip replacement waiting lists were reduced to 180 days and for cataract surgeries to 90 days). It can also be said for knee replacement surgeries that overall there is a clear improvement in waiting (from 684 days to 400 days). For this we also have to consider that in the waiting list reduction programmes the second highest number of surgeries were knee replacement surgeries.

Transplant waiting lists

Among the issues incurred and regulated prior to the agreement with Eurotransplant, the issue of filling the transplant waiting lists was a professional priority – already prior to the preliminary cooperation agreement –, because there are data which clearly show that the chances of transplantation for patients placed on time on the waiting list are better and organ transplants carried out this way are more successful. Under the agreement concluded with Eurotransplant our patients benefit the most from the cooperation if all patients requiring an organ transplant are placed on the waiting list in due time. The relevant representatives of the profession have already taken the necessary measures regarding this issue, following consultations between the Ministry of Human Capacities and the representatives of the profession.

The domestic legal background of the rules of procedure of waiting list registration that have changed due to the conclusion of the contract providing full membership has been established through the amendment of Government Decree No 287/2006 (XII. 23.) on the detailed regulation of health services provided based on waiting lists.

Pursuant to Section 3(3) of Government Decree No 287/2006 (XII. 23.) on the detailed regulation of health services provided based on waiting lists healthcare providers may only provide the healthcare under Section 3(2) in accordance with the transplant waiting list.

Section 215(1) of Act CLIV of 1997 on health stipulates that Patients in whose cases organ or tissue transplantation is medically justified shall be put on a national waiting list maintained separately by type of organ and tissue.

Persons eligible for being put on transplantation waiting lists shall be

- a) the insured persons under Section 5 of Act LXXX of 1997 on the eligibility for social security benefits and private pensions and the funding for these services (hereinafter “Tbj.”),
- b) persons eligible for health services under Section 16(1) of the Tbj., with the exception of persons eligible for health services under Section 16(1)(p),
- c) and from among the persons not subject to point (a) and (b) those, whose health insurance body authorised the use of healthcare services pursuant to Union regulations or bilateral conventions previously or in accordance with the provisions of the convention.

Pursuant to the new provisions of the Health Insurance Act in force as of 1 July 2015 Section 20(5)(b) was amended so as to exclude from the eligibility reasons to be put on the waiting list – similarly to other healthcare already regulated in this manner – the persons eligible for health services under an agreement. The primary reason behind this was that eligibility to be put on the waiting list is adapted to the eligibility rules of other healthcare services, because those who concluded an agreement under Section 34(10) of the Tbj. for healthcare services are currently not eligible for the reimbursement of domestic costs of emergency services used in a third country under Section 27(1) of the Health Insurance Act, to use healthcare services under an EU regulation or international convention pursuant to Section 27(3) of the Health Insurance Act, to use cross-border healthcare services pursuant to Section 27(6) of the Health Insurance Act, or to use healthcare services not available in Hungary in another country at the expense of the Health Insurance Fund pursuant to Section 28(1) of the Health Insurance Act. The amendment entered into force on 1 July 2015.

- **The ECSR claims citing other sources that the Hungarian population in general is unsatisfied with healthcare services. On the satisfaction list Hungary occupies the 26th place out of the 27 Member States. There are vast differences among services based on geographical location, level of specialisation and equality of access. The same is demonstrated by the differences in the health status of population groups. The Commission asks the opinion of the government regarding this statement.**

The draft publication of OECD entitled “Government at a Glance” – as a possible alternative source – has found that public satisfaction had risen from 54 % to 60 % in the period between 2007 and 2013. According to the related evaluation statement, the satisfaction rate is still

below the rate of several neighbouring countries (e.g. 80 % in Slovenia) and the OECD average (above 70 %), but the graphs of the draft publication showed that satisfaction is way higher than in Poland (around 40 %), Slovakia (55 %) and is round the data of the Czech Republic (65 %). We believe it is important to note that this trend is positive, because while in Hungary satisfaction grew in the examined period, it dropped in all three mentioned countries; in the case of Poland it fell by more than 10 % points.

- **The ECSR requests information concerning drug rehabilitation possibilities, and the available tools and treatments.**

See the detailed information given under point **1)PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS** and point **2) MEASURES TAKEN IN ORDER TO ENFORCE THE LAWS.**

[With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:]

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS, AND MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

The role of schools in promoting health – healthcare area of expertise

Changes in laws:

- Government Decree 110/2012 (VI. 4.) on the publication, introduction and application of the National Syllabus
- Decree of the Minister of Human Capacities No. 20/2012 (VIII. 31.) on the operation of public education institutions and on the use of names of public education institutions
- Decree of the Minister of Human Capacities No 51/2012 (XII. 21.) on the rules of issuing and approval of framework curricula
- Decree of the Minister of Human Capacities No 16/2013 (II. 28.) on the rules of approving textbooks, textbook support and school supplies of textbooks

1. Annual working plan of the public education institutions, which includes tasks related to health development and education

Regulatory background:

Section 3 of Decree of the Minister of Human Capacities No. 20/2012 (VIII. 31.)

Section 23(1)(e) of Government Decree 229/2012 (VIII. 28.)

2. The rules governing the supporting institutional work order on healthy lifestyle extended to protective and safeguarding instructions shall be regulated in the regulations of the public education institutions

The new rule stipulated in Section 129(1) of Decree 20/2012 (VIII. 31.) EMMI (Ministry of Human Capacities) covers all rules concerning healthy lifestyle that are not regulated in the organisational and operational regulations; of course, local rules must comply with the relevant provisions and instructions of the other institutional documents.

Regulatory background:

Act CXC of 2011 on National Public Education, paragraphs (2) and (4), Section 25

Decree 20/2012 (VIII. 31.) EMMI (Ministry of Human Capacities), Section 5

The Pedagogical Programme

Priorities in the Pedagogical Programme:

- educational and training principles based on local values relating to the conditions (lex loci criterion),

- health education and environmental education (the health education programme is an integral part of the educational programme),
- measures to improve equal opportunities,
- the possible involvement of meaningful issues that are deemed important strengthens the professional autonomy of the teaching staff,
- full health improvement,
- first aid – basics of giving first aid,
- rules of exams during studies (exams rules and regulations),
- institutional tasks of teachers, content of homeroom teachers' work.

3. Decree on public catering

On 30 April 2014, Decree of the Minister of Human Capacities No. 37/2014 (IV. 30.) on the nutritional and health regulations of public catering was published, its application is mandatory as of 1 September 2015.

2) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR requests information concerning the activities of public health institutions or other organisations promoting healthy lifestyle and disease prevention.**

This topic is discussed in detail under Section 11(1).

- **The ECSR requests information on whether health education in schools is compulsory, whether it is part of the curriculum and what its contents are.**

See the information under point (1) above.

- **The ECSR requests information on the ratio of pupils participating in the medical check-up.**

School health services are, pursuant to Act CXXII of 2015 on primary health service, part of the primary health service that is a mandatory responsibility of municipal governments.

The tasks of school health services are defined in Decree of the Minister of Welfare No. 26/1997 (IX. 3.) on school health services (hereinafter: Decree). Pursuant to this decree, the kindergartens and schools ensure the regular attendance of the 3-18 age group and the persons participating in full-time upper-secondary school education above the age of 18 in preventive school health services organised within the framework of primary health service. Based on this it can be ascertained that in Hungary school health service covers the whole country and is extended to all students.

School health service is a combination of services of the school doctor and the district nurse, which are provided with the cooperation of a dentist and a dental assistant. Pursuant to Annex 2 of the Decree, the responsibilities of school doctors (including those working in kindergartens) are the following:

1. Examination and follow-up of the health conditions of children and students

- Examination of children in kindergartens in case of communicable diseases under the ministerial decree on the epidemiological measures necessary for the prevention of communicable diseases and epidemics, and the examination of school pupils in grades 2, 4, 6, 8, 10 and 12. Within this context:¹⁵
 - complete physical examination,
 - repeated recording of medical history and family history, finding vulnerable children based on their medical history and their guidance to specialist medical practice services,
 - mandatory disclosure of data on grades 2, 4, 6, 8, 10 and 12 and the closing check-up condition at the age of 16, (The screening success ratio of even grades is around 97 % annually),
- Increased examination and priority care of students having chronic diseases or physical, mental or sensory disabilities as agreed with the general practitioner using specialist clinics or medical centres. Provision of medical opinion if these children are educated together with healthy students.
- Disclosure of data relating to the health condition of the students to the expert committee establishing corporal, sensory, mental or speech disability in case they are summoned to such committee.
- Cooperation in the organisation of the overall children’s dental programme and checking of its execution.
- Performance of the closing check-up by the age of 16 as per separate legislation with the cooperation of the school nurse.

2. Performance of aptitude tests

- Performance of professional aptitude tests, performance of medical tasks related to vocational guidance.
- Preparation of the physical education group division, performance of school health service tasks related to physiotherapy, physical education and sports.

3. Public health and epidemiological tasks

- Performance and documentation of compulsory vaccinations linked to school ages and campaign vaccinations.
- Controlling compliance with epidemiological instructions and ordering epidemiological measures in case of communicable diseases, information of district authorities on measures taken.
- Controlling public catering in public education institutions.
- Recommendations to remedy errors if public health and epidemiological shortcomings are found, information of the public authority.

4. Provision of first aid

Primary aid in case of accidents, injuries and acute diseases happening in the school, and referral of students to general practitioner, family paediatrician or other institution.

5. Participation in the health education of the public education institutions.

- Participation in school education of healthy lifestyle and execution of the national core curriculum.
- Disclosure of health information to parents and teachers.
- Teaching basic self-examination techniques.

6. Environmental health tasks

- Checking the institutional environment – classrooms, practical classrooms, gym, other service rooms –, detection of deficiencies, taking measures.
- Monitoring workplace circumstances related to the practical education of students.

7. Keeping a register of attended children, making reports as specified in separate legislation, and documentation of performed examinations and vaccinations in the Health Record Card as specified in separate legislation.

The self-government concludes a contract on school health services, and it decides also on the place and form of the provision of service. The responsibility is adequately defined, but it is important for us to realise that primary prevention is given a greater role in the service. From the perspective of the state and health policy the most important aspect is that schools are public health arenas, where there is a possibility to lay the foundations of health knowledge of children, to assess their health, to perform their campaign vaccination, and to indicate certain examinations and taking into care. Currently there are approximately 200 full-time school doctors working in school health service, and the rest are mainly general practitioners, paediatrician, i.e. they perform this task besides their regional medical work.

It is also important to mention the regional nursing service covering the whole country. The regional district nurse system provides care close to the public (kindergartens are also served by regional district nurses), while school district nurses participate in the preventive school health services of the 6-18 age group and the persons participating in full-time upper-secondary school education above the age of 18. They participate in school health education programmes and their organisation, they perform the nurse screening of students, they check their personal hygiene (if public health need arises), they organise school doctor examinations and school campaign vaccinations, and they communicate with the parents, if necessary.

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:

3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS, AND MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

I. Public health and epidemiological security

1. HIV/AIDS prevention

Hungary is currently among the most favourable countries in the world as regards the HIV/AIDS epidemiological situation. According to the data of the National Centre for Epidemiology (hereinafter: NCE), in 2014 51 AIDS cases were diagnosed, and altogether 15 patients died as a result of the Syndrome. In Hungary, the number HIV-positive persons registered on 31 December 2014 was 2,845. Since 1985, 796 people were diagnosed with AIDS, of which 358 died as a result of the Syndrome. Above this, in 72 cases the cause of death was not AIDS, so a total of 430 HIV-positive deaths are contained in the register.

Measures in 2012

Pursuant to Government Decree 38/2012 (III. 12.), it has become necessary to review advisory bodies. Accordingly, as of 1 January 2013 the National AIDS Commission was replaced by the National HIV/AIDS Working Group, which took over the Commission's previous tasks. The National HIV/AIDS Working Group operates as the advisory body (giving opinion and proposals) of the minister for human capacities to help in the national combat against HIV/AIDS and to develop its professional management.

Measures in 2013

In 2013, EMMI launched a call for proposals entitled "Preventing HIV/AIDS with non-governmental organisations" for NGOs working in the field of HIV/AIDS prevention to support preventive work. The total amount to be granted was HUF 15 million, and its aim was to demonstrate and mitigate the risk among the members of communities exposed to the high risk of HIV infection, to establish the necessary behaviour, and to provide for voluntary screening and the possibility of counselling. 10 NGOs received grants from the total budget of HUF 15 million.

Measures in 2014

In the first half of 2014, NCE assessed the prevalence of infections (HIV, HCV) in 2014 related to domestic drug use from the HUF 3 million grant provided by EMMI.

The preparation of the 3-year-long EU joint action started in 2014, the objective of which is to improve the prevention and treatment of HIV and coinfections for the promotion of the realisation of EU policies. Its target group consists of people who inject drugs, thus it includes injecting drug users belonging to the youth. The overall objective of the project is to contribute to the goals of the EU HIV/AIDS policy framework by reducing the number of HIV infections and by ensuring improved access to screening and the subsequent healthcare

of HIV-infected people, as well as to improve the health condition and health expectancy of people suffering from HIV. Hungary is not only a partner in this joint action, but is selected as a target country besides Latvia and Lithuania. The Office of the Chief Medical Officer participates in the following working packages:

- WP6: Improving access to harm reduction for injecting drug users held in detention facilities;
- WP7: Identification of the adequate model for the healthcare services provided for injecting drug users;
- WP8: Improving the sustainability of national HIV/AIDS programmes.

NCE participated in working package WP4: Development of low-threshold services for injecting drug users: promoting early diagnosis and improving sexual health-related services.

Measures in 2015

NCE realised the following tasks in 2015 from the granted provided by EMMI:²⁶

- Training of HIV testing and related consultation in the Dermato-Venereology Clinic network, in anonymous HIV/AIDS consultation services operated by the policy administration services of public health of the government offices, in healthcare institutions treating AIDS-patients and at non-governmental organisations (HUF 2.4 million).
- Assessment of the prevalence of HIV, HBV, HCV infections in 2015 related to domestic intravenous drug use by NCE (HUF 5.6 million).
- Assessment of HIV prevalence and sexually transmitted infections attached to HIV (hepatitis B, hepatitis C, syphilis) among homo/bisexual men in 2015 (HUF 5 million).

In 2015, the total sectoral grant of HUF 15 million available for HIV/AIDS prevention was awarded to the Anonymous AIDS Consultation Service to realise HIV testing and related consultation.

Beyond this, UNAIDS has published regular estimations on the development of the country's HIV epidemiology, and it prepares annual country reports on the indicators with the help of the background institutions concerned; also, the government provides interim data supply.

2. The Vaccination Programme

The compulsory vaccinations linked to age against 10 infectious diseases (invasive diseases caused by tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis anterior acuta, morbilli, rubella, mumps, Haemophilus influenzae B, hepatitis B) were complemented as of 28 March 2014 by the vaccine against Streptococcus pneumoniae (pneumococcus), so the Hungarian vaccination order currently prescribes vaccinations against 11 infectious diseases. [Codified by Section 1(1) of Decree 23/2014 (III. 27.) EMMI (Ministry of Human Capacities).

1. The following point (*k*) is inserted after Section 5(1) of Decree 18/1998 (VI. 3.) NM (Ministry for National Economy) on the epidemiological measures necessary for the prevention of communicable diseases and epidemics:

²⁶ The professional and financial statement received is currently under assessment.

“Hungarian citizens, persons falling within the scope of the act on the admission and residence of persons with the right of free movement and residence, who exercises their right of free movement and residence for over three months in Hungary, third country nationals who are long-term residents or who have settled, immigrant or admitted status, as well as refugees and beneficiaries of temporary protection shall receive vaccination against

...

k) Streptococcus pneumoniae (pneumococcus)

...

”

As of 1 September 2014, the vaccination against the Human papilloma virus is compulsorily offered – and financed from the central budget – and voluntarily electable from the free vaccinations to avoid the risk of infection for girls over the age of 12 and in the 7th grade of primary school who can receive free vaccination under a school vaccination campaign taking into account the vaccination order in the Vaccination Methodology Letter of the National Centre for Epidemiology and professional medical aspects. [[Codified by Section 6 of Decree 43/2014 (VIII. 19.) EMMI (Ministry of Human Capacities)]

“6. The following paragraph (5) is inserted after Section 7 of Decree 18/1998 (VI. 3.) NM (Ministry for National Economy) on the epidemiological measures necessary for the prevention of communicable diseases and epidemics:

(5) Girls over the age of 12 and in the 7th grade of primary school may be vaccinated free of charge against the Human papilloma virus under a school vaccination campaign taking into account the vaccination order in the Vaccination Methodology Letter of the National Centre for Epidemiology and professional medical aspects.”

This reporting system promotes the maintenance of epidemiological security, through which the National Public Health and Medical Officer Service, the government offices performing public health responsibilities and the district offices can have up-to-date and reliable data on communicable diseases and epidemics, thereby ensuring the taking of prompt and necessary action.

Decree 1/2014 (I. 16.) EMMI on the rules of reporting communicable diseases entered into force on 1 February 2014, which also repealed the previous Decree 63/1997 (XII. 21.) NM (Ministry for National Economy).

The amendment of the Health Act in effect from 28 September 2015 also serves the maintenance of epidemiological security and the minimisation of higher epidemiological risks caused by the mass immigration into EU Member States (Codified by: Section 1 of Act CLXIII of 2015 .

The subheading “Other epidemiological measures” of the Health Act shall be supplemented by the following Section 74/A:

“74/A. (1) The Chief Medical Officer may order compulsory screening of persons lodging an application for recognition (hereinafter “persons seeking recognition”) under the act on asylum in case of crisis situations caused by mass immigration or other health-related emergency situation specified herein.

(2) The compulsory screening mentioned in paragraph (1) shall be performed at a location designated by the asylum authority. The body conducting the screening shall issue a certificate for the taking of samples necessary for performing the screening.

(3) If the persons lodging an asylum application are staying in the transit zone as specified in the act on the state border, the screening mentioned in paragraph (1) shall be performed prior to their authorised admission to Hungary. In such a case the leaving of the transit zone for entry into Hungary shall be conditional upon the existence of a certificate for the taking of samples necessary for performing the screening issued by the body conducting the screening.

(4) In case of persons seeking recognition in need of special treatment as defined in the act on asylum the screening mentioned in paragraph (1) shall be performed as a matter of priority, prior to any other person seeking recognition.

(5) The screening results are communicated to the asylum authority by the district (Budapest district) office exercising the public health responsibilities of the government offices of Budapest and the counties.

(6) The district (Budapest district) office exercising the public health responsibilities of the government offices of Budapest and the counties may request stricter guarding measures for the healthcare providers at the competent police station if the health-related emergency situation specified herein or the rules of the health-related emergency situation are applied.

(7) The provisions of paragraphs (1) to (6) shall not apply to admissions to the territory of Hungary for the purposes of compulsory appearance in other official or judicial procedures, pursuant to which the Chief Medical Officer may order compulsory screenings of persons lodging an application for recognition under the act on asylum in case of crisis situations caused by mass immigration or other health-related emergency situation.

3. Protection of pregnant women, children and adolescents

Changes in maternity care

A new decree was adopted in 2014. The aim of Decree 26/2014 (IV. 8.) EMMI (Ministry of Human Capacities) on maternity care is to increase the number of pregnancies without complications and of healthy new-born infants, as well as to reduce the number of perinatal deaths and premature births by promoting equal opportunities in access to adequate level of maternity care and making maternity care more efficient.

The development of medical science and the introduction of new diagnostic and therapeutic procedures, as well as new international guidelines necessitated the adoption of a new decree. Maternity care is a complex healthcare service, which is based on the cooperation between obstetricians and gynaecologists, general practitioners, district nurses and pregnant women. The new legislation allows midwives with an operating licence and adequate qualifications to intervene in maternity care (instead of the obstetrician-gynaecologist), if the mother decides so and belongs to the low risk category. Risk assessment is performed by the obstetrician-gynaecologist who verifies pregnancy.

The new legislation also determines the person responsible for maternity care. It names the obstetrician-gynaecologist or the midwife performing the maternity care as the responsible person. The role of the responsible person, besides profession-specific tasks, is to coordinate and professionally control the care of the mother.

The information and educational tasks of professionals performing the care have also been given an emphasis in the new decree, especially in relation to the necessary and optional screening tests, as well as the prevention and discontinuation of tobacco, drug and alcohol consumption.

The problems incurred with regard to the introduction of the decree in 2014 were solved with its amendment of 2015.

Changes in the protection of children and adolescents

Decree of the Minister of Health, Social and Family Affairs No. 49/2004 (V.21.) on regional nursing service was amended in 2014:

- Within the framework of this change the regional care obligation of nurses was clarified with the obligation that regional nurses shall offer nursing care for persons habitually residing in their district (e.g. not registered) who come to their knowledge, and whose care belongs to their nursing competence. In this case the nurse shall notify immediately – upon acceptance of taking into care – in writing the relevant nurse of the registered residence of the person on taking them in care.
- The tasks relating to the child protection notification system were nominated in the decree:
 - annual written report to the competent child welfare provider;
 - participation in the annual consultation and *ad hoc* meetings of the child welfare service;
 - if necessary, performance of *ad hoc* guardianship upon request in areas falling outside their scope.
- The tasks of workers (hospital nurses) in healthcare providers of in-patient care were also regulated. Their tasks are:
 - to cooperate in the preventive care of pre-natal and post-natal women,
 - to cooperate in preparing mothers for feeding and caring of new-born infants, to establish cooperation between medical institutes and primary health service, to ensure the continuity of healthcare and child protection services according to needs, to help in establishing the bond between mother and child, to help in breastfeeding, to keep records, to collect and disclose data to the regional nursing service, to record data related to the care of post-natal mothers and new-born infants in accordance with the relevant professional rules of procedure,
 - to notify the district nurse with territorial competence at the location of the mother or the location of arrival of the new-born infant and the chosen family paediatrician or general practitioner – as per the declaration of the mother – on births and their departure from the medical institute.

Decree of the Minister of Health, Social and Family Affairs No. 60/2003 (X. 20.) on the minimum professional requirements for the provision of healthcare services regulated the ensuring of nurses in neonatological departments and “Rooming in” type neonatal departments, and at maternity wards, and determined the number of nurses in accordance with the number of births:

- less than or equal to 1000 births/year: 1 nurse, who cooperates in tasks related to intra-institutional departments (neonatology, paediatrics, maternity care)
- over 1000 births/year but less than or equal to 3000 births/year: 2 nurses, who cooperate in tasks related to intra-institutional departments (neonatology, paediatrics, maternity care)
- over 3000 births/year: 3 nurses, and 1 extra nurse for each 1000 births, who cooperate in tasks related to intra-institutional departments (neonatology, paediatrics, maternity care)

A new act was adopted to ensure the sustainability of the functioning of the primary health service being an integral part of healthcare services, and to strengthen it from professional and financial point of view, to confirm the role of family paediatricians and general practitioners

as gatekeepers, as well as to improve the health condition of the population and the standard of patient care, Act CXXIII of 2015 on primary health service.

The Act provides for the tasks of primary health service, the tasks of primary health service within the framework of preventive care, and includes in detail, *inter alia*, the tasks of nursing service and school health service. For the uniform level of nursing service, it provides for the operation of district, country and – within the framework of the national healthcare administrative body responsible for the professional management of nursing service – national professional leading nurses' network.

Due to the amendments of legal provisions relating to child and adolescent protection, Section 12(4) of Government Decree No. 323/2010 (XII. 27.) on the National Public Health and Medical Officer's Service, the fulfilment of administrative responsibilities related to public health and the appointment of the state administration agency for pharmacology (XII. 27.) the government designated the Office of the Chief Medical Officer and the healthcare administrative body for the performance of (professional nursing management) tasks under Section 14 of Act CXXIII of 2015 on primary health service.

II. Environmental health

1. Air quality

1.1. Degree of contamination of outside air

1.1.1. Reduction of allergic diseases caused by ragweed

Nowadays, respiratory allergy has become a public health problem affecting a significant portion of the world population, and therefore the Hungarian population. In Hungary, ragweed pollens are the most significant aerial biological allergens among the factors affecting the occurrence of allergy and asthma in the population as regards aerial environmental nuisances. From the factors affecting the occurrence of allergy and asthma in the population, the aerial concentration (primary and direct risk factor) of ragweed pollens, the territorial coverage and biological activity of ragweed (primary and indirect factors), as well as health conditions, lifestyle peculiarities, surrounding living space (secondary human and environmental indirect factors) can be mentioned.

Based on the findings of allergological tests, in Hungary almost 2 million people are sensitive to aerial allergens, of whom around 40 to 70% are sensitive to ragweed.

On 6 July 2012, the government of Hungary adopted its Decision 1230/2012 (VII. 6.) on the Short and Medium Term Action Plan for Protection against Ragweed to resolve the issue of protection against ragweed on the long term. The Action Plan contains the objectives related to protection against ragweed, the tasks to be completed and the persons responsible for them for the period between 2012 and 2020.

In relation to the pollen exposure and vulnerability of the population, the trap stations of the Aerobiological Network of NPHMOS provide data and analyses of the origin and output, as well as spatial and temporal distribution of pollen pollution in 19 cities of the country, in Budapest and in county seats with constant aerobiological data collection and assessment. As

a result, a ragweed report is published for the public and the experts, and the informative maps of the estimated domestic distribution of ragweed pollen concentration are updated weekly with sufficient reliability (Ragweed Pollen Alarm System – RPAS). With the help of this system, allergic people and interested parties can easily determine the severity and importance of the concentration for the given week for the region in question.

High aerial pollen numbers have become an ever-increasing burden for the health of the people living in the most contaminated area of Europe regarding ragweed: the Carpathian Basin. Thus, RPAS was extended, in cooperation with the professional representatives of neighbouring countries, from 2014 to the Pannonian Biogeographical Region. Thanks to building connections, 27 cities submit data on a weekly basis. With the involvement of these areas, national forecasts are more accurate, since the data of cross-border pollen sources fine-tuned the cross-border values. Thanks to the development in 2014, the system is ready to generate and send back maps for the partners in English and in their own language every week.

Besides the monitoring of aerial ragweed concentration, it is a priority to inform properly the public about the “pollen situation”. During ragweed season, NPHMOS publishes the information in various ways on its website and on other internet sites.

As a new development, the Hungarian version of the pollen diary was prepared with international help. On the pollen diary website users can get information on the connection between their symptoms and pollen concentration, and with its help they can follow how their allergic reactions correlate with the aerial pollen concentration measured in their place of stay in previous days. The pollen diary is a great step forward to new generation patient information, since it contains personalised information.

Data on diseases associated with ragweed pollen contamination

	name/years	2013.	2014.	2015.
1.	number of days causing allergic reaction in given year	60	53	49
2.	of which number of days reaching very high (over 100) concentration	17	22	18
3.	annual average total pollen number (pc/m ³ /year)	4212	6902	5619
4.	national daily average concentration of ragweed pollen (pc/m ³ /day)	81	183	140
5.	occurrences of “hay fever”/allergy-related diseases (persons) – <i>Social security numbers reported with ICD codes marked with ** treated in out-patient care and associated with ragweed sensitivity (based on data provision of OEP)</i>	209 734	215 021	202 571
6.	occurrences of asthma-related diseases (persons) – <i>Social security numbers reported with ICD codes marked with *** treated in out-patient care and associated with ragweed sensitivity (based on data provision of OEP)</i>	222 220	221 504	217 416
7.	<i>Total number of cases reported with ICD codes marked with ** and *** treated in out-patient care and associated with ragweed sensitivity over social security numbers (based on data provision of OEP)****</i>	396 268	400 550	387 460

** ICD code

H1010 Acute atopic conjunctivitis;
H1030 Acute conjunctivitis, w/o p. n.
J3010 Allergic rhinitis due to pollen
J3020 Other seasonal allergic rhinitis
J3030 Other allergic rhinitis
J3040 Allergic rhinitis, w/o p. n.
T7840 Allergy, w/o p. n.

** ICD code

J4500 Mainly allergic asthma
J4580 Mixed asthma
J4590 Asthma, w/o p. n.
J46H0 Status asthmaticus

****The reason for the derogation in amount of the total amounts indicated in row 8 of the table from the total amount row 5 and 6 is that several ICD codes could be determined for 1 social security number for the same patient.

1.1.2. Assessment of air hygiene situation of Budapest and rural settlements

Pursuant to Section 4(1)(a) of Act XCVI of 1999 on the amendment of Act XI of 1991 on National Public Health and Medical Officer Service, the purpose of the Service is to examine regularly the air pollution of settlements from a public health point of view.

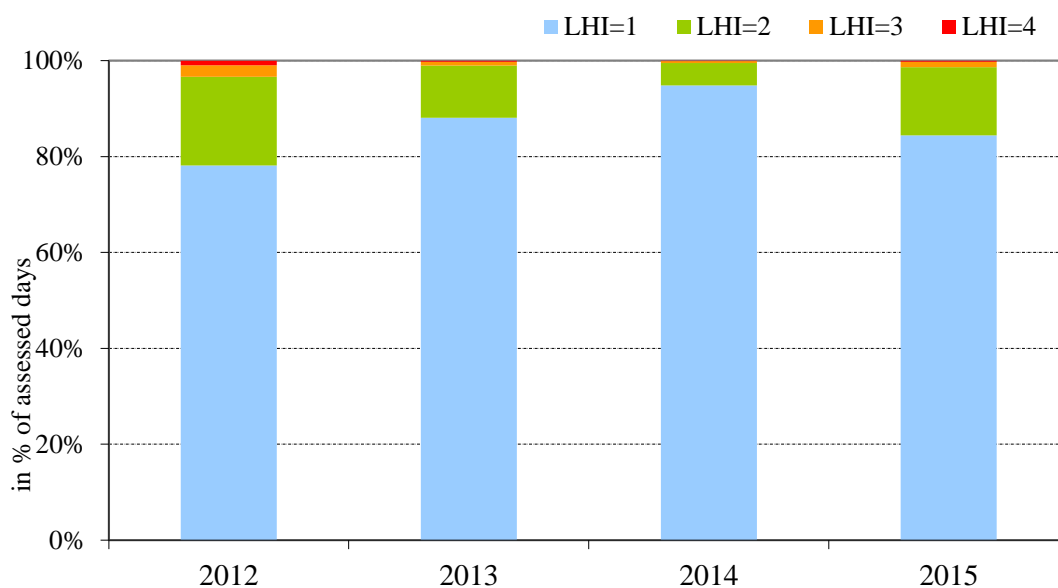
The National Institute of Environmental Health (hereinafter: “NIEH”) elaborated an assessment system, the purpose of which is to demonstrate the expected health effects of short term exposure caused by regularly checked air polluting materials to protect the health of the potentially affected population. The expected acute health deteriorating effect can be mitigated by keeping the advices on health presented on the website.

The assessment of the air hygiene situation has been performed daily for Budapest from 2007 and for 27 other Hungarian settlements from 2010, which are published on the website of NPHMOS and the institute for public information purposes.

In the period between 2012 and 2015, the assessment of the air hygiene situation of settlements was extended to several settlements by the National Environmental Health Directorate of the National Public Health Centre. Currently the population of 31 settlements are informed about the health risks borne by the current air quality.

The air quality of Hungary has improved constantly between 2012 and 2014, which is shown in the table below.

Evolution of the air hygiene situation of Hungary 2012-2015

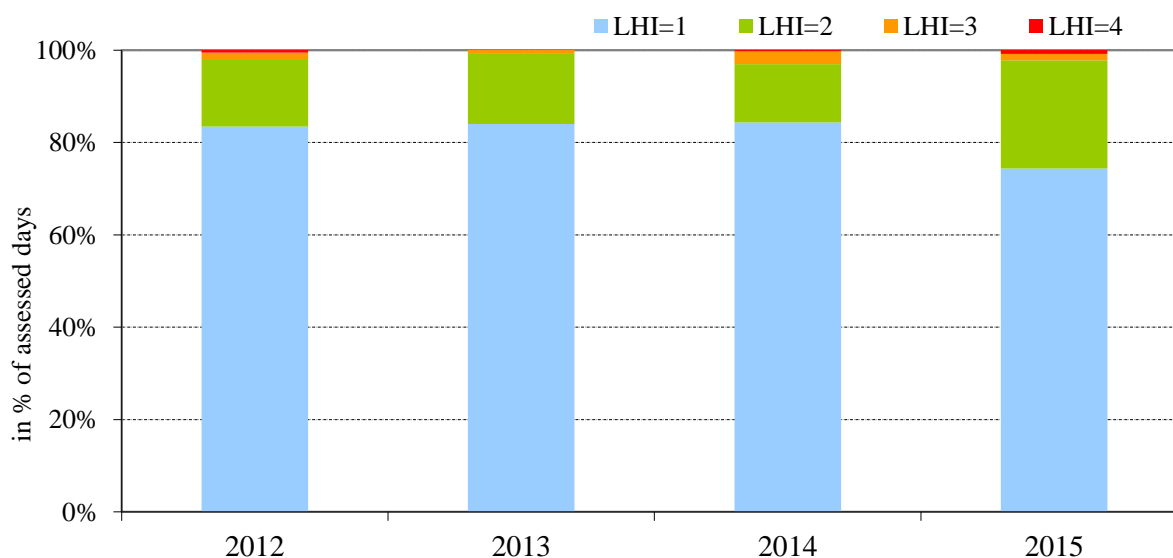


In 78, 88 and 95 % of assessed days the Air Hygiene Index (hereinafter: AHI) fell within the acceptable category. Air quality was of concern in 19, 11 and 5 % of the assessed days. Unhealthy air pollution situation arose in 2 and 1 % of the assessed days. A situation jeopardising the health of the total population occurred in 1 % of assessed days in 2012. In 2015, the quality of environmental air in the country was less favourable compared to previous years. 4 of assessed days fell within the acceptable category, 14 % caused concern, and 1 % of assessed days was characterised by unhealthy air quality. The deterioration of air quality was mainly caused by the warmer summer weather compared to previous years. Permanent sunshine encourages higher ozone concentrations that frequently exceed the exposure limits.

The air quality of several large cities have improved through building bypass roads (e.g. Miskolc, Nyíregyháza). The air quality of smaller settlements did not change significantly due to the use of solid fuels in the heating season.

The air hygiene situation of the capital was almost identical in the first three years of the examined period.

Evolution of the air hygiene situation of Budapest 2012-2015



Between 2012 and 2014, in 83-84 % of assessed days the quality of environmental air was acceptable, and in 13-15 % AHI fell within the category of concern. Air quality fell within the unhealthy category the most frequently in 2014 in 3 % of assessed days. An air pollution situation jeopardising the health of all residents of Budapest occurred on two days in 2012, and on one day in 2014. Air hygiene fell within the acceptable category in 2015 in 74 % of the assessed days. 23 % of assessed days were characterised by air quality of concern, while unhealthy and hazardous air pollution occurred in 1 % of the assessed days each. The increase in the number of days with an air pollution of concern was caused by the high ozone concentration values due to the long sunny weather.

The radioactivity of air was examined jointly by the National Research Institute for Radiobiology and Radiohygiene (hereinafter. NRIRR) of the National Public Health Centre and the Radiohygiene Decentres operated by the public health departments of county government offices at their own sites and established stations. They operated small air flow (approx. 4 m³/h) aerosol samplers at 8 locations, medium air flow (approx. 140 m³/h) aerosol samplers at 5 locations, and as of October 2013, at 6 locations. Based on the measurements of the meter system, the radioactive cloud after the Fukushima nuclear power plant accident in Japan in March 2011 reached the territory of Hungary in around two weeks. First the presence of I-131 linked to aerosols could be detected on the samples, and around a week later the Cs-134, Cs-137 radioisotopes could also be detected. The concentration of air pollutants fell below the detection threshold at the beginning of May (a few µBq/m³). The dose inhaled by the population of these isotopes is estimated at only a few nSv at the most. Since then, the meter system did not record any outstanding artificial radioactivity on the aerosol samples that would indicate a radiological event.

1.1.3. Decree on smog alert

Pursuant to Government Decree No. 306/2010 (XII. 23.) on the protection of the air, the mayor and in the capital the mayor of Budapest proceeds at first instance in official air clarity protection cases related to the implementation of the smog alert plan, and the local government prepares the smog alert plan. In most counties one town continues to have smog alert decrees: Baranya (Pécs 2009), Borsod-Abaúj-Zemplén (Miskolc 1993), Budapest (2008), Csongrád (Szeged, 2005), Fejér (Székesfehérvár 2010), Hajdú-Bihar (Debrecen 2010), Heves (Eger 2011), Nógrád (Salgótarján 2009), Szabolcs-Szatmár (Nyíregyháza 2010). Two towns have such decrees in Győr-Moson-Sopron (Győr 2003, Sopron 2009) and Komárom-Esztergom counties (Tatabánya 2009, Dorog 2010). No towns have smog alert decrees in force in Bács, Békés, Jász-Nagykun-Szolnok, Somogy, Tolna, Vas and Zala counties.

With regard to the reporting period, the following table shows the smog alerts ordered in the towns.

	2012.	2013.	2014.	2015.
Budapest	2I,1A	5I	2I	9I(O3)*,3I,1A
Debrecen	1A	1A	1A	2I
Eger	3I	1I	0	-
Győr		1I(O3)*		-
Miskolc	6I	3I	2I	11I
Nyíregyháza	1I	1I	4I	4A
Pécs	1I			-
Salgótarján	1I,1A	1I	2I	2I
Sopron				-
Szeged				-
Székesfehérvár	1I,1A			1I
Tatabánya	1I,1A	1I	-	-
Várpalota	1A	1A		-
Veszprém	1I		1I	-

*I: information level, A: alert level, *: the ordering of the information level was due to high ozone concentrations*

The information of the public may prevent the health deterioration of vulnerable population groups.

1.1.4. Critical air pollutants

The typical pollutant of the Hungarian settlements are still nitrogen-oxides ((NO₂, NO_x) and particles smaller than 10 µm (PM₁₀), regarding which the values exceed hygiene thresholds the most frequently. Ozone pollution may cause problems especially during the summer, however, the degree of contamination very rarely exceeds the information level of smog alert.

Objective: As to nitrogen-dioxide pollution, the number of cases when the thresholds are exceeded for over an hour of the hygiene norm remains below 18, and for PM₁₀ the number of cases when the thresholds are exceeded daily remains below 35 for each year. For ozone, reaching the long-term target objective is necessary.

Under the enforcement of the inter-sectoral PM₁₀ reduction action programme, NIEH participated in inter-ministerial Commission meetings, which may promote the reduction of the ratio of respiratory diseases of environmental aerosol origin. Under the responsibilities of NIEH to give a professional opinion, it prepares proposals, while giving an opinion on county territorial development concepts, spatial plans, and other strategic and operational programmes, in relation to the improvement of air quality of settlements.

1.1.5. Assessment of air pollution of the cycle routes of Budapest (2004, 2008/2009 and 2013/2014)

The fundamental task of NIEH is to assess different detrimental environmental effects for the mitigation of the burden of diseases of environmental origin, and this is how their attention wandered to cyclists. In recent years, there is a growing number of people living in big cities who use bicycles for everyday tasks (shopping, commuting to work or school, etc.).

Nitrogen-dioxide (NO₂), which shows air pollution of transport origin, was used to describe the aerial environment of cycle routes, since it is a generally accepted indicator.

The tests were carried out in Budapest and its immediate surroundings, at altogether 47 locations, of which 20 measurement points were established in Buda, 21 in Pest, and 6 in the three surrounding settlements. The sampling locations were designated according to the type of cycle route and the estimated traffic volume of the nearest public road, thereby placing the selected cycle routes into four main and two subcategories.

Based on the analysis of the results of the air ambient test of the selected cycle routes of the agglomeration in three measurement cycles, the following conclusions can be drawn:

- For the people using cycle routes or cycle lanes for cyclists only or used together with pedestrians built along high traffic roads, the annual NO₂ pollution exceeded the exposure limit (40µg/m³). This is twice as high of a pollution for them compared to those who chose the less busy routes.
- The NO₂ contamination of connecting cycle routes with asphalt cover or on the pavement was much less influenced by local traffic circumstances. The extra pollution of only 20 to 25 % experienced in relatively busy locations did not cause contamination that exceeded the exposure limit either.
- Cyclists opting for unpaved routes or roads with crushed stone cover could enjoy the best air quality environment.
- Compared to 2004, the NO₂ pollution of cycle routes rose equally by 10 % on average in the 2008/2009 and in the 2013/2014 measurement period as well. The greatest increase in air pollution was measured on the Lágymányosi bridge and the section of Szilágyi Erzsébet fasor close to Gábor Áron Street during the 2008/2009 measurement period. In 2013/14, the increase of concentration was the highest at the Budapest, Belváros railway stop.
- In the summer of 2004 and 2013/14 and in the spring of 2008/2009 air quality was a little more favourable in the tested cycle routes.

The nitrogen-dioxide pollution of cycle routes built next to busy roads exceeding the exposure limit may pose a risk for cyclists travelling in this area. Persons who use these routes day-to-day for longer periods of time and whose body is more sensitive to air pollution place their health in great jeopardy. Based on their findings it can be concluded that better quality cycle routes are usually built mostly next to busy roads.

1.1.6. Carrying out air quality tests at priority areas used by children and young people especially sensitive to air pollution: examination of air quality of playgrounds (2015-2016)

NIEH carried out again the air quality testing of playgrounds near roads with different traffic levels – near high traffic roads; far from high traffic roads; near medium traffic roads; near low traffic roads; background – based on the research carried out between 2010 and 2011, and the tests were extended with aerobiological, soil and water hygiene tests.

Air quality:

- The annual pollution of playgrounds built near high traffic roads was close to the exposure limit (40µg/m³)
- The air quality of playgrounds near medium traffic roads was also influenced by the density of buildings in the area.
- Playgrounds near low traffic roads and background type environments were in the most favourable situation, the NO₂ pollution of which only reached 58 and 15% of the allowed limit.
- Compared to Normafa, the long term NO₂ exposure of children and mothers near high traffic roads was 6 times higher.

Status of sandboxes:

- Both fresh and at least six-month old faecal pollution was manifested in the examined sandboxes of public playgrounds in Budapest.
- In all examined playgrounds there are still shortcomings in the maintenance of sandboxes.

Drinking fountains in playgrounds:

- The water quality of drinking fountains in playgrounds are appropriate at most measurement points.
- E. coli, coliform bacteria or Pseudomonas aeruginosa could not be manifested in any measurement point.
- No bacteria was found that would indicate pollution.
- The water quality of hotter, busier summer months is a little worse.

Suggestions:

- air quality aspects should be included in the planning instructions of playgrounds, so that children, as a sensitive population group can play under an air quality which does not pose a risk for them.
- We should choose playgrounds in green areas that are less affected by traffic and are ventilated well.
- Besides fences, it is advisable to cover sandboxes during the night.
- The sand of sandboxes in public playgrounds should be changed at least once a year, possible at early spring, before the sandboxes are put into use.

- Continuous maintenance – e.g. with raking –, with which children’s playing tools left behind and other pollutants (e.g. tossed cigarettes, sacks, papers) are removed from the sand, and which ensures the adequate ventilation of the playing sand and prevents the growing-in of tree and weed roots.
- Drinking fountains should be regularly monitored.

1.2. Indoor air quality

Pursuant to Section 4(1)(a) of Act XCVI of 1999 on the amendment of Act XI of 1991 on National Public Health and Medical Officer Service, the purpose of the Service is to examine from public health point of view the air quality of enclosed spaces.

For the healthy and secure use of enclosed spaces and the improvement of indoor air quality, air quality measurements were conducted in the air hygiene and aerobiological department of NIEH in different enclosed spaces (schools, offices, flats, sports facilities) within the framework of targeted research programmes and unique tests for the establishment of thresholds and minimum requirements for the adequate indoor air quality of newly built buildings.

1.2.1. School Environment And Respiratory health of Children: SEARCH-II – 2010-2013

The aim of the project is to assess the connection between the school environment and respiratory health of children, and to make recommendations on the basis of the results to improve the school environment. This project is the extension of the SEARCH-I project (2006-2010) with the participation of four new countries (Ukraine, Belarus, Kazakhstan, Tajikistan), and to enforce the energy audit in the old (Albania, Bosnia and Herzegovina, Hungary, Italy, Serbia and Slovakia) and new countries in designated schools.

In 2013, the passive and monitoring database from the four new countries was formed and the results were assessed. A report entitled “Monitoring of indoor air pollution in the classroom – SEARCH-II” was drawn up on that basis.

The data of the 10 countries participating in the SEARCH-I and SEARCH-II projects were analysed. In the air of classrooms PM_{10} concentration was between 28 and 102 $\mu\text{g}/\text{m}^3$, but the maximum values were in fact 3 to 4 times higher. The lowest concentrations were found in Belarus and Ukraine. Indoor *benzene* pollution was between 1.7 and 33.07 $\mu\text{g}/\text{m}^3$. The lowest concentrations were found in Belarus, Ukraine, Hungary, Albania and Italy. In these countries the average benzene pollution measured did not exceed the EU directive thresholds (5 $\mu\text{g}/\text{m}^3/1$ year). Indoor *toluene* pollution was between the wide range of 4.6 and 29.5 $\mu\text{g}/\text{m}^3$. The highest values were measured in Serbia and Slovakia, where the measured values exceeded the WHO recommendations (260 $\mu\text{g}/\text{m}^3/1$ week). The average *xylene* pollution was between 4.3 and 9.1 $\mu\text{g}/\text{m}^3$, with the highest level measured in a Hungarian classroom. *Ethylbenzoyl* pollution remained low in most countries. The highest concentrations were found in Italy and Hungary (10.88 and 12.9). For *formaldehyde*, the average concentration was between the range of 1.7 and 33.07 $\mu\text{g}/\text{m}^3$, but it never exceeded the WHO recommendation for 30 minutes (100 $\mu\text{g}/\text{m}^3$). The highest CH_2O pollution was measured in Italian schools. *Nitrogen-dioxide* polluted the air of examined classrooms to a little extent (15 to 22 $\mu\text{g}/\text{m}^3$). The *carbon-dioxide* level measurements, which give information on the supply of fresh air of

classrooms, have shown a way higher amount of carbon-dioxide already at the beginning of the class (>1000ppm) than the level measured in outdoor environments.

A report entitled “Monitoring of indoor air pollution in the classroom – SEARCH-I-II” was drawn up on the results.

1.2.2. Garage in the house (2012-2014)

The adverse effects of polluted urban air are known for long, but our health is jeopardised by the polluted air of workplaces and flats just as much as the presence of other sources. The aim of the research is to map the indoor air quality of different types of flats, with special regard to the problem of “garage in the house”. The air quality of ten different flats/houses was assessed in the test based on chemical indicators and physical parameters used in practice. CO/CO₂/T/RH and aerosols were determined with real-time monitors with a 24-hour exposure period. The determination of nitrogen-dioxide, formaldehyde and volatile organic hydrocarbons was conducted by passive samplers with a one-week sampling period. Parallel to indoor measurements, tests were also carried out outdoors for reference.

The measurement results were analysed on the basis of threshold values recommended in the draft decree on the “public health requirements for the design, construction and operation of buildings” prepared by NIEH. From the physical parameters, room temperature was optimal in 41 % of the tested rooms (21-23°C), and relative humidity was found to be ideal in 47 % of sampling locations (45-55 %). CO₂ pollution exceeded the recommended values in three flats. Benzene and formaldehyde pollution exceeded the exposure limits set out in the draft decree by 15 and 25 % of monitored locations, respectively. The concentration of other volatile organic hydrocarbons remained low. PM₁₀ pollution was found to be ideal in three houses, while NO₂ concentration exceeded the exposure limit in one flat.

CO₂ concentrations exceeding the recommended limit were found in flats with smaller airspace and well-insulated doors and windows. Low aerosol pollution was found in rural houses in the suburbs. The cause of volatile organic hydrocarbon pollution over the exposure limit was the proximity of a garage or main road, or recent renovation works on the house. NO₂ is present indoors primarily when convector heating or gas cookers are in use.

The received results reveal the hazard risks occurring in the house/flat, and by eliminating them it would be possible to avoid that the different factors of existing flats, flats to be renovated or newly built flats do not put at risk the health of their residents.

1.2.3. Testing the air quality of swimming pool spaces (2015-2016)

The chlorine derivatives and their degradation products used to disinfect spas with swimming pools – primarily trihalomethanes (CHBr_xCl_y, where x+y=3) – may pose a serious health risk for sensitive groups during water uptake by the drinking water. Having regard to this risk, the Directorate made calculations for the bathing water as well, during which it found that exposure through inhalation would pose a serious risk primarily, mainly for the persons spending a longer period of time in the airspace of the swimming pool. The chloroform concentration if air was calculated under different models from the chloroform concentration of bathing water, which is not sufficiently precise.

The aim of the research is to determine the bathing water and indoor pollution of chloroform, bromoform, dibromochloromethane and bromodichloromethane for the purpose of more accurate risk assessment calculations. In 2015, the testing protocol was defined and test measurements were carried out in two swimming pools (Budapest, Siófok). The CHCl_3 , CHCl_2Br , CHClBr_2 , CHBr_3 concentration of air was performed by the active sampling technique on active charcoal sorbent (226-01 – Anasorb CSC charcoal tubes), with 1 house sampling at 0,16 l/minute flow rate. Measurements were carried out in two heights (40 cm, 150 cm) with 1 m distance from the pools. Sample analysis was carried out by CS_2 solution and with GC-MS. Based on the test measurements, the testing protocol is suitable for testing the trihalomethane pollution of swimming pool airspaces, therefore, research continues in 2016 with the assessment of the indoor air quality of 20 to 25 swimming pools.

1.2.4. Testing the air quality of salt rooms and salt caves (2016)

The air quality control of salt caves is currently not regulated in laws. However, the analysis of this topic deserves attention from both health and technological aspects. Appropriate air quality would be a fundamental requirement for salt room/cave services and operation.

The microbial composition of the air of salt rooms/caves is important. The pathogenic bacteria and mould that might be found in the vaporised air may cause asthma, allergy or other diseases. One cause for this may be the inappropriate hygienic condition of the equipment (e.g. water stagnating in containers), but the contamination of building materials cannot be excluded both (because salt caves are frequently built in cellars, and their walls may retain water, which may lead to the spread of mould and other allergens). The quality of air is not a side issue from the aspect of air chemistry either: whether it really contains the active substance (NaCl) advertised by the service provider, and whether it is able to provide this in the aerosol size range appropriate for the treatment. Is there enough quality salt released into air necessary for the treatment by the applied technology (piled salt, dry or wet salt blow, salt wall, salt sandbox, etc.) at all? The physical parameters of air must also remain within the suggested range in salt rooms/caves.

Based on the above, the following testing protocol was elaborated for salt rooms/caves:

1. Aerobiological test:
 - Measurement of total air concentration of bacteria
 - Measurement of air concentration of mould
 - Measurement of Legionella concentration (only for wet vaporisation) in air and in containers
2. Aerochemical test:
 - Determination of size distribution of salt aerosol particles
 - Determination of mass concentration of salt aerosol
3. Determination of physical parameters
 - Examination of temperature and relative humidity

1.2.5. Elaboration of air quality standards of enclosed spaces (2014-2015)

Pursuant to Section 4(1)(a) of Act XCVI of 1999 on the amendment of Act XI of 1991 on National Public Health and Medical Officer Service, the environmental and settlement

hygiene task of the Service covers the elaboration of air quality standards related to enclosed spaces.

The Directorate participated in the repeated submission and codification of the EMMI draft decree on the “public health requirements for the design, construction and operation of buildings” and the preparation of the necessary guidelines. On the one hand, the public health and health protection requirements set out in the decree are indispensable for the work of healthcare administrative bodies, on the other hand, it may reduce the serious health risk caused by the inappropriate quality of the indoor environment and it may improve public health indicators.

2. Water quality

2.1. Drinking water

Various amendments were adopted for Government Decree 201/2001 (X.25.) on the quality standards and monitoring of drinking waters that improved drinking water quality and safety during the reporting period. The most important amendments include:

- The preparation of the so-called drinking water safety plan compulsory for water utilities, with the help of which risk assessment of possible risks can be conducted from the water base to the consumers’ tap, thus the principle of prevention comes to the foresight instead of end-point inspection.
- In line with the EU Directive (1314/2013/EURATOM), requirements for the analysis of radioactive components of drinking waters were also incorporated into national legislation. Legal harmonisation was realised by the publication of Government Decree 313/2015 (X. 28.) . Pursuant to the provisions in force, the following radiological parameters of drinking water are to be assessed: calculation of tritium concentration, dissolved radon concentration and indicative dose. With the entry into force of the provision, drinking water suppliers have started to analyse the waters of wells and public rivers under their operation in accredited laboratories.
- The modification of instructions concerning the public health applicability of materials entering into contact with the drinking water and water treatment technologies.

Practical arrangements of public health regulations – projects, programmes

• Drinking water improvement project

The drinking water improvement project was launched under the environment and energy operational framework programme (KEOP) in 2007 (KEOP-1.3.0 between 2007 and 2010, KEOP-7.1.0 from 2011). The aim of the programme is to provide grants to settlements with disputed quality drinking water as regards the priority drinking water quality standards from EU funds to carry out drinking water improving investments.

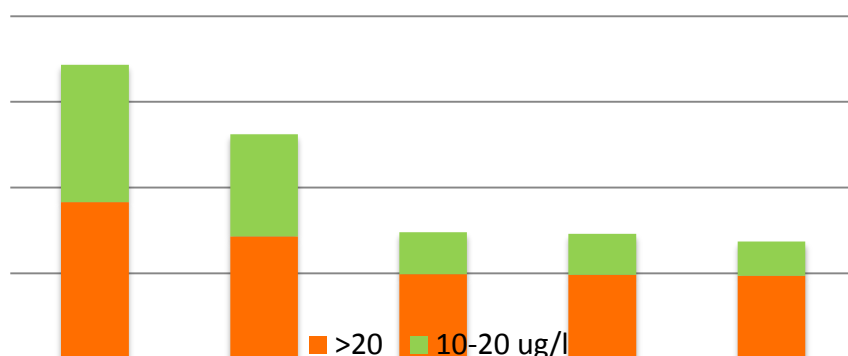
Development projects had been accelerated since 2012 and most of them were finished in 2015. The number of water supply systems concerned have fallen substantially in the examined period, primarily due to the serious decrease in the number of settlements and the size of population affected by arsenic (see table below). The following table shows the

changes in the number of settlements and inhabitants affected by the priority water quality dispute over the reporting period.

Changes in the number of settlements and inhabitants affected by the priority water quality dispute (2012-2015)

	2012.		2013.		2014.		2015.	
	Number of settlements	Population concerned	Number of settlements	Population concerned	Number of settlements	Population concerned	Number of settlements	Population concerned
Arsenic	277	722 431	176	410 954	167	466 984	133	366 481
Boron	36	46 636	36	45 150	28	45 848	27	42 175
Fluoride	2	1 144	3	2 571	2	1 839	3	2 517

Evolution of the number of settlement affected by above-threshold arsenic concentration (2011-2015)



- **Secure drinking water for everyone**

As per the proposal of the National Research Institute for Radiobiology and Radiohygiene, from 2015 the testing programme of the Radiological Monitoring and Data Acquisition Network (RAMDAN) were complemented by the determination of the indicative dose of drinking waters. According to the experience gained, the indicative dose value of the examined samples did not exceed 0.1 mSv/year as defined in the 2013/51/EURATOM Directive.

- **Other projects related to drinking water quality**

In the examined period two significant projects were realised, which had an indirect effect on domestic drinking water quality:

The project entitled “Laboratory development in public health necessary to ensure healthy drinking water” was realised under KEOP-1.5.0/15-2015-0001, with the help of which the instruments of both central and regional official laboratories were improved.

The project entitled “Construction of the national information infrastructure laying foundation to the environmental health surveillance of human water use” was realised under EKOP-2.A.2-2012-2012-0011, with the help of which data was collected online on national drinking water quality.

- **Other activities related to water**

Besides drinking water quality, from public health point of view the number of inhabitants supplied and equal access to drinking water supply is also important. This was also assessed in Hungary during the period under examination: with the help of the self-assessment sheet elaborated within the framework of the so-called Protocol on Water and Health international collaboration, the situation in Hungary was assessed at national level between 2014 and 2015. The main conclusion is that despite high service coverage (95 %) access to drinking water remains a challenge for socially and economically disadvantaged groups and for rural farming areas located far from public supply. This population is not included in official statistics, and they are highly dependent on the help of NGOs to improve their situation.

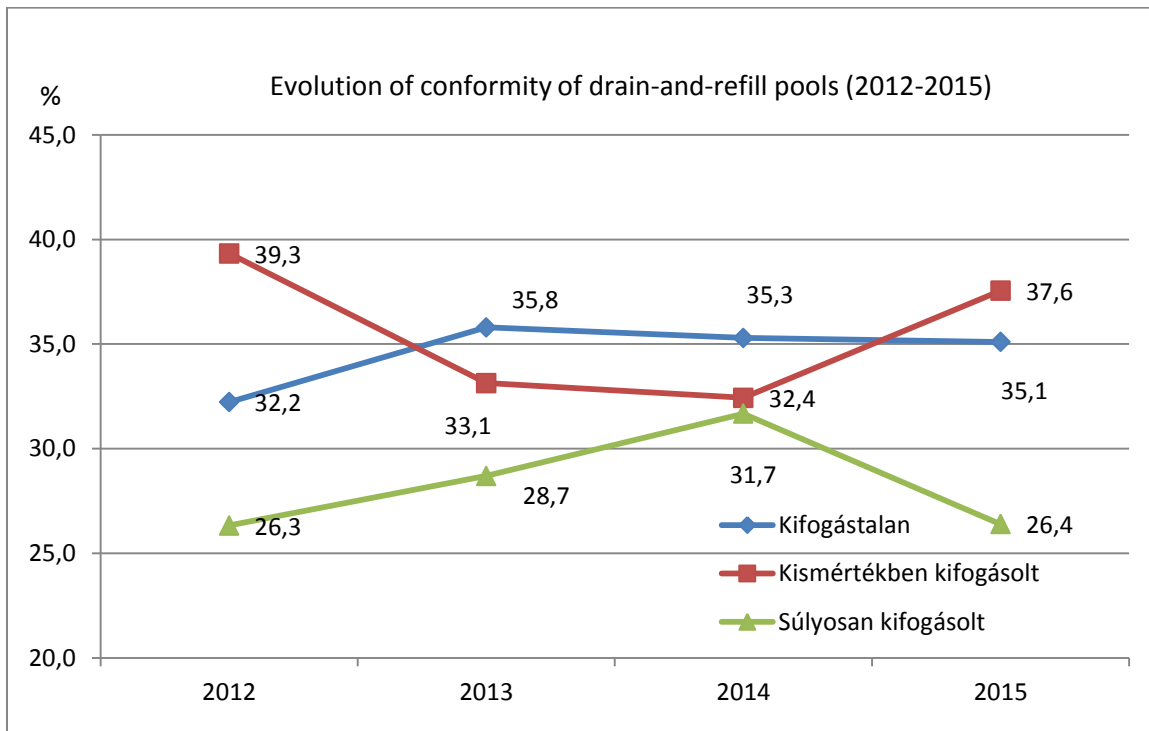
2.2. Bathing water

2.2.1. Pool spas

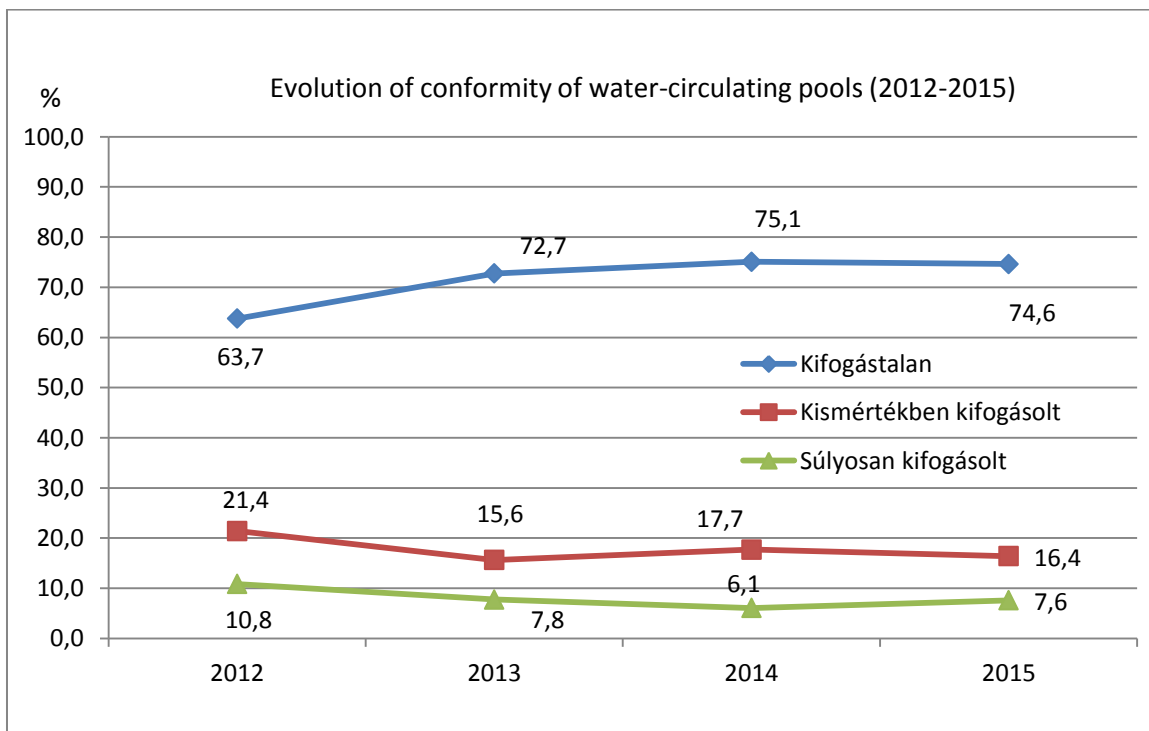
The water quality of pool spas is defined in Decree 37/1996 (X. 18.) NM (Ministry for National Economy) on public health requirements of establishing and operation of public baths. No significant amendments were made to laws in the period under review.

The evolution of the classification of pool bathing waters for drain-and-refill pools and water-circulating pools are shown in the following tables.

Annual evolution of water classification of drain-and-refill pools (2012-2015)



Annual evolution of water classification of water-circulating pools (2012-2015)

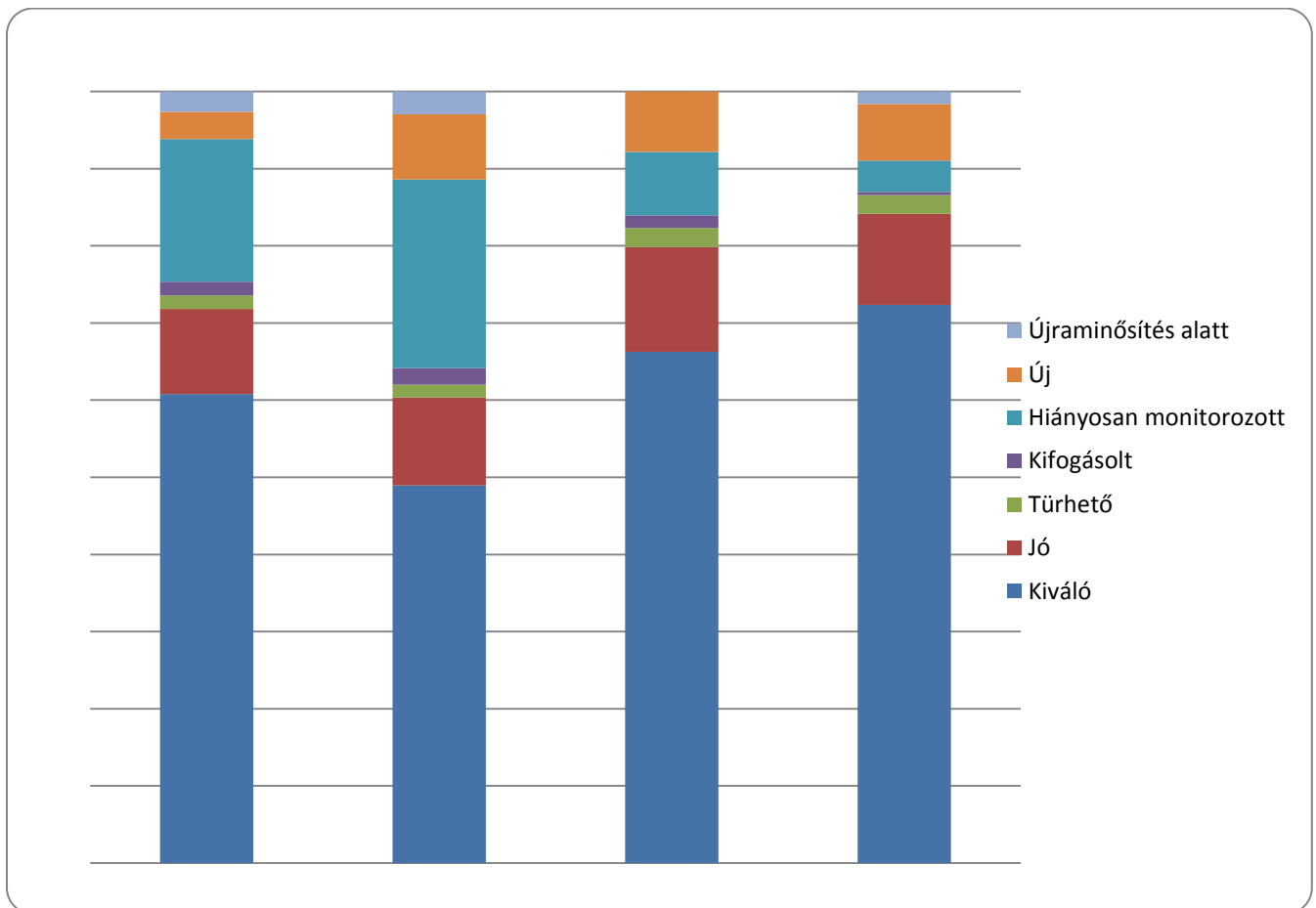


2.2.2. Natural bathing waters

The water quality of natural bathing waters is defined in Government Decree 78/2008 (IV. 3.) on the quality requirements relating to natural bathing waters and the designation and operation of natural bathing resorts. No significant amendments were made to laws in the reporting period.

The evolution of the water quality of designated natural bathing resorts in the reporting period according to the EU assessment system is shown in the following table.

Annual evolution of classification of natural bathing resorts (2012-2015)



3. Soil and waste hygiene

In the previous period the sewage treatment and waste management of settlements has been developed significantly, mostly from European Union grants, which is illustrated in the following table.

With regard to the fact that the previous National Report did not include statistical data assessing the area of expertise of soil and waste hygiene, we also present these data in this report for informational purposes.

Waste water disposal and cleaning of settlements

Year	Through the public sewerage		Led and transported to public sewerage treatment plant through the public sewerage for cleaning purposes				Waste water collected through the public waste collection network but not cleaned (1000 m ³)	Domestic waste water not collected through public network (1000 m ³)
	collected (1000 m ³)	led to public sewerage treatment plant (1000 m ³)	only mechanically (%)	biologically as well (%)	with purification grade III as well (%)	Total (1000 m ³)		
2008	542,106	516,796	26.1	39.4	34.5	519 787	25,311	4,325
2009	529,022	505,069	24.3	39.8	35.9	507 525	23,953	3,921
2010	556,338	551,207	3.2	50.7	46.1	553 375	5,131	3,643
2011	467,594	464,170	1.9	47.0	51.0	465 963	3,424	3,311
2012	435,692	429,355	0.2	24.6	75.2	431 647	6,336	3,002
2013	497,930	482,997	0.2	22.4	77.4	484 885	14,932	2,928
2014	500,882	481,057	0.1	22.7	77.2	482 783	19,825	2,746

Source: KSH (http://www.ksh.hu/docs/hun/xstadat/xstadat_eyes/i_uw005.html).

The number of settlements having sewage pipes increased from 854 in 2000 to almost the double, 1900 in 2014. However, there were 8 of the settlements having no operating public sanitation system were towns: Csanádpalota, Fegyvernek, Nagybjom, Nagyecsed, Sándorfalva, Sülysáp, Tápiószele and Tompa. The other 1254 settlements having no operating public sanitation system at all were municipalities, 944 of them with less than 1000 inhabitants.

Settlements and houses having the public sewerage in Hungary

Year	With public sewerage						Length of the public waste collection network (km)	Length of public waste collection network for each km of public water mains (m)
	settlement		house					
	total (pc)	% of all settlements	total (pc)	% of all houses				
				country	city	municipality		
2008	1 669	53.0	305 4956	71.0	84.0	41.1	41 897	643
2009	1 725	54.7	3 119 437	72.0	84.7	42.3	42 438	651
2010	1 741	55.2	3 144 228	72.3	84.7	43.2	43 200	655
2011	1 763	55.9	3 169 234	72.7	84.7	43.4	41 786	633
2012	1 833	58.1	3 258 172	74.0	85.0	46.7	42 958	657
2013	1 860	59.0	3 310 105	75.1	85.9	48.0	43 586	669
2014	1 900	60.2	3 397 557	77.0	87.1	50.4	44 917	685

Source: KSH (http://www.ksh.hu/docs/hun/xstadat/xstadat_eyes/i_zrk002.html).

By examining the number of settlements without supply per county, it can be concluded that mostly the settlements of the counties of Baranya (198), Somogy (125), Zala (107), Vas (95), Borsod-Abaúj-Zemplén (87) and Szabolcs-Szatmár-Bereg (60) – with usually a low number of inhabitants – have no operating public sanitation system.

There is an improving trend country-wise in the area of sewerage and waste water treatment, however, in smaller settlements, where sewerage is not satisfactory, there are still reports about problems; this issue emerges typically in the settlements of small villages of the country. In these settlements it is not always profitable to operate an installed sewage system.

Ratio of houses connected to the public sewerage (%)

Territorial unit	2008	2009	2010	2011		2012	2013	2014
Budapest	96.7	96.4	96.6	96.6		95.8	95.8	95.7
Pest	65.0	66.5	68.2	67.9		68.6	70.5	73.4
Central Hungary	86.1	86.4	87.0	86.9		86.5	87.1	88.0
Fejér	68.5	70.4	71.6	71.9		72.7	77.0	80.0
Komárom-Esztergom	80.1	80.1	79.9	79.9		80.6	80.7	90.5
Veszprém	80.2	81.5	81.5	81.6		82.4	82.7	83.1
Central Transdanubia	75.7	76.9	77.3	77.4		78.1	79.9	84.0
Győr-Moson-Sopron	84.5	85.2	84.5	85.9		86.6	86.8	88.1
Vas	67.8	70.7	71.9	72.2		75.7	76.3	77.0
Zala	67.7	69.6	70.0	70.4		72.3	73.0	73.3
Western Transdanubia	75.0	76.7	76.8	77.7		79.5	80.0	80.8
Baranya	73.0	73.4	71.6	71.9		71.1	72.5	74.1
Somogy	62.1	63.3	62.6	63.2		63.7	64.7	66.6
Tolna	58.6	59.7	60.5	60.9		63.4	64.7	69.7
Southern Transdanubia	65.7	66.6	65.8	66.2		66.7	67.9	70.4
Transdanubia	72.3	73.5	73.5	73.9		75.0	76.2	78.7
Borsod-Abaúj-Zemplén	65.2	65.9	65.8	66.3		70.3	71.2	72.5
Heves	60.1	62.9	60.6	61.1		65.2	71.6	73.9
Nógrád	64.6	66.3	67.1	67.5		70.5	69.2	69.8
Northern Hungary	63.8	65.2	64.7	65.1		69.0	71.0	72.4
Hajdú-Bihar	64.1	64.9	64.3	66.4		68.0	69.7	70.6
Jász-Nagykun-Szolnok	62.3	63.3	65.5	66.2		68.3	68.7	70.1
Szabolcs-Szatmár-Bereg	52.5	54.0	54.8	56.6		60.0	59.4	61.5
Northern Great Plain	59.5	60.5	61.3	62.9		65.3	65.8	67.3
Bács-Kiskun	46.4	47.3	47.6	48.0		49.7	50.6	52.4
Békés	48.1	52.3	52.7	53.6		58.1	61.4	64.8
Csongrád	64.7	65.0	65.1	64.0		63.9	65.2	70.5
Southern Great Plain	52.7	54.4	54.6	54.7		56.6	58.3	61.7
Country total	71.0	72.0	72.3	72.7		74.0	75.1	77.0

Source: KSH(http://www.ksh.hu/docs/hun/xstadat/xstadat_eves/i_zrk005.html).

The waste management obligations of the European Union primarily foresee the recycling of wastes: in case of packaging waste, e.g. the recycling obligation is 60 % for paper, 22.5 % for plastic, 60 % for glass, 50 % for metal, 15 % for wood and 60 % for all packaging waste, of which the minimum recycling obligation is 55 %.

It would be important for this area to grant state aid and to enforce developments aimed at the excess collection and recycling of wastes. The current situation is shown in the table below.

Volume and recycling ratio of packaging waste

Waste type	Produced quantity	Obligation			Output
	tonnes	Type	%	tonnes	tonnes
Total packaging waste	1,060,000	recovery	60	636,000	650,000
		recycling	55	583,000	530,000
Paper fraction (textile, associated also)	400,000	recovery	60	240,000	340,000
Plastic fraction	270,000	recovery	22,5	60,750	170,000
Glass fraction	105,000	recovery	60	63,000	35,000
Metal fraction	65,000	recovery	50	32,500	70,000
Wood fraction	220,000	recovery	15	33,000	35,000

Source: <https://nhkv.hu/wp-content/uploads/2013/12/Orszo%81gosHullade%CC%81kgazda%CC%81koda%CC%81siKo%CC%88zszolga%CC%81tata%CC%81siTerv2016.pdf?dl=1>.

The alternative solutions to the elimination of waste status, the possibilities to declare something a by-products, and the solutions to the reduction of health risks related to the production and management of hazardous waste should be considered priority sub-areas, taking into consideration the public and environmental health effects of waste management. Health risks related to the production and management of hazardous waste could be reduced significantly by the classification of hazardous waste and the classifying review of their waste treatment technologies.

Our findings are founded by the data of the following table showing the volume and forms of appearance of hazardous waste, which demonstrate well how much amount of hazardous waste is produced nowadays; their quantities have not decreased much since 2008, only the volume of the gaseous forms of hazardous waste has shown a satisfactory decrease.

However, we must not forget about the environmental health risks of the most frequent form of disposal of hazardous wastes, their incineration, because the dioxine and/or furan emissions of hazardous waste incinerators is often ten times higher than the exposure limits.

Volume of hazardous waste by form (tonnes)

Year	Total	Of which			
		solid	sludge	liquid	gaseous
2008.	714 456	410 818	96 869	206 697	72
2009.	851 126	585 286	93 752	172 030	58
2010.	569 348	298 452	89 160	181 518	217
2011.	777 287	478 470	122 619	176 107	92
2012.	776 379	430 031	156 543	189 712	93
2013.	564 761	278 636	98 112	187 994	19
2014.	652 541	359 556	102 783	190 193	9

Source: http://www.ksh.hu/docs/hun/xstadat/xstadat_eves/i_ur002.html.

With hazardous waste management, there are still many issues to be resolved in the field of regulation and organisation of hazardous medical waste collection and disposal.

Decree 1/2002 (1.11.) EüM (Ministry of Health) (1.11.) contains the instructions on the treatment of wastes of healthcare institutions. The regular collection and treatment of medical waste produced in hospitals, private clinics and during general practice services in compliance with the laws is sufficiently regulated.

Local air and soil degradation caused by illegal waste incineration and incineration of inappropriate wastes does not only affect socially disadvantaged persons and their family members (including small children), but the families living in the wider living environment. Waste incineration is usually applied for heating during the heating season by the socially disadvantaged people.

To tackle this problem, the National Institute of Environmental Health prepared a professional paper in March 2012 entitled “The impact of illegal incinerators on human health and environment”, which represents an important awareness raising information paper until this area is put in order by legal provisions.

([https://www.antsz.hu/data/cms36282/Tajekoztato_illegalis_hull_egetesrol_OKI_20120326_\(3\).doc?](https://www.antsz.hu/data/cms36282/Tajekoztato_illegalis_hull_egetesrol_OKI_20120326_(3).doc?)).

Public spaces are kept clean mostly by public-sector employees in many counties, however, the ratio of regularly cleaned public spaces has risen a little only in the Central Hungarian territory.

Regularly cleaned public space (1000 m²)

Territorial unit	2008	2009	2010	2011	2012	2013	2014
Budapest	27 927	28 074	28 371	29 641	32 141	32 095	33 007
Pest	4 620	6 829	6 663	7 623	7 485	7 210	7 428
Central-Hungary	32 547	34 903	35 034	37 264	39 626	39 305	40 435
Fejér	1 639	1 804	1 579	1 514	3 121	2 799	2 803
Komárom-Esztergom	4 212	4 212	4 235	3 948	4 024	4 314	4 866
Veszprém	3 982	3 838	4 019	4 128	4 153	4 160	4 175
Central-Transdanubia	9 833	9 855	9 832	9 590	11 298	11 273	11 843
Győr-Moson-Sopron	3 613	4 320	4 310	4 351	4 348	4 357	5 573
Vas	2 905	2 905	2 958	3 375	3 381	3 381	3 381
Zala	2 105	2 183	2 073	1 988	2 130	2 224	2 258
Western-Transdanubia	8 623	9 407	9 341	9 714	9 859	9 962	11 212
Baranya	4 071	4 091	3 563	4 208	4 199	4 199	4 193
Somogy	4 566	4 573	4 453	4 450	4 139	4 145	4 147
Tolna	872	944	892	838	857	857	834
Southern-Transdanubia	9 509	9 607	8 908	9 496	9 195	9 200	9 174
Transdanubia	27 964	28 869	28 081	28 800	30 353	30 435	32 229
Borsod-Abaúj-Zemplén	8 725	9 369	9 379	10 710	10 791	10 791	10 844
Heves	1 430	1 509	1 509	1 509	1 569	1 380	1 401
Nógrád	1 196	1 229	1 234	1 068	1 069	1 226	1 226
Northern-Hungary	11 350	12 107	12 122	13 288	13 429	13 397	13 471
Hajdú-Bihar	3 270	3 133	3 035	2 838	3 211	3 641	3 680
Jász-Nagykun-Szolnok	2 662	3 026	3 028	3 211	2 881	2 523	2 524
Szabolcs-Szatmár-Bereg	4 263	4 523	4 265	4 301	4 718	4 286	4 286
Northern Great Plain	10 195	10 683	10 328	10 350	10 810	10 450	10 490
Bács-Kiskun	3 865	3 510	3 543	3 665	4 303	4 563	4 523
Békés	3 534	3 427	3 757	3 243	3 210	3 270	3 278
Csongrád	4 444	4 501	4 509	4 524	3 381	3 476	2 255
Southern Great Plain	11 842	11 439	11 808	11 432	10 894	11 309	10 056
Country total	93 899	98 000	97 372	101 133	105 111	104 895	106 681

Source: http://www.ksh.hu/docs/hun/xstadat/xstadat_eves/i_ur004b.html.

In big cities the presence and activity of homeless people poses a public health risk.

Following the changed regulations concerning livestock farming, local governments cannot restrict the production of farmed agricultural farmed animals in local decrees anymore. The number of complaints concerning the stench and the propagation of insects and rodents originated from livestock farming and manure storage has increased. The nitrite, nitrate and ammonia pollution of soils and groundwater has increased in the surroundings of animal holdings.

As to funeral activities, growing discipline and focus can be witnessed in comparison to previous years, in which the frequent inspections carried out by the district offices and the public health departments of the government offices of Budapest and the counties play a significant role. The typical trend is that the frequency of funerals of cremated remains constantly increases due to financial considerations. The collection of papers of the long deceased who are buried into graves raises serious problems in almost all counties.

In Hungary, the share of measures necessary at units doing funeral activities was low in 2015 in contrast to previous years compared to the number of inspected units (0 % to 14.3 %) and

the number of inspections (0 % to -13.2 %) as well. In the capital and in 12 other counties no measures had to be taken during the inspection.

At the units doing funeral activities measures over 10 % had to be taken only in 2 counties during the official inspection of NPHMOS authorities in the reference year: in Fejér county (14.3 % measure/inspected unit) and in Heves county (11 % measure/inspected unit). However, the share of inspected units compared to the registered unit numbers does not reach 20 %, so the data of necessary measures need to be considered with certain reservations.

Measures taken by the district offices and the public health departments of the government offices of Budapest and the counties during soil hygiene inspections related to funerals in 2015

NPHMOS	Registered units	Inspected units	Official inspection in registered units	All measures (Call for enforcement of legal provisions)
	qty	qty	qty	qty
Capital city	19	10	11	0
Pest	179	87	87	0
Baranya	119	7	7	0
Bács-Kiskun	107	12	12	0
Békés	41	0	0	0
Borsod-Abaúj-Zemplén	394	13	18	0
Csongrád	38	2	2	0
Fejér	211	63	68	9
Győr-Moson-Sopron	92	3	3	0
Hajdú-Bihar	99	20	21	2
Heves	42	9	9	1
Jász-Nagykun-Szolnok	148	90	45	1
Komárom-Esztergom	106	63	55	0
Nógrád	57	0	0	0
Somogy	184	3	3	0
Szabolcs-Szatmár-Bereg	280	55	65	4
Tolna	118	46	48	4
Vas	256	83	114	4
Veszprém	89	0	0	0
Zala	158	8	7	0
Country total:	2737	574	575	25

Healthy environment of playgrounds

The Soil Hygiene Department of the National Institute of Environmental Health of the National Public Health Centre (hereinafter “NIEH of NPHC”) carries out hygienic microbiological inspections from spring to autumn in every playground season since 2014 at children’s playgrounds from the soil samples of sandboxes, the results of which clearly show the importance of hygienic microbiological inspection. In this connection, various proposals were elaborated:

- The constructor and/or the installer of playgrounds must provide for the adequate soil hygiene of playground soils, and the installer or operator of playgrounds must ensure

that the playground soils are constantly maintained from the inauguration of the playgrounds.

- When choosing the place for the playground, the preliminary public health monitoring of the selected location and the hygienic microbiological inspection of the soil of the planned location should be considered as substantial criteria. Sampling at the planned location and the processing of samples should only be performed by a laboratory accredited for this purpose.
- When designating the area of the playground, the territory should be physically cleansed at least 40 cm deep of all tools or glass chips etc. that may cause cutting or needlestick injuries, and of all construction waste and tree branches that may cause tripping or falling.
- The whole area of the playground should be easily accessible and its soil has to be easily maintainable from public health point of view.
- The playground must be enclosed and equipped with a lockable door, which has to be closed every day after opening hours.
- Various easy-to-empty and washable waste bins must be placed in the area of the playground, and the operator of the playground must ensure their daily emptying.
- Dogs are not allowed in playgrounds.
- The operator of the playground must pay particular attention to keep the sandy soil of playground sandboxes and the sandy soil of the shock absorbers under toys in adequate soil hygiene condition:
 - Sandboxes have to have covers which cannot open up due to weather conditions. After opening hours the sandbox have to be covered every day.
 - The change of sand of sandboxes should be performed immediately depending on the exposure and status of the sand in the sandbox, if necessary, however, for the human health protection of children playing there it is advisable to perform the hygienic microbiological inspection of sandboxes at least once a year from at least two different depths of the sandbox sand (e.g. close to the surface 0-10 cm and 10-20 cm depth).

4. Examination of the health effects of climate change and promoting adaptation to climate change

According to the scientific community, the around 0.5°C warming having occurred in the second half of the 20th century is most likely to be caused by humans, and it can practically be excluded that this is a natural fluctuation occurring in the status of our environment. The most recent 5th report (2014) of the Intergovernmental Panel on Climate Change (hereinafter “IPCC”) is clearer than ever on this issue, that is, it can be stated with great certainty that human activity, which transforms nature and most of the times is detrimental, has reached the climatic system of the Earth.

In accordance with the IPCC reports, based on the climate health assessments performed by NIEH of NPHC since 2000, it was found that the most important health risk in the Carpathian Basin is currently caused by the effects of temperature and extreme temperature events. This fact is included in the following document: “Government Decision 1384/2014 (VII. 17.) on the report on the national disaster risk assessment methodology of Hungary and its results”.

Between 2005 and 2014, during the heat waves 700 people lost their lives on average each year (extreme values: 24 persons in 2014; 1900 persons in 2015;). According to the forecasts of NPHC elaborated in 2015, it is expected that the frequency of heat waves will further

increase in the future; by 2050, their number may double, thereby significantly raising the number of excess mortality caused by the heat by around 150 %. Between 2071 and 2100, taking the demographic and socio-economic status of today as a basis, climate change will increase the current number of excess mortality by more than six times.

Within the framework of the 2014 project of the European Environment Agency entitled the Foresighted Reasoning on Environmental Stressors and Health (FRESH), NPHC examined the topics of environment, health and well-being in a wider context, taking into account both the importance of ecosystems services and the comprehensive socio-economic effects. For the prepared complex model the criteria were collected with the help of which a topic can be described, and indicators were identified to explore relationships and to monitor the effects of climate change on health (<http://www.eea.europa.eu/Sections/a-europe-to-thrive-in>).

The National Climate Change Strategy (hereinafter “NCCS”) (2008-2025) identifies the main action lines for Hungary's medium-term climate policy, “it is a highly inter-sectoral and overall social framework system, which affects all economic sectors and social groups, and therefore the relevant strategic objectives and tasks must be integrated into all sectoral (ministerial) activities”. The strategy was adopted by the Parliament in 2008, and its revised and updated edition was adopted by the government in 2015 and submitted to the Parliament. NIEH of NPHC actively participated in the realisation of the strategic objectives of the NCCS.

Several actual measures were carried out in recent years:

- Heat alert – NPHC elaborated and introduced it in 2005, since then the Office of the Chief Medical Officer operates it continuously with the professional collaboration of the NPHC
- UV alert – Hungarian Meteorological Service operates it since 2007, NPHC participates in informing the public
- Pollen information system and forecast – NPHC started the pollen forecast in 1992, and it is continuously developed and operated.

Providing professional materials for (social, educational) institutions supplying bigger groups to create heat plans, elaborating and updating the central criteria.

Environmental health protection – “near-real time” surveillance of excess mortality related to heat. The system was established in 2007, and it still operates: comparison of daily raw mortality data transmitted once a week and daily average temperature in Budapest and at county level, evaluation of excess mortality.

Increasing conscientiousness, education and raising awareness: specialised training of healthcare and social workers, teaching climate health studies in educational institutions of different levels. Increasing climate health awareness of the public by involving the media, preparation of educational materials. Regular information of the public on potential dangers. NPHC successfully contributed to the targeted public communication by preparing professional background material on the basis of WHO educational materials and domestic experiences.

NPHC participated in the elaboration of the National Adaptation Geo-information System in 2015 as regards the assessment of the effects of heat waves causing excess mortality for the present and the future. It elaborated the exposure, sensitivity and vulnerability indicators related to heat waves in the NUTS4, NUTS3, NUTS2, NUTS0 territories for the present and

on the basis of the ALADIN climate model for two future periods (2021-2050, 2071-2100) (<http://nater.mfgi.hu/>).

Strengthening the healthcare systems for the purpose of getting prepared to risks originating from climate change, with special regard to extreme weather conditions. For successful adaptation the transformation of healthcare institutions is also of great importance. Here the primary factor is mainly the insulation and cooling of buildings. Ensuring appropriate indoor temperature is very important in healthcare institutions. NPHC initiated a survey in 2015, according to which in hospitals most of the operating theatres, and around half of the doctors' rooms and staff rooms have air conditioning systems. Around 30 % of hospital beds are placed in air-conditioned rooms. Based in the survey it plans to prepare a guide in 2016 entitled "Certain healthcare issues related to the best practices of hospital maintenance".

Detailed description of performed activities

Heat alert during heat waves, description of noticed excess mortality

It is the ordinary task of NIEH to evaluate the health effects of extreme temperature situations and to introduce the heat alert. During 2012, NPHMOS ordered heat alerts on four occasions: 18-21 June: second-degree alert, 30 June–9 July: third-degree alert, 3-7 August: third-degree alert and 21-26 August: second-degree alert was ordered.

The excess mortality seen during heat alerts was also examined in 2012 at regional level. In 2012, average mortality during the third-degree heat alert (13 days) increased by 33 % in the capital and by 27 % at national level. The greatest increase was recorded in Central Hungary (34.6 %) and in Budapest (33.25 %), while the lowest was found in the Northern Great Plain (16.7 %).

During the second-degree heat alert excess mortality was at 14 % at national level, the lowest in Western Transdanubia (6 %), the highest in the Northern Great Plain and Central Transdanubia (18 %). On heat days excess mortality was between 129 and 553 cases per region. During the four alerts altogether 1666 excess mortality cases occurred in the country.

During 2013, NPHMOS ordered heat alerts on three occasions: 17-22 June: second-degree alert; 24-30 July: third-degree alert; 2-9 August: third-degree alert was ordered.

The excess mortality seen during heat alerts was also examined in 2013 at regional level. The daily average temperature was above 25°C for altogether 20 days. The first heat wave in June one week after the flood situation caused very high excess mortality around the country. During the second-degree heat alert excess mortality was 20 %, while during the third-degree alerts it was at 15.5 %, altogether 1,144 excess cases were registered. At regional level the highest excess mortality – until then unprecedented – was experienced in Western Transdanubia (21 %), while the lowest was in Northern Hungary (15.5 %).

During 2014, NPHMOS ordered second-degree heat alert once between 18 and 20 July for 3 days, during which the daily average temperature exceeded 25°C. During the second-degree heat alert 2.7 % excess mortality (24 extra cases) was registered on average in the country. At regional level the highest excess mortality was experienced in Northern Hungary and Central Transdanubia (11 %), as well as in Budapest (25 %), while the lowest was in Northern Hungary (15.5 %).

In 2015, during the summer heat waves excess mortality occurred as follows: during the four-day long second-degree alert in June excess mortality was at 6.4%. During the third-degree heat alert between 4-8 July it was 25.6 %, during the third-degree heat alert between 17-26 July it was 22.7 %, during 7-16 August it was 17.3 %, during the second-degree heat alert between 29 August-1 September it was 4.2 %; in sum, during the 35 alert days 16.4% or 1799 extra cases were registered, which is higher than in 2007 and 2012.

The monthly excess mortality was evaluated for the last three years during summer heat waves, and it was found that at the beginning of the summer heat waves above lower threshold temperature also caused significant excess mortality. During heat waves, excess mortality relative to a 1°C daily increase in June is considerably higher (in June 55 persons) than in later months (in July and August 27 persons). Based on the results lower threshold temperatures must be applied at early summer for heat alerts.

The effects of climate change on the frequency and intensity of heat waves and its harmful effects on health

Estimations were carried out to discover how excess mortality caused by heat will evolve in the near and far future. The number of daily excess mortality between 2021 and 2050 and between 2071 and 2100 was estimated on the basis of the regional climate model applying the A1B emissions scenario (hereinafter: RegCM). During the estimation of excess mortality attributable to climate change it was found that compared to the reference period the ratio of days with average temperature above the 25°C threshold will increase by 45.5 % between 2021 and 2050 and by 373.1 % between 2071 and 2100. In the reference period (1961-1990) the number of such days was 167. Excess mortality attributable to days with average temperature above 25°C will rise as a result of both the number and intensity of such days.

Based on the RegCM climate model, the annual average 121 cases in the reference period will rise by 121 % to 267 cases between 2021 and 2050, and between 2071 and 2100 the rise will reach 778 %, which suggests 1,060 cases annually.

In 2015, excess mortality caused by heat waves was re-evaluated by using the ALADIN climate model in a similar emissions scenario at sub-regional level in the present (2005-2014) and in the near (2021-2050) and far 2071-2100) future. It was found that between 2005 and 2014 the average daily sub-regional excess mortality relative to temperature above the threshold temperature was 15.8 %. Based on the climate model, both the number and intensity of heat wave days will increase by between 107 % and 182 % compared to the present. Excess mortality will rise by around 2.6 times, to 2030 cases annually compared to the period between 1991 and 2020. The climate model foresees an excess mortality increase of 531 % to 668 % between 2071 and 2100 for sub-regions, which, evaluated at national level, will rise by approximately 7.4 times to 5,800 deaths annually compared to the period between 1991 and 2020.

Effects of climate change on vector-borne and food-borne diseases

The evolution of vector-borne communicable diseases related to climate change were also examined. The comparison of the territorial spread and seasonality of Lyme Borreliosis (hereinafter “LB”) and the territorial characteristics of the climate was performed for the first time in the country. The effects of temperature characteristics and the beginning of the season were assessed in 2 north-eastern (Nógrád and Borsod-Abaúj-Zemplén) and 3 south-western (Zala, Baranya, Somogy) counties. The biggest difference of around 1-1,5°C in weekly average temperatures of the two territories was found in the period between late autumn and

early spring. The beginning of the LB season in north-eastern counties shifted significantly to 2.5 weeks earlier between 1998 and 2010. Parallel to that, LB incidence increased considerably in south-western counties continuously, while in north-eastern counties it rose typically after 2006. 3 weeks of difference was found between the annual maximum values of LB and the descending seasonal phase. Between 1999 and 2004 and between 2005 and 2010 the LB incidence of both areas rose by 23 to 29 %; in the north-eastern region the annual peak shifted to one week earlier.

The spread of Leishmaniasis was also examined as a model for the currently spreading vector-borne disease with warm climate vector. Leishmaniasis is a parasitic disease affecting almost 100 countries of the tropical and warm temperate zones, which is currently on the spread. It is spread by sand flies (*Phlebotomus*). Due to climate change leishmaniasis may become endemic in the Carpathian Basin, which might pose a serious challenge to both human and animal health. Similarly unfavourable trends are to be expected in other temperate climate zones of Europe.

The purpose of the research was to understand the climate needs of the 5 most important *Phlebotomus* species (*Phlebotomus ariasi*, *P. neglectus*, *P. perfiliewi*, *P. perniciosus* and *P. tobbi*) spreading the *Leishmania infantum* parasite and *Leishmania infantum* itself and, by using this data, to estimate the potential distribution area to be expected of these species in the future under the REMO climate model. From climatic point of view 1961 to 1990 formed the reference period, and the projections were made to the periods between 2011 and 2040 and 2041 and 2070. To draw the potential distribution area, a climate envelope model (niche modelling, correlative modelling) was used.

Climatic data were provided by the REMO regional climate model. According to the results significant differences are to be expected in the present and future potential distribution areas of the 5 examined sand fly species, and none of the species cover completely the potential distribution area modelled for the reference period (1960-1990).

The occurrence and climate dependence of West Nile fever was also evaluated. The (flavi)virus of the West Nile fever is spread in the temperate zone by the *Culex* mosquitoes. The disease was first noticed in Uganda, but since 1937 its occurrence was registered in several countries of the northern temperate zone, thus in Hungary as well since the 1990s. Various cases became known in Europe, including, inter alia, in Greece, Romania, Italy, Macedonia, Serbia and Spain. The disease is supposedly spreading. The potential spread of the disease was analysed according to the method mentioned in relation to the *Phlebotomus* species and the *Leishmania infantum* parasite in the reference period and for the period between 2011 and 2040 and between 2040 and 2071. Given that the disease has not reached its final spreading volume and does not cover the whole territory which is historically and in principle suitable for it, the results were assessed with care. It can already be concluded that the spreading potential of the virus is large, and in principle it could reach that of the *Culex* species.

Relationship between climate change and food-borne diseases It is well-known that from among the effects of climate change on health, food-borne diseases, and from among these, the incidence of *Salmonellosis* is expected to increase significantly. In Hungary the annually registered cases of *Salmonellosis* disease in the previous period (between 2000 and 2010) showed a decreasing trend (annual incidence calculated for the Hungarian population fell from 1.5 per mile to 0.6 per mile).

The increase in the incidence of *Salmonellosis* attributable to climate change was estimated over the daily average temperature of 5°C as threshold temperature. Compared to the reference period (1961-1990) the ratio of days with average temperature above 5°C will increase by 7.0 % between 2021 and 2050 and by 18.0 % between 2071 and 2100. In the reference period the number of these days is 7,843, which equals to 72 % of the whole period. The incidence of *Salmonellosis* attributable to days with average temperature above 5°C will rise as a result of the number and the intensity of such days. Based on the RegCM climate model, the annual average 8090 cases in the reference period will rise by 8.2 % to 8,489 cases between 2021 and 2050, and between 2071 and 2100 the rise will reach 18.7 %, which suggests 9,311 cases annually.

Monitoring the harmful effects of heat waves on health with climate-specific indicators

The Regional Office of WHO/ECEH in Bonn has been developing a climate-specific indicator system for years. The employees of NIEH participated in the elaboration of indicators suitable for revealing exposures represented by heat waves.

With the indicator connected to the heat the changes in the frequency of heat waves can be monitored depending on climate change over the whole population and people over the age of 65. A software was developed to calculate the heat wave indicator, which was tested on the 10-year data series of Budapest. The software will be freely available for download from the website of the institute.

Along the development of the heat wave indicator, further examinations were carried out to determine the threshold temperature values necessary for estimating excess mortality caused by heat waves by analysing the data of six European cities. The daily mortality data were provided by the statistical offices of the participating countries for the examination, in which the summer season (15 May to 15 September) of Budapest and 5 European cities (Bratislava, Helsinki, Rome, Stockholm, Valencia) were analysed, while the meteorological parameters needed were facilitated by the database of the National Oceanic and Atmospheric Administration. The total daily mortality data and the mortality data of people over the age of 65 were used to define the mortality rate. A 10-year reference period (1990-1999) was designated to follow the temperature changes, and the different frequency (percentage) values of the distribution of daily average temperature were used to identify heat days. Periods exceeding these threshold values for three or more days were identified as heat waves. The impact of heat waves on daily mortality were calculated as the excess mortality defined as the difference between daily mortality during heat waves and expected average mortality. It was found on the basis of three threshold temperatures (p85, p90, p95) that at higher threshold values a few heat waves disappear, while “negative” results also appear if lower threshold values are applied. The elaborated, relatively easy method is suitable for measuring temperature changes and the uniform examination of the impact of heat on daily mortality on the longer term as well. The results are in line with the findings of previous domestic and foreign analyses. If the 90% frequency threshold value is applied (which seems appropriate for all cities), the results can also be compared on the level of the cities.

Elaboration of indicators, the impacts of climate change and adaptation possibilities in the context of environment, health and well-being

Within the framework of the 2014 project of the European Environment Agency, the topics of environment, health and well-being were examined in a wide context, taking into account both the importance of ecosystems services and the comprehensive socio-economic effects.

For the prepared complex model the criteria and indicators were collected with the help of which a topic can be described.

2) FURTHER KEY DATA AND STATISTICS

The immunisation programme

Compared to the situation of 31 December 2011, in 2012 and 2013 no changes occurred with respect to compulsory vaccinations linked to age. The voluntary and free pneumococcus vaccination became compulsory for children under the age of 2 as of 2014. Accordingly, compulsory vaccinations linked to age for infants and children born after 30 June 2014 now provide protection against 11 communicable diseases (invasive diseases caused by tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis anterior acuta, morbilli, rubella, mumps, Haemophilus influenzae B and pneumococcus, hepatitis B).

As part of the complex cervical cancer preventive programme, the free and voluntary vaccination against the Human Papillomavirus (HPV) was introduced in the 2014/2015 school year, which can be given to girls over the age of 12 and studying in 7th grade in the given school year. Vaccinations are performed within the framework of school campaign vaccinations with the written declaration of the parent/guardian. The performance of vaccinations linked to age, i. e. vaccination coverage is excellent in international comparison (see the tables below). The epidemiological situation of vaccine-preventable communicable diseases is satisfactory thank to the high vaccination coverage.

Main characteristics of the compulsory vaccination order linked to age:

- vaccinations (both vaccines and carrying out the vaccination) are provided free of charge for the population
- legislative background provides for state liability
- taking into account the domestic situation, but in accordance with the recommendations of the World Health Organisation (WHO) and the European Centre for Disease Prevention and Control (ECDC), vaccinations are carried out in the optimal age, and the vaccines used are excellent in quality and effectiveness, and they are also safe
- they are equally accessible to everyone.

Performance rate of compulsory vaccination linked to age* (2012-2013)

Vaccination name	Performance rate of vaccinations (%)	
	in 2012	in 2013
BCG	99.9	99.8
DTPa +IPV +Hib (2 months)	99.9	99.9
DTPa +IPV +Hib (3 months)	99.9	99.9
DTPa +IPV +Hib (4 months)	99.9	99.8
MMR (15 months)	99.8	99.9
DTPa +IPV +Hib (18 months)	99.6	99.6
DTPa+IPV (6 years)	99.8	99.7
dTap	99.2	99.5
MMR revaccination	99.4	99.3
Hepatitis B I	¹ 99.4	³ 99.4
Hepatitis B II	² 99.2	¹ 99.1

BCG = Bacillus Calmette-Guérin / vaccine against tuberculosis

DTPa= diphtheria–tetanus and acellular pertussis

Hib = Haemophilus influenzae type b

IPV = Inactivated polio vaccine

MMR = measles, mumps, and rubella

dTap = diphtheria–tetanus and acellular pertussis booster vaccine

* Report based on the aspects as defined in the 2013 Vaccination Methodology Letter

¹ data of persons vaccinated in the 2012/2013 school year

² data of persons vaccinated in the 2011/2012 school year

³ data of persons vaccinated in the 2013/2014 school year

Performance rate of compulsory vaccination linked to age* (2013-2014)

Vaccination name	Performance rate of vaccinations (%)	
	in 2013	in 2014
BCG	99.8	99.9
DTPa +IPV +Hib (2 months)	99.9	99.9
DTPa +IPV +Hib (3 months)	99.9	99.9
DTPa +IPV +Hib (4 months)	99.8	99.9
MMR (15 months)	99.9	99.8
DTPa +IPV +Hib (18 months)	99.6	99.6
DTPa+IPV (6 years)	99.7	99.7
dTap	99.5	99.5
MMR revaccination	99.3	99.4
Hepatitis B I	¹ 99.4	³ 99.5
Hepatitis B II	² 99.1	¹ 99.3

BCG = Bacillus Calmette-Guérin / vaccine against tuberculosis

DTPa= diphtheria–tetanus and acellular pertussis

Hib = Haemophilus influenzae type b

IPV = Inactivated polio vaccine

MMR = measles, mumps, and rubella

dTap = diphtheria–tetanus and acellular pertussis booster vaccine

* Report based on the aspects as defined in the 2014 Vaccination Methodology Letter

¹ data of persons vaccinated in the 2012/2013 school year

² data of persons vaccinated in the 2011/2012 school year

³ data of persons vaccinated in the 2013/2014 school year

Performance rate of compulsory vaccination linked to age* (2014-2015)

Vaccination name	Performance rate of vaccinations (%)	
	in 2014	in 2015
BCG	99.9	99.9
DTPa +IPV +Hib (2 months)	99.9	99.9
DTPa +IPV +Hib (3 months)	99.9	99.9
DTPa +IPV +Hib (4 months)	99.9	99.8
MMR (15 months)	99.8	99.9
DTPa +IPV +Hib (18 months)	99.6	99.3
DTPa+IPV (6 years)	99.7	99.7
dTap	99.5	99.6
MMR revaccination	99.4	99.6
Hepatitis B I	¹ 99.5	³ 99.6
Hepatitis B II	² 99.3	¹ 99.5

BCG = Bacillus Calmette-Guérin / vaccine against tuberculosis

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Hib = Haemophilus influenzae type b

IPV = Inactivated polio vaccine

MMR = measles, mumps, and rubella

dTap = diphtheria–tetanus and acellular pertussis booster vaccine

* Report based on the aspects as defined in the 2015 Vaccination Methodology Letter

¹ data of persons vaccinated in the 2013/2014 school year

² data of persons vaccinated in the 2012/2013 school year

³ data of persons vaccinated in the 2014/2015 school year

2) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THE PARAGRAPH

- **The ECSR requests information on the measures (water quality, soil and waste hygiene, food safety, ionising radiation) and regulations mentioned in the previous report, as well as on air pollution, communication on the importance of water consumption and the “contamination” of foodstuffs.**

1. Waste management

Act XLIII of 2000 on waste management (hereinafter “Waste Management Act”) was reviewed under the competence of the Ministry of Agriculture, and was adapted to the new or amended EU laws and directives by the adoption of Act CLXXXV of 2012 on waste, which was adopted by the Parliament on 26 November 2012.

With the entry into force of the new act, it became necessary to review and amend the relevant legislative background on the healthcare sector: Decree of the Minister of Health No. 16/2002 (IV.10.) on public health requisites with respect to solid and liquid urban waste; Decree of the Minister of Health No. 1/2002 (I.11.) on the handling of waste created in health institutions and Decree of the Minister of Health No. 20/2005 (VI.10.) on waste management of human medicines and their packaging.

The consultation between the Ministry of Human Capacities and the Ministry of Agriculture about the 3 draft decrees has reached the final phase.

Following this, the draft decrees need to be notified in accordance with Section 8-10 of Directive 98/34/EC of the European Parliament and of the Council of 22 June 1998 laying down a procedure for the provision of information in the field of technical standards and regulations. The Directive 98/34/EC has been replaced by Directive (EU) 2015/1535 of the European Parliament and of the Council of 9 September 2015 laying down a procedure for the provision of information in the field of technical regulations and of rules on Information Society services (codification), the transposition of which into the national legislation has already been started.

The decrees are to be published in the Official Health Journal and are to enter into force following their successful notification.

2. Radiation protection

Radiation protection means both the protection of humans against the adverse effects of radiation originating from ionising radiation and the set of tools serving this purpose. Radiation protection should not be directed at the unjustified restriction of useful activities, but it should rather promote the application of useful activities by ensuring safety.

The establishment of the legislative background and the creation and operation of the system of regulatory control for radiation protection remains state responsibility. In Hungary, the minister for health was responsible for the radiation protection of workers and the general public until 31 December 2015. As of 1 January 2016, this responsibility was transferred to the Hungarian Atomic Energy Authority (hereinafter: "HAEA").

It is the responsibility of the radiation protection (radiation health) authorities to authorise, as well as to control and supervise the use at work of ionising radiation sources and the radiation workplaces with a view to ensure full safety. Pursuant to Government Decree No. 323/2010 (XII. 27.) on the National Public Health and Medical Officer's Service, the fulfilment of administrative responsibilities related to public health and the appointment of the state administration agency for pharmacology, the official tasks related to workplace radiation protection and radiohygiene were carried out by the public health departments of the 7 county government offices as regional radiohygiene authorities (previously Radiohygiene Decentres) in 2015. The professional management of the radiohygiene authorities of the public health department of the government offices is performed by the Office of the Chief Medical Officer of NPHMOS with the collaboration of the National Research Institute for Radiobiology and Radiohygiene of NPHC (hereinafter: "NRIRR"). NRIRR performs professional-methodological, scientific research, training, further training, registration, coordination, expertise activities that support official decisions in various fields, and the National Radiohygiene Stand-by Service (hereinafter: "NRSS") and the National Personal Dosimetry Service (hereinafter "NPSS") operates within the framework of NRIRR as well.

The Government Decree 487/2015 (XII. 30.) on the protection against ionizing radiation and the corresponding licensing, reporting (notification) and inspection system promulgated on 30 December 2015 transferred official control from the public health departments of the 7

government offices as regional radiohygiene authorities and from the Office of the Chief Medical Officer to HAEA as of 1 January 2016. Most of Decree 16/2000 EüM of the minister of health was repealed.

A most of the workplace radiation sources are composed of X-ray equipment, while a smaller, but significant part of such sources are constituted by sealed radioactive sources. In isotope laboratories unsealed radioactive sources are used. A very small, but important part of equipment producing ionising radiation is composed of accelerators.

The registration of workplace units using ionising radiation and their categorisation according to work areas and areas of application were performed in accordance with the domestic radiation protection regulation, Decree of the Minister of Health No. 16/2000 (VI. 8.) (hereinafter: Minister of Health Decree) on the implementation of certain provisions of the Act CXVI of 1996 on atomic energy. Based on the work reports of workplace radiohygiene activities of the official bodies, the number of registered workplace units increased to 6,523 in 2015 compared to 2014 (6,216).

From the areas of application, the medical X-ray diagnostics are still dominant in respect of the number of units, the number of employees, and the public exposure of artificial origin.

81 % of registered units are related to the medical or therapeutic application of ionising radiation. In 2015, 5,059 medical, dental and veterinary registered units using X-ray equipment, 27 therapeutic registered units, 26 registered units using medical linear accelerators, and 148 medical isotope laboratory units had an operating licence. The rest of the registered units are composed of industrial applications (1,263 registered units). From industrial uses the most important ones are: radiography workplaces for quality control purposes (373 registered units), measurement and regulatory equipment operating with sealed radioactive source (156 registered units), material and fine structure testing equipment (113 registered units), industrial isotope laboratories (106 registered units). Accelerators used by the industries and for research purposes are present in lesser amounts (34 registered units), and irradiation equipment for industrial or metrological purposes (15 registered units).

NRSS operated by NRIRR was the only constant stand-by service in the country in 2015, which could be called any time about issues related to radiohygiene happening in the country. Its role is to evaluate and handle the extraordinary event reported in relation to radioactive materials from the radiation protection perspective. The reason of the extraordinary event could be a found, confiscated or incidentally found and unclaimed radiation source, or radioactive material or material deemed as radioactive. NRSS established good connections with the bodies acting in extraordinary events, above all with Disaster Management. During on-site action it is usually the local unit of Disaster Management which arrives first to the site. NRSS provides professional support to tackle and eliminate the harm. By obtaining modern instruments, the ability of NRSS to measure and identify isotopes has increased significantly in 2014 and 2015.

From among the notified extraordinary events, on-site action was needed on 10 occasions in 2015, of which radioactive material had to be transported to NRIRR on 6 occasions, and 5 samples had to be transported for analysis. Action was needed on 15 occasions due to the fact that the alarm went off at the radiation gates installed on the Hungarian borders. Complaint from the public was assessed one time. NPSS participated in one training organised by Disaster Management.

Exposure of the population

Exposure of the population is composed, on the one hand, of cosmic and natural exposure originating from the Earth's crust to be found everywhere in nature, and on the other hand, of artificial exposure related to the use of human-made radiation sources, devices emitting ionising radiation and facilities using them or radioactive materials, and within this, primarily from medical X-ray and isotope diagnostic activities.

The average natural environmental exposure of the Hungarian population is approximately 3.1 mSv/year, which is higher than the world average (2.4 mSv/year, UNSCEAR 2000 Report). This is due to the fact that for climatic and civilisation reasons we spend more time than the world average inside buildings where radon concentration is higher than the world average. To check the domestic level of natural external background radiation measurable outside, NRIRR operates a passive detector dosimetry network consisting of 105 measurement points in the country and another 39 measurement points around the Paks Nuclear Power Plant. The detectors are replaced and evaluated following an exposure of three months. The annual average values of measurement results fall within the typical background range of 85 to 120 nSv/h both at national level and around the surrounding network of Paks.

To evaluate the exposure of the public to radon, the environmental assessment programme of the healthcare sector was complemented in 2012 at the recommendation of NRIRR by indoor radon concentration measurements. The Radiohygiene Decentres cooperated in the installation and collection of passive track detectors, and the measurements were performed by NRIRR. The detectors were installed in residential buildings, and they were replaced every quarter. The measurement results are included in a database and they therefore contribute to making the Hungarian indoor radon map more accurate. On the basis of the available results it can be estimated that the ratio of buildings where the annual average indoor radon concentration exceeds the 300 Bq/m³ reference level is 6 %.

The operation and reporting procedures of the National Environmental Radiation Protection Control System carrying out country level monitoring of radiation exposure is being introduced under point 3.

Occupational exposure

Also, NPSS operated within NRIRR carries out the central control of occupational exposure of workers carrying out jobs as their profession that are exposed to the enhanced risk of ionising radiation.

In 2015, the control of exposure from gamma and X-ray radiation meant 93,135 evaluations for the 16,388 workers employed in 1104 workplaces. The distribution of workers according to the most significant employment areas are as follows:

- healthcare: 52 %,
- nuclear power plant: 26 %,
- industry: 9 %,
- education: 9 %,
- research and development, other: 4 %.

NPSS initiated official investigation in the case of 7 workers and workplace investigation in the case of 31 workers in 2015 during the control of occupational exposure.

The personal dosimetry control of radon exposure of natural origin was carried out with altogether 37 workers in two workplaces in 2015.

Pursuant to the provisions of Decree of the Minister of Health No. 30/2001 (X. 3.) on the protection from radiation of external employees, external employees may only perform activities under the appropriate control of individual dosimetry inspection. In 2015, NPSS issued 60 and accepted 22 dosimetry certificates for the external employment of Hungarian citizens abroad and external employment of foreign nationals in Hungary.

In relation to early retirement procedures, certificates for the recognition of the length of service were issued on 86 occasions.

Environmental control systems

To reduce and control the exposure of the public, certain facilities of concern, inter alia, nuclear installations, must operate an environmental control system or laboratory.

Ministries and authorities having competence may also operate national and regional systems to independently monitor emissions and environmental radiation conditions and radioactivity concentrations. Due to the low level of environmental radioactivity of arctic origin, exposure originating from this can only be determined on the basis of calculations. Exposure from nuclear power plant emissions is lower than 0.001 mSv/year for residents living in the immediate vicinity of the nuclear power plant.

NRIRR monitors the impact of the Slovakian Mohi (Mochovce) nuclear power plant near the border on Hungarian territory since the putting into operation of the power plant. The inspections have not shown any environmental implication attributable to the power plant in 2015 either. The environmental radiological monitoring activity is regulated in Decree 8/2002 (III. 12.) on the operation and structure of the radiological monitoring and data acquisition network of the health sector. The monitoring is carried out by the carried out by the public health departments of 6 county government offices as the laboratories of the regional radiohygiene authorities and the Accredited Testing Laboratory of Radiohygiene of NRIRR.

3. Networks measuring environmental background radiation

National Radiation Monitoring and Signalling System (hereinafter: NRMSS)

In case of nuclear emergency it is important to have adequate information to take prompt measures. This requires the central collection and handling of information even in the preparation phase, therefore NRMSS was established with national competence.

The duty of NRMSS is to monitor and signal constantly the national radiation conditions, and to send notifications or alerts when radiation rises. Online gamma dose rate metering stations belong to the Distance Metering Network of NRMSS, which send the measurement results every 10, 30 or 60 minutes to a centre, the Nuclear Incident Information and Assessment Centre of the National Directorate General for Disaster Management of the Ministry of the Interior. The members of the Distance Metering Network are the institutions of different sectors. The National Directorate General for Disaster Management of the Ministry of the Interior has 26, the Hungarian Meteorological Service has 29, the Hungarian Defence Force has 40, PAE Zrt. has 20, higher education institutions have 13, and RHK Kft. has 4 metering stations. The current measurements are available on the website of the National Directorate General for Disaster Management of the Ministry of the Interior and NRMSS as well.

Environmental metering stations of universities – Sectoral Information Centre

In 2011, 13 environmental metering stations and 11 fixed laboratories operated in 10 Hungarian universities, which cooperate with the National Environmental Radiological Monitoring System (NERMS) and NRMSS. Environmental gamma dose rate is constantly monitored, but according to the profile of the universities, the processing and nuclide-specific analysis of environmental (air, water, ground, biological) samples are also performed, if necessary. Its activities are managed by the Sectoral Information Centre established within the Institute of Nuclear Techniques (INT) of the Budapest University of Technology and Economics (BME). The Centre constantly collects and processes the measurement results. The measurement data summarised and batched daily are transmitted to the Centre for Emergency Response, Training and Analysis of HAEA. In 2011, the 13 distance metering stations altogether showed 97 % availability, which is a 0.4 % increase compared to last year. Due to several information technology and personnel changes, this result is expected to improve further. The fixed stations perform several important measurement tasks related to environmental checks and accident prevention in accordance with the profile of the given university department, e.g. aerosol sampling and simultaneous radioactivity measurement and the nuclide-specific analysis of water, groundwater, ground and plant samples.

Official Environmental Radiological Monitoring System

The normal operating radioactive emissions of the nuclear power plant are regulated by strict standards, and are monitored by constantly operating metering systems. The Official Environmental Radiological Monitoring System has been developed along the environmental radiological plant monitoring system of Paks Nuclear Power Plant Ltd., under which the sectors (healthcare sector of the Ministry of Human Capacities, the agrarian and environmental protection sector of the Ministry of Rural Development), specialised institutions and regional laboratories of the ministries having competence perform harmonised measurements and checks within the 30 km radius of the nuclear power plant.

The system was undisturbed in 2015, and the annual assessment report is prepared, just like in previous years, by the Data Processing and Evaluation Centre operated by NRIRR together with data providers. No significant increase was found compared to previous years during the preliminary evaluation of the 2015 data.

National Environmental Radiological Monitoring System – NERMS

The operation of NERMS was regulated by Government Decree No. 275/2002 (XII. 21.) on the monitoring of the environmental radiation situation and levels of radioactivity in Hungary, which was replaced as of 1 January 2016 by Government Decree No. 489/2015 (XII. 30.). The national system is composed of the specialised institutions and sectoral networks of the ministries concerned and the Hungarian Academy of Sciences, and the systems of Paks Nuclear Power Plant Ltd. and Public Limited Company for Radioactive Waste Management. Data were collected to the central computers, then processed and the annual reports were prepared by NRIRR of NPHC, according to the practices of previous years, with the collaboration of NERMS members and under the management of the NERMS commission. However, due to the mentioned legislative change, the official publication of the 2014 final report adopted by the commission and the finalisation of the annual report summarising the 2015 results prior to its adoption are still in progress. According to the processed data, exceptionally high values indicating an irregularity were not found in 2014 and in 2015 either.

4. Protection of nuclear and other radioactive materials

The police has continuously performed official activities related to administrative procedures initiated in relation to the use of nuclear energy, in accordance with the practices of previous years. With the entry into force of Government Decree No. 190/2011 (IX. 19.) this official function of the police ceased to exist in radiohygiene procedures, however, the independent physical protection authorisation procedure of HAEA was introduced, in which the official cooperation of the police is still required.

The performance of official police authority tasks related to the use of atomic energy constitutes a special task within the public security activities of the police, especially the issuing of police authority licences needed for persons employed in facilities and jobs as defined in law, and the annual control of persons employed permanently.

All operations related to radioactive materials are subject to a licence, as is prescribed in Decree of the Minister of Health No. 16/2000 (VI. 8.) to ensure safety. In Hungary, all sealed radioactive sources above the exemption level as well as the used radioactive material are being registered in a central registry, which is operated by HAEA. The central registration system operates since the end of the 1960s, and it helps to extend the official surveillance of radiation sources during their whole lifecycle. The registration system was re-regulated in 2010 by the decree of the minister supervising HAEA (Decree 11/2010 (III.4.) KHEM). The new uniform local and central computerised registration system has tightened significantly and improved the efficiency of the official supervision of radiation sources by introducing regular electronic stock change and inventory reports, and an official certificate identifying radiation sources separately and containing technical parameters and the owner.

As to nuclear materials, Decree of the Minister of Justice and Law Enforcement No. 7/2007 (III. 6.) regulates their registration and supervision, which is performed by HAEA.

Law stipulates that spent radioactive sources must be placed in a repository. The reporting obligations set out in the registration system allow for the notification of the authority about that a radiation source is not in use for a longer period of time. The Radioactive Waste Treatment and Disposal facility of Püspökszilágy serves to store spent sources. There is enough space and adequate infrastructure in this repository to safely handle spent sources.

In Hungary, manufacturers undertake to take back radioactive sources manufactured by them from domestic or foreign users as well, if requested by the user. These sources are either recycled or placed in the Radioactive Waste Treatment and Disposal facility of Püspökszilágy.

ARTICLE 12 – THE RIGHT TO SOCIAL SECURITY

With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1. to establish or maintain a system of social security.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

I. Presentation of social security services

In Hungary, social security services are provided through the mandatory social security system and the state-operated system of social services. In the reporting period, the system of mandatory social benefits covered the following services:

- in kind health insurance services,
- sick pay,
- old age pension,
- survivor's pension,
- benefits in case of a workplace accident,
- family benefits (partially),
- maternity benefits (partially),
- benefits for persons with changed working capacity (rehabilitation benefit and invalidity benefit).

Major legislative acts on social security:

- Act LXXX of 1997 on Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services (hereinafter: Social Insurance Act), furthermore, Government Decree 195/1997 (XI. 5.) on the implementation thereof;
- Act LXXXI of 1997 on Social Insurance Pensions (hereinafter: Pensions Act), furthermore, Government Decree 168/1997 (X. 6.) on the implementation thereof;
- Act LXXXIII of 1997 on Benefits under the Statutory Health Insurance Scheme (hereinafter: Health Insurance Act), furthermore, Government Decree 217/1997 (XII. 1.) on the implementation thereof;
- Government Decree 284/1997 (XII. 23.) on the Fees for Certain Healthcare Services which are not available Free of Charge;
- Act CXCI of 2011 on Benefits for Persons with Changed Working Capacity (hereinafter: Changed Working Capacity Act), furthermore, Government Decree 327/2011 (XII. 19.) on the implementation thereof;
- Act XXXI of 1997 on the Protection of Children and on Guardianship Administration (hereinafter: Child Protection Act);
- Act LXXIX of 1992 on the Protection of Foetal Life;
- Act CLIV of 1997 on Health (hereinafter: Health Act);
- Act III of 1993 on Social Administration and Social Services (hereinafter: Social Act).

Act IV of 1991 on the promotion of employment and provisions to the unemployed (hereinafter: Employment Act) is a stand-alone system to cover unemployment benefits. The

State provides some of the family benefits and maternity benefits as benefits to which all eligible persons are entitled, pursuant to Act LXXXIV of 1998 on family support (hereinafter: Family Act).

II. Changes in the rules concerning insurance obligation

1. Legislative changes related to entitlement to health insurance benefits in the reporting period

From 1 January 2012

Start of the insurance relationship

As of 1 July 2012 when Act I of 2012 on the labour code (hereinafter: Labour Code) came into force, employment starts on the day set in the employment contract or on the day following the conclusion of this contract. Accordingly, pursuant to the Social Insurance Act, the insurance relationship of the employed person starts this day; therefore, the employee is already insured on the first day even without actual work done. [Section 42(1) of the Labour Code and Section 7(1) of the Social Insurance Act]

From 1 July 2012

Disbursing cash benefits also in advance

As of 1 July 2012, pursuant to Section 39/B of the Health Insurance Act, cash benefits related to health insurance (for instance sick pay and accident sick pay) can be paid also in advance if the entitlement to benefits exists, but the payment request cannot be complied with within 30 days.

From 1 January 2014

Insurance relationship of foster parents

Parallel to the amendments of the Child Protection Act and its related regulations, the legal relationship of foster parent and professional foster parent was replaced by the employment type legal relationship of foster parent from 1 January 2014. Thus every foster parent became fully insured and entitled to all cash and in kind social security benefits.

The Government, when amending the legislation, aimed at showing appropriate financial appreciation in addition to professional appreciation of foster parenthood. As a result, persons having an employment type legal relationship of foster parent became entitled to sick pay, sick leave, holidays and severance pay. The time spent as a foster parent is considered a period of service when calculating the expected amount of pension. [Section 5(1) of the Social Insurance Act]

2. Legislative changes related to the suspension of insurance

In principle, insurance is suspended during unpaid leave. Exceptions are regulated in Section 8 of the Social Insurance Act. As of 1 January 2014, this act is modified as follows:

- Unpaid leave due to doing service as a voluntary reserve soldier is also included among the exceptions. Pursuant to this provision, the insurance of voluntary reserve

soldiers is considered uninterrupted regarding their 'civil' legal relationship and they suffer no disadvantages concerning later social security entitlements.

- According to the former text of the act, the insurance of lawyers was suspended during the suspension of their membership of a Bar. Lawyers, however, cannot suspend their membership of a Bar (they are members or not); they can only suspend their activities. In the future, accordingly, legislation links the suspension of insurance not to the membership of a Bar, but to the suspension of activities.
- Persons having a student contract and doing vocational school studies are insured. According to the new rule, however, if the student contract is suspended pursuant to the act on vocational training (there are no actual studies), the insurance is also suspended.
- The act clarifies the text of legislation: as long as the activity of a veterinary providing animal health services is suspended, his or her insurance is also suspended.

3. Legislation related to posted workers from third countries

Pursuant to Section 5 of the Social Insurance Act, in principle every person in paid employment in Hungary is compulsorily subject to insurance under the rule of law. Persons not subject to mandatory insurance are specified in Section 11 of the Social Insurance Act. Persons not subject to mandatory insurance still have an opportunity to enter into an agreement in order to acquire entitlement to health care services and pension.

As of 1 January 2014, the rule concerning posted workers from third countries is supplemented with a provision which grants exemption from personal payment of contributions in the case of being posted for more than 2 years, but only if the extension beyond 2 years happens for unforeseen reasons. Another condition is that this unforeseen reason emerges after 1 year, and the employee reports it to the tax authority.

The amendment is due to the fact that if the posting period of less than 2 years was extended creating a period of more than 2 years and the posted worker had obligations to pay contributions retrospectively, using health care services in exchange for the contributions retrospectively is de facto impossible. The amendment rectifies the resulting anomaly by granting exemption to posted workers from paying personal contributions in such cases.

However, the obligation to pay social contribution tax which is imposed based on this legal relationship and is regulated in a separate act is not affected by this provision. Therefore, after 2 years, the employer will be obliged to pay a social contribution tax of 27 %.

[Section 11/A of the Social Insurance Act]

4. Changes in the obligation to pay social contributions

Participation in social security is still mandatory in accordance with provisions of law. In the social security system, the insured persons, unless otherwise stated, may acquire, as a result of paying contributions, a right to social security benefits for themselves and their relatives specified by law according to the principle of individual responsibility. The amount of cash benefits, unless there are statutory exemptions, is proportionate to the income of the insured person on which the contribution covering the benefits is based. The health insurance and labour market contribution charged in the case of the insured person is 8.5 % in the period examined. Within the health insurance and labour market contribution, the in kind health

insurance service contribution is 4 %, the cash health insurance contribution is 3 % and the labour market contribution is 1.5 %.

As of 1 January 2012, changes introduced by Act CLVI of 2011 on the amendment of tax laws and other related regulations are as follows:

- health insurance and labour market contribution should also be paid on jubilee benefits, severance pay, job-finding aids, holiday compensation and amounts paid after terminating an employment relationship of definite duration;
- if several legal relationships with an insurance obligation coexist, pension contribution and health insurance and labour market contribution should be paid according to the contribution base regarding each legal relationship;
- insured persons in an employment relationship of at least 36 hours per week are not exempt from paying a cash health insurance contribution of 3 %.

From 1 January 2014

As of 1 January 2014, self-employed persons or members of an economic association engaged in auxiliary activities are not obliged to pay health service contributions regarding a period when

- they are incapable of work, they receive child care allowance or they are detained;
- their activities providing animal health services are suspended;
- their activities as lawyers, the chamber membership as notaries or patent lawyers, or their self-employed activities are suspended;
- the working time is a minimum of 36 hours per week in an employment relationship (in several employment relationships).

[Section 37/A of the Social Insurance Act]

III. Pension system

The mandatory social security pension system covers old age pension and survivors' pension as well as the related risks.

The previous report provided detailed information about the changes of the social security pension system as of 1 January 2012, and since then there have been no substantial changes in the regulation.

IV. Invalidity benefits system

As of 1 January 2012, the system of benefits for persons with changed working capacity changed.

On 31 December 2011, the Changed Working Capacity Act and Government Decree No. 327/2011 (XII. 29.) on the benefits for persons with changed working capacity came into force, which resulted in a complete change of the cash benefits system and the occupational rehabilitation system for persons with changed working capacity and for persons with health impairment.

The changes aimed at establishing a unified and transparent system of benefits related to health impairment with employability aspects and occupational rehabilitation playing a more

important role. The goals and provisions of the act, in addition to unifying and simplifying the benefits system, wish to stimulate persons with changed working capacity to reenter the labour market as soon as possible.

Invalidity pension, accident invalidity pension, regular social allowance and temporary allowance were terminated as of 1 January 2012 and were replaced by a new, unified sick pay type benefit in the framework of health insurance benefits. Granting entitlement to the new benefits, also in the case of persons receiving the benefits concerned, is based on a full assessment which creates a new basis for the system, which is often highly controversial and is not implemented uniformly, used to determine the extent of health impairment.

Persons entitled to benefits are as follows:

- who suffered a health impairment of at least 40 % based on a full assessment;
- who was insured for at least 1,095 days over the five-year period prior to submitting a claim or, as of 1 January 2014, who was insured for at least 2,555 days over the ten-year period or for 3,650 days over the fifteen-year period prior to submitting the claim;
- who is not engaged in paid employment and does not receive other regular funds.

As a result of the full assessment, persons entitled to cash benefits may receive one of the two following benefits based on the rehabilitation proposal:

Rehabilitation benefit

The rehabilitation benefit includes rehabilitation services provided to persons who are recommended for employment and rehabilitation and a cash benefit to compensate for income loss, and can be given for the period of occupational rehabilitation for a maximum of 3 years. It aims at supporting restoration of employability partly by rehabilitation services, partly by a cash benefit. Its amount depends on the extent of health impairment and the previous monthly average income. If the person receiving rehabilitation benefit is engaged in paid employment, the disbursement of cash rehabilitation benefit should be suspended, then as of 1 January 2013, paid employment of 20 hours per week is allowed parallel to receiving rehabilitation benefit. The employment of persons receiving rehabilitation benefit is facilitated by different employment aids (for instance the Rehabilitation Card grants social contribution tax relief for employers employing persons with changed working capacity who can be rehabilitated).

Extent of health impairment	The amount of rehabilitation benefit/minimum and maximum amount (HUF/person/month)
Health impairment of 40–50 %	employability can be restored with rehabilitation 35 % of the monthly average income minimum amount: 30 % of the minimum wage (HUF 27,900) maximum amount: 40 % of the minimum wage (HUF 37,200)
Health impairment of 50–70 %	person requiring lasting occupational rehabilitation 45 % of the monthly average income minimum amount: 40 % of the minimum wage (HUF 37,200) maximum amount: 50 % of the minimum wage (HUF 46,500)

Invalidity benefit

The invalidity benefit is an income replacement allowance for persons who are not recommended for employment and rehabilitation, and it can be paid without time restrictions

as long as the eligibility conditions are met. Its amount depends on the extent of health impairment and the previous monthly average income. Besides receiving the benefit, these persons may be engaged in paid employment, but the income for 3 consecutive months may be a maximum 1.5 times bigger than the actual monthly minimum wage. Persons who receive invalidity benefit and are engaged in paid employment cannot apply for a Rehabilitation Card.

Extent of health impairment	The amount of invalidity benefit/minimum and maximum amount (HUF/person/month) 2012–2015
Health impairment of 40–50 %	<p>considering their health, they could be rehabilitated, but due to their other circumstances laid down in separate legislation, they are not employable and their occupational rehabilitation is not recommended</p> <p>40 % of the monthly average income minimum amount: 30 % of the minimum wage (HUF 27,900) maximum amount: 45 % of the minimum wage (HUF 41,850)</p>
Health impairment of 50–70 %	<p>considering their health, they require lasting rehabilitation, but due to their other circumstances laid down in separate legislation, they are not employable and their occupational rehabilitation is not recommended</p> <p>60 % of the monthly average income minimum amount: 45 % of the minimum wage (HUF 41,850) maximum amount: 150 % of the minimum wage (HUF 139,500)</p>
Health impairment of a minimum of 70 %	<p>persons with changed working capacity who can only be employed with continuous aid</p> <p>65 % of the monthly average income minimum amount: 50 % of the minimum wage (HUF 46,500) maximum amount: 150 % of the minimum wage (HUF 139,500)</p>
Health impairment of a minimum of 70 %	<p>their health impairment is considerable, they are partly or fully not capable of sustaining themselves</p> <p>70 % of the monthly average income minimum amount: 55 % of the minimum wage (HUF 51,150) maximum amount: 150 % of the minimum wage (HUF 139,500)</p>

From 1 January 2013

Based on the one-year long experience regarding the benefits system, the regulation of paid employment parallel to receiving rehabilitation benefit changed; therefore, the disbursement of the benefit is only suspended if the working time in paid employment exceeds 20 hours per week. Previously, the disbursement of the benefit was suspended regardless of the period of paid employment.

As of 1 January 2013, the amount of invalidity and rehabilitation benefits increased with 5.2 % which is consistent with the increase in pension benefits.

From 1 January 2014

The calculation of the preliminary insurance period necessary to establish entitlement to invalidity and rehabilitation benefits changed. As of 1 January 2014, a preliminary insurance period of 1,095 days over the 5-year or 2,555 days over the 10-year or 3,650 days over the 15-

year period preceding is necessary to establish entitlement to benefits (previously, persons were only eligible to receive benefits if they had 1,095 days over the 5-year period preceding).

The method for calculating the amount of rehabilitation/invalidity benefits for those who received rehabilitation allowance on 31 December 2011 changed, and the amount of benefits for people with changed working capacity was determined based on the minimum wage. As of 1 January 2014, 140 % of the amount of the benefit should be considered the monthly average income to be used for the purposes of calculation as there is no monthly average income.

The amount of rehabilitation and invalidity benefits increased with 2.4 % as of January 2014 which is consistent with the increase in pension benefits.

From 1 January 2015

The amount of rehabilitation and invalidity benefits increased with 1.8 % as of January 2015 which is consistent with the increase in pension benefits.

V. The system of family support

A. The system of family support as on 1 January 2012

Family support under the Family Support Act

Hungarian citizens, immigrants or persons with resident legal status, furthermore, persons recognised by the Hungarian authority as refugees, persons enjoying subsidiary protection or stateless and persons with the right of free movement and residence pursuant to Act I of 2007 on the entry and residence of persons with the right of free movement and residence (hereinafter: Residence Act) and, with the exception of maternity support, persons belonging to the scope defined in EU regulations on the coordination of social security systems and its implementation, are eligible for family support under the Family Support Act.

Family support is partly a benefit to which all eligible persons are entitled regardless of the existing insurance relationship, and partly a benefit depending on insurance relationship.

1. Benefits to which all eligible persons are entitled

Benefits to which all eligible persons are entitled without a preliminary insurance period:

- 1.1 family allowance,
- 1.2 child home care support,
- 1.3 child-raising support,
- 1.4 maternity support.

1.1 Family allowance

The State provides monthly child-raising benefit or schooling support (hereinafter together: family allowance) for the costs of raising and schooling the child.

Child-raising benefit is paid in respect of a child not yet obliged for compulsory education, until 31 October of the year in which the child becomes obliged for compulsory education. In addition, a permanently sick or severely disabled person who turned 18 years of age is entitled to child-raising benefit in his or her own right from the time his or her right for schooling support expires, while schooling support is paid in respect of a child, obliged or not for compulsory education, studying in a public education institution.

The monthly amount of family support is as follows:

- a) family with a single child: HUF 12,200;
- b) single parent raising one child: HUF 13,700;
- c) family with two children, per child: HUF 13,300;
- d) single parent raising two children, per child: HUF 14,800;
- e) family raising three or more children, per child: HUF 16,000;
- f) single parent raising three or more children, per child: HUF 17,000;
- g) family raising permanently sick or severely disabled child, or in respect of a permanently sick or severely disabled child living in a children's home, youth detention centre, penal institution or social institution, or placed at a foster parent: HUF 23,300;
- h) single parent raising a permanently sick or severely disabled child, in respect of the permanently sick or severely disabled child: HUF 25,900;
- i) permanently sick or severely disabled person entitled to child-raising benefit in his or her own right: HUF 20,300;
- j) child living in a children's home, youth detention centre, penal institution or social institution, or placed at a foster parent and not covered by point g) and h); furthermore, child placed on a provisional basis pursuant to Section 72(1) of the Child Protection Act, person indicated by the guardianship authority in its decision permitting leaving the family home, and person subject to Section 8(3): HUF 14,800.

The following persons are eligible for family allowance:

- a) biological and adoptive parents, spouse living together with the parent, the person who wants to adopt a child raised in his or her own household, where the relevant procedure is already in progress; cohabitant living together with the parent if he or she and the child subject to the benefit have the same domicile or place of residence and is included as cohabitant of a parent for a minimum of one year in the Register of Declarations of Cohabitants or he or she testifies his or her cohabitation with a parent with an official document issued at least a year prior to the benefit application (hereinafter: parent); foster parent; guardian; furthermore, the person in whose custody the child was placed temporarily pursuant to the Child Protection Act; with respect to the child raised in his or her own household,
- b) the head of the children's home with respect to the child raised in the children's home
- c) the head of the social institution with respect to the child placed in the institution who is not yet obliged for compulsory education, until 31 October of the year in which the child becomes obliged for compulsory education.

A permanently sick or severely disabled person who turned 18 years of age is entitled to child-raising benefit in his or her own right from the time his or her right for schooling support expires.

1.2 Child home care allowance (hereinafter: GYES)

GYES is payable to the parent or the guardian until the child raised in their own household turns 3 years of age or, for twins, until the end of the year in which they reach the age of compulsory schooling or, in the case of permanently sick or severely disabled children, until they reach the age of 10. Besides the persons entitled, biological or adoptive parents of the child's parent and his or her spouse living together (grandparents) are also entitled to child home care allowance when the child has reached the age of one, the child is raised in their own household, and the parents of the child have confirmed in writing that they waive the child home care allowance and agree that the child home care allowance is claimed by the grandparent. The persons receiving GYES are not permitted to be engaged in paid employment until the child reaches the age of 1. The grandparent receiving the allowance is permitted to be engaged in paid employment for not more than 30 hours per week after the child reached the age of 3, or without any time limitation if the activity is pursued in his or her home.

The monthly amount of GYES equals the minimum amount of old age pension (HUF 28,500), or in the case of twins, it is twice the minimum amount of old age pension. Only pension contributions are deducted from the amount, and the term of its payment is considered service time.

1.3 Child raising support (hereinafter: GYET)

It means support for the home care of children to families where at least three children are raised and the youngest child is older than 3 but younger than 8 years of age. The person receiving GYET is permitted to be engaged in paid employment for not more than 4 hours per day, or without any time limitation if the activity is pursued in his or her home.

The monthly amount of GYET equals the minimum amount of old age pension (HUF 28,500), from which pension contribution is deducted, and the term of payment is recognised as service time.

1.4 Maternity support

The following persons are entitled to maternity support after childbirth:

- a) women who have attended prenatal care on at least 4 occasions during their pregnancy, or once in the case of a premature delivery;
- b) adoptive parents if the adoption was permitted in a legally binding manner within 6 months following the birth of the child;
- c) guardians if the child was placed in their custody based on a legally binding decision within 6 months following the birth of the child.

Maternity support is due to the beneficiary also if the child was stillborn.

The amount of maternity support, per child, equals 225 % of the lowest amount of old age pension at the time of the birth of the child, or 300 % in the case of twins.

No maternity support is payable if

- a) before the birth of the child, the parents consented to the adoption of the child in a statement;

- b) the child born receives child protection care under a legally binding court order of the guardianship authority resulting in removal from the family.

2. Benefits to the insured persons

Benefits for persons with a preliminary insurance period:

- 2.1 sick pay,
- 2.2 sick pay on child nursing,
- 2.3 pregnancy-confinement benefit (as from 1 January 2015: infant care fee),
- 2.4 child care fee (except for student GYED which requires no insurance period).

2.1. Sick pay

Those who become incapable of work during the insurance period and are obliged to pay a certain amount of cash health insurance benefit specified in the Social Insurance Act are entitled to sick pay.

Among others, the following persons are incapable of work:

- a) those who cannot do their work due to pregnancy or giving birth and are not entitled to infant care fee;
- b) mothers who breastfeed their hospitalized children under the age of 1;
- c) parents for the duration of the hospital treatment of a child under the age of 12 if they stay with their child in an institution providing inpatient care;
- d) parents who nurse a sick child under the age of 12 at home and raise the child in their household;
- e) in the case of sick pay on grounds of fairness, the parent
 - ea) who nurses a sick child between the age of 12 and 18 at home, or
 - eb) for the duration of the hospital treatment of a child between the age of 12 and 18 if the parent stays with the child in an institution providing inpatient care.

Sick pay is paid for the duration of incapability of work, but

- a) for a maximum of 1 year during the insurance relationship;
- b) only until the child turns one year of age in the case of breastfeeding a child under the age of 1, during home nursing and while the child stays in an institution providing inpatient care;
- c) for a maximum of 84 calendar days per year and per child in the case of home nursing a child between the age of 1 and 3 and while the child stays in an institution providing inpatient care;
- d) for a maximum of 42 calendar days per year and per child for parents and for a maximum of 84 calendar days for single parents in the case of home nursing a child between the age of 3 and 6 and while the child stays in an institution providing inpatient care;
- e) for a maximum of 14 calendar days per year and per child for parents and for a maximum of 28 calendar days for single parents in the case of home nursing a child between the age of 6 and 12 and while the child stays in an institution providing inpatient care;

If the insured parent claims sick pay to nurse his or her child, the sick pay period from the previous birthday of the child to the next birthday has to be taken into consideration as antecedents.

2.2 Cash benefits on grounds of fairness

The health insurance body can provide the insured person with infant care fee, child care fee and sick pay on grounds of fairness if the insured person does not have the insurance period necessary for it.

In addition, the health insurance body can provide sick pay for child nursing beyond the period of sick pay on grounds of fairness.

2.3 Pregnancy-confinement benefit (hereinafter: TGYÁS)

A person is entitled to TGYÁS if she was insured for 365 days over a two-year period before giving birth, and

- a) gives birth during the insurance period or within 42 days after the termination of the insurance, or
- b) gives birth during the disbursement period of accident sick pay after 42 days following the termination of the insurance or within 28 days after the termination of the disbursement.

A mother giving birth is entitled to infant care fee from the day the child is born, or in the case of a premature child from the first day of the maternity leave.

The following must be included in the 365-day insurance period required for eligibility for TGYÁS:

- a) the disbursement period of accident sick pay, infant care fee or child care fee after the termination of the insurance,
- b) 180 days from the full-time studies exceeding 1 year at secondary or higher education institutions,
- c) the disbursement period of rehabilitation allowance and rehabilitation benefit.

TGYÁS is paid for a period consistent with maternity leave. The insured person is not entitled to TGYÁS

- a) for a period of maternity leave when she gets her full salary,
- b) if she is engaged in paid employment, apart from having an employment type legal relationship of foster parent.

The amount equals 70 % of her calendar day income.

2.4 Child care fee (hereinafter: GYED)

The following persons are entitled to child care fee:

- a) the insured parent if he or she was insured for 365 days over the two-year period prior to applying for child care fee or in the case of a mother giving birth, prior to giving birth;
- b) the mother and another person who was granted TGYÁS and whose insurance relationship terminated during the entitlement period to TGYÁS provided that his or her entitlement to TGYÁS started during the insurance relationship and was insured for 365 days over the two-year period prior to giving birth and the child is raised in his or her own household.

The following must be included in the 365-day insurance period required for eligibility for child care fee:

- a) the disbursement period of accident sick pay after the expiry of the insurance;
- b) 180 days from the full-time studies exceeding 1 year at secondary or higher education institutions;
- c) the disbursement period of rehabilitation allowance and rehabilitation benefit.

The child care fee is due from the day after TGYÁS or the corresponding period expired until the child turns two years old.

B. Changes in the family support system in the reporting period

As of 1 January 2014, GYED Extra package was introduced, and it has four main aspects:

1. Possibility of working while receiving GYED/GYES

As of January 2014, it is allowed to be engaged in employment without any restrictions while receiving GYED or GYES if the child is more than one year old. Previously, it was impossible to work while receiving GYED and it was allowed to work a maximum of 30 hours per week while receiving GYES.

- If the parent did not work before, he or she will receive the benefit disbursed until then even after returning to work.
- If the parent already worked before 1 January 2014 and as a result, no benefit could be disbursed, although he or she is still entitled to it, he or she has to apply for the renewed disbursement of the benefit for the remaining period of entitlement at the social insurance pay office at the workplace or if there is no such office, at the relevant territorial health insurance body in the case of GYED, or at the territorial office of the Hungarian State Treasury in the case of GYES. The application has to be submitted to the body/pay office which previously granted that benefit.

This measure gives a choice for parents as they can freely decide when to return to employment, and they do not have to fear losing benefits for the remaining period. In addition to their salary, they also get family support.

2. Sibling GYED/GYES

Child care benefits (GYED, GYES) are still provided if another child is born in the family after 1 January 2014 and the parents are entitled to such benefits also in relation to this child. Previously, disbursement in relation to the older child terminated, and benefits were only provided in relation to the younger sibling.

According to the parents' choice, any of the parents can claim child care benefits on grounds of a child living in the same household, but only one parent at a time can receive child care benefits.

Parents of twins born after 1 January 2014 can decide after GYED, which is originally determined based on their employment, terminated (usually after the child turns two years of age) if they claim multiply GYES they are entitled to according to current legislation or they

still claim GYED for one more year (in the latter case, they can only receive multiple GYES for this period after GYED terminated).

No additional steps are necessary, in the case of another child, family support has to be claimed in the usual way, and in the case of the older sibling, benefits are automatically further provided.

3. Degree holder GYED

As of 1 January 2014, university/college students with full-time studies exceeding 1 year or graduates giving birth within one year after graduation can also be entitled to GYED for one year after giving birth even in the absence of employment. The gross amount of benefits is the minimum wage (HUF 101,500) in the case of BA studies and 70 % of the guaranteed minimum wage (HUF 114,000) in the case of MA or doctoral studies.

The benefits claim has to be submitted to the employer (if the person concerned is insured at the time of giving birth), otherwise to the health insurance body at the place where the person concerned is domiciled.

4. The entitlement period for child care fee in the case of twins

In the case of parents of twins born after 31 December 2013, the disbursement period of GYED is extended for another year starting from the day the pregnancy-confinement benefit or the corresponding period expired after the entitlement to child care fee terminated.

As of 1 January 2015, the pregnancy-confinement benefit is called infant care fee.

As of 1 January 2016, it is possible to be engaged in paid employment while receiving GYED/GYES without any time restrictions after the child turns six months old.

5. Change of organisation

From 1 April 2015, tasks relating to family supports have been transferred from the competency of Hungarian State Treasury to the government offices of the Capital City of Budapest and the counties.

VI. Unemployment benefits system

A. Changes in the support and cash benefits of job seekers in the reporting period

According to legislation as on 1 January 2012, job seeker's benefits (jointly called job seeker's support in the legislation) consisted of three types of benefits: job seeker's allowance, job seeker's aid and reimbursement. Job seeker's benefits/supports are regulated in Section V of the Employment Act.

- **Job seeker's allowance**

Job seeker's allowance was paid to those registering themselves as job seekers, had an employment record of at least 360 days over the four-year period preceding the date of

becoming a job seeker, were not entitled to a benefit for persons with changed working capacity, did not receive sick pay, wanted to find a job, but their independent job seeking activity was unsuccessful, and the state employment service was also unable to offer them a suitable job.

The amount of the job seeker's allowance had to be calculated on the basis of the average monthly amount of the labour market contribution base set in Section 19(3) of the Social Insurance Act (hereinafter: contribution base) regarding the four calendar quarters preceding the date of becoming a job seeker. The contribution base was confirmed by the employer in a manner specified by law. If the job seeker was employed by more than one employer over the four calendar quarters preceding the date of becoming a job seeker, or performed more than one entrepreneurial activity, or was employed but was also engaged in entrepreneurial activity, the amount of the job seeker's allowance has to be calculated taking into account the contribution base earned at each employer or in each entrepreneurial activity. If there is no contribution base in the preceding four calendar quarters, the calculation of the allowance must be based on the monthly average of the contribution base earned over a shorter period. If the job seeker has no contribution base whatsoever in the preceding four calendar quarters, the job seeker's allowance must be determined based on 130 % of the mandatory minimum wage applicable on the first day of eligibility. The job seeker's allowance per one day is based on the one-thirtieth part of the average monthly amount of the job seeker's contribution base. The amount of the job seeker's allowance is 60 % of the contribution base. The upper limit of the job seeker's allowance is the daily amount of the mandatory minimum wage applicable on the first day of eligibility.

The disbursement period of the job seeker's allowance has to be calculated based on the period of time spent by the job seeker in employment or legal relationship of public employment over the three-year period preceding the date of becoming a job seeker, or the period of time when he or she had been engaged in entrepreneurial activity as a sole trader or a member of an economic association, assuming in this latter case that he or she complied with his or her obligation to pay contributions during performing entrepreneurial activities (hereinafter: entitlement period). The time during which the job seeker received job seeker's allowance or entrepreneur's allowance shall not be part of the entitlement period. The three-year period defined above shall be extended by the following periods: regular or reservist military service, civilian service, illness leading to absence from work, sick leave for the purposes of nursing a sick child, disbursement of pregnancy-confinement benefit, child care fee or child home care allowance, benefits for persons with changed working capacity, rehabilitation benefit, invalidity pension and accident invalidity pension, regular social allowance, temporary allowance, and health impairment allowance of miners, as well as pre-trial detention, incarceration and detention punishments, payment of nursing fee and child raising support, with the period of doing full-time studies, provided that no employment relationship or no legal relationship of public employment was established during these periods or the job seeker was not engaged in entrepreneurial activity which is considered a part of the entitlement period. The disbursement period of the job seeker's allowance was calculated on the basis of the period of employment in a way that 10 days of employment corresponded to 1 day of allowance disbursement. The longest period of disbursing the job seeker's allowance was 90 days. The first day of disbursing the job seeker's allowance is the day when the job seeker applies to the state employment service. The period between the date when the job seeker applied to the state employment service and the first day of disbursing the job seeker's allowance did not count towards the disbursement period of the job seeker's allowance.

If the person receiving job seeker's allowance established an indefinite-term employment relationship with at least four hours' employment before the end of the disbursement period of the allowance, at his or her request, 80 % of the amount of the allowance still outstanding for the remaining part of the disbursement period had to be paid in a lump sum. Further, such payment was conditional upon the continuous employment of the person receiving the job seeker's allowance from the date when the allowance was terminated to the date of the above-mentioned payment.

The disbursement of the job seeker's allowance had to be discontinued if the job seeker requested such termination, received job seeker's allowance and was cancelled from the records, became entitled to a benefit for persons with changed working capacity, was engaged in paid employment except for a casual employment relationship, agreed to an educational programme with a grant reaching the amount of the applicable mandatory minimum wage, pursued full-time studies at an education institution, died or exhausted the disbursement period of the job seeker's allowance.

The disbursement of the job seeker's allowance had to be suspended for the following periods: if the job seeker reported being granted entitlement to TGYÁS, GYED or GYES, from the day after the entitlement was granted in the case of pregnancy-confinement benefit and child care fee, or starting from the day the entitlement was granted in the case of child care allowance for the duration of the disbursement period; was in pre-trial detention, was incarcerated or was in detention, unless incarceration was imposed as a conversion of a monetary fine; was engaged in paid employment (except for a casual employment relationship) for a short period of time consisting of up to 90 days while working in a short public employment scheme, provided the notification requirement was fulfilled, he or she received activity allowance, for the entire duration of performing voluntary reservist military service.

- **Pre-retirement job seeker's aid**

At the request of the job seeker, pre-retirement job seeker's aid had to be granted to a job seeker who was not entitled to benefits for persons with changed working capacity, had not received sick pay, benefits prior to reaching the required age, any service benefit, annuity of a ballet artist or temporary allowance of miners, wanted to find a job, but his or her independent job seeking activity was unsuccessful, and the state employment service was also unable to offer a suitable job. Another requirement of receiving job seeker's aid is that on the date of filing the application, the job seeker was at an age that is maximum five years before the applicable retirement age, and he or she received job seeker's allowance for a period of at least 45 days, and the disbursement period of the job seeker's allowance was exhausted. As a further condition, the job seeker had to reach the age defined above within three years after exhausting the disbursement period of the job seeker's allowance, and had a period of service necessary for receiving old age pension. The aid could be disbursed for a period up to the job seeker received old age pension or became entitled to the benefit for persons with changed working capacity,

The amount of the job seeker's aid for all three types is 40 % of the mandatory minimum wage applicable on the date of submitting the application. If the average salary or wage over the four calendar quarters preceding the date of becoming a job seeker is less than this, the amount of the job seeker's aid equals the contribution base.

The disbursement of the job seeker's aid had to be terminated in the cases described in relation to the job seeker's allowance. Being engaged in paid employment was an exception because in this case the aid had to be suspended regardless of the period of paid employment, and another exception was suspension for 90 days regardless of the period of paid employment if the job seeker failed to fulfil his or her notification requirement. If the job seeker became entitled to job seeker's allowance as a result of paid employment during the suspension of the disbursement of the aid, the payment of the aid had to be suspended also for the disbursement period of the job seeker's allowance. In the latter case, after the disbursement period of the job seeker's allowance was exhausted, the payment of the job seeker's aid had to be continued.

- **Reimbursement**

Reimbursement meant that any justified costs arising from the use of interurban public transport in connection with the job seeker's allowance or aid and the job seeking activity had to be reimbursed. In justified cases, legislation could also provide for the reimbursement of local transport costs of the job seeker.

B. Major changes

1. Changes in the regulation of benefits in 2012 and 2013

In relation to the Employment Act, there were also changes regarding job seeker's benefits. The modification took place based on the proposals by the work group consisting of the officials of the Ministry of National Economy, the National Employment Office and labour centres within the Magyary programme aiming at the modernisation of public administration, in the framework of a State Reform Operative Programme 1.2.6. called 'Coordination of simplifying legislation and legal procedures'. Changes primarily focused on granting, disbursing, suspending and terminating job seeker's benefits as well as on contact and cooperation with labour centres, and led to considerable time and work gain for both clients and the authority during the administrative procedure. The amendments were approved on 27 December 2012 and became effective the next year. As a result of simplification, job seekers and clients requesting intermediation and services can, in a statement, opt for electronic interaction as a way of cooperation. This way they can submit their registration claim, fulfil their application requirements as well as report the changes in their circumstances and events affecting their registration.

Furthermore, the number of cases when a decision had to be made in every case related to handling benefits decreased; therefore, if the benefit is terminated or suspended by law, there is no need for a decision on it in the future.

2. Changes in the regulation of benefits in 2014 and 2015

In 2014, there were no substantial changes related to the job seeker's benefit.

As of 1 January 2015, in relation to the Employment Act, the following changes occurred concerning job seeker's benefits. Receiving job seeker's benefits while being engaged in an employment type legal relationship of foster parent became possible, but this period is only

considered an entitlement period if the foster parent does not receive job seeker's benefits during this period.

Regarding the suspension of benefits, there is a new case: the job seeker participates in a training in whose framework he or she receives integration facilitating maintenance aid. Furthermore, the job seeker's active job seeking activity is only suspended in the case of reporting his or her entitlement to child care home allowance and child care fee if he or she is not allowed to be engaged in paid employment during disbursement according to the act on family support and the act on statutory health insurance provisions, or he or she is allowed to be engaged in paid employment, but requests suspending his or her active job seeking activity and registration as a job seeker.

Another modification was that persons receiving child home care allowance could be registered as job seekers if they were allowed to be engaged in paid employment according to the act on family support during its disbursement.

As of 3 July 2015, a modification of the Employment Act came into force according to which the period of short-term paid employment increased from 90 days to 120 days.

2) KEY DATA AND STATISTICS

Average number of insured persons, 2011–2015

2011 million persons	2012 million persons	2013 million persons	2014 million persons	2015 million persons
3.9	3.9	3.9	4.1	4.1

Development of pension contributions, 2011–2015

2011 (%)		2012 (%)		2013 (%)		2014 (%)		2015 (%)	
person al	by the employ er	person al	soc. cont r.*	person al	soc. cont r.*	person al	soc. cont r.*	person al	soc. cont r.*
10	24	10	24	10	27	10	26	10	23.1**

* As of 1 January 2012, the employer's contribution is known as social contribution (Social Insurance Act).

** Rounded value

New pensions in the applicant's own right in the given year, 2011–2015

2011	2012	2013	2014	2015
146,222	50,263	59,899	54,617	58,716

Number of those receiving pension in their own right and the average amount of benefits, 2011–2015

2011		2012		2013		2014		2015	
thousan d persons	thousan d HUF	thousan d persons	thousan d HUF	thousan d persons	thousan d HUF	thousan d persons	thousan d HUF	thousan d persons	thousan d HUF
2,463	89.1	1959.2	94.4	2000.1	102.1	2037.1	104.9	2022.9	107.3

Number of old age pensioners and the average amount of benefits, 2011–2015

2011		2012		2013		2014		2015	
thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF
2,101	92.3	1959.2	94.4	2000.1	102.1	2037.1	104.9	2022.9	107.3

Number of those receiving widowers' or widows' pension and the average amount of benefits, 2011–2015

2011		2012		2013		2014		2015	
thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF
126.6	55.4	118.8	57.4	108.1	60.7	99.6	61.5	92.0	62.2

Number of those receiving orphan's pension and the average amount of benefits, 2011 - 2015

2011		2012		2013		2014		2015	
thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF	thousand persons	thousand HUF
97.3	35.1	93.9	36.1	88.0	37.8	81.2	38.0	75.2	38.0

Main data regarding benefits for persons with changed working capacity

	2012	2013	2014	2015
Average number of those receiving benefits* (persons)	514,648	488,659	467,806	437,764
Expenditure spent on benefits (billion HUF)	342.4**	349.0**	335.5**	336.0**

source: data by the paying institution

* In addition to invalidity and rehabilitation benefits, it also includes the number of persons receiving invalidity allowance and health impairment allowance of miners.

** Expenses approved in the discharge act for the given year

*** Earmarked amount approved in the central budget for the given year

The amount of family allowance by family type, per number of children, per month

Family type	Amount (HUF/month/child)
Family raising one child	12,200
Single parent raising one child	13,700
Family raising two children	13,300
Single parent raising two children	14,800
Family raising three or more children	16,000
Single parent raising three or more children	17,000
Permanently sick or severely disabled child	23,300
Permanently sick or severely disabled child	25,900

Changes in the amount of family support

Support	2012	2013	2014	2015
Maternity support*	64,125	remained the same	remained the same	remained the same
– for twins	85,500	remained the same	remained the same	remained the same
Child home care allowance		remained the same	remained the same	remained the same
– for twins	2 child: 57,000 3 child: 85,500 4 child: 114,000 5 child: 142,500 6 child: 171,000	remained the same	remained the same	remained the same
Child-raising support	28,500	remained the same	remained the same	remained the same

**Benefits are usually due monthly and regardless of the number of children, except for maternity support which is a one-time benefit, and in the case of twins, it is paid per child.*

Headcount figures of family support benefits

Year	Recipient of family allowance			Average number of families receiving child-raising support per month	Maternity support, number of disbursements/year	Average number of recipients of child home care allowance per month
	families	children	children per thousand families			
	monthly average					
2012	1,167,640	1,891,431	1,620	38,608	86,196	168,037
2013	1,149,796	1,841,497	1,602	37,411	85,512	161,274
2014	1,134,556	1,836,618	1,619	36,101	87,408	161,226
2015	1,108,302	1,796,726	1,621	34,587	89,656	163,376

3) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR requests information about the proportion of persons covered by old age and invalidity insurance to the entire active population.**

The number of persons covered by old age and invalidity insurance increased in the reporting period. Employees, registered job seekers, persons doing vocational training, persons engaged in employment based on an assignment contract and those who made an agreement with the pension insurance body acquire a new right to pension in the given year. In 2012, the proportion of employed persons to the active population (aged between 15 and 74) was 50 %, and that of job seekers to the active population was 6 %. The number of persons making an agreement with the pension insurance body and as a result paying contribution for the purposes of acquiring rights is not significant. The number of persons belonging to other categories can be estimated based on daily average data. In 2012, based on the comparison of this data, 58 % of the entire population was covered by old age and invalidity insurance. In 2015, the number of employed persons increased with 383,000, and the number of the active

population decreased (but the decrease of about 98,000 was less than the increase); therefore, the proportion of employed persons to the active population also increased with 6 percentage point between 2012 and 2015. The number of job seekers decreased. In summary, 62 % of the entire active population was covered by old age and invalidity insurance in 2015.

- **The ECSR requests information about the proportion of persons subject to unemployment insurance to the entire active population.**

Entitlement to unemployment benefits is granted to all persons engaged in an employment type legal relationship specified in the Employment Act. Self-employed persons who pay labour market contributions are also included. Under the rule of law, job seekers are entitled to job seeker's allowance, pre-retirement job seeker's aid and reimbursement.

Those persons are entitled to job seeker's allowance who are registered job seekers and have an entitlement of 360 days over the three-year period preceding registration, are not engaged in employment or entrepreneurial activity, but are actively seeking job.

Those persons are entitled to pre-retirement job seeker's aid who are registered job seekers, want to work, and are at an age that is maximum five years before the retirement age applicable to them, and they received job seeker's allowance for a period of at least 45 days, or the disbursement period of the job seeker's allowance was exhausted.

Nearly 91 % of the entire active population is entitled to cash unemployment benefits after becoming job seekers. Those who are only entitled to active age benefits (it has two forms: health impairment and child care support, and employment substitution support) are not included.

- **The ECSR requests information whether other benefits such as housing support are available to persons receiving the minimum amount of sickness benefits and job seeker's benefits.**

Persons receiving job seeker's allowance and sick pay can be entitled to the following social benefits if they comply with the income-related and other conditions in legislation.

Public health care provision

Public health care provision is an allowance provided to socially deprived persons in order to reduce their expenditure on maintaining and recovering their health condition.

Persons specified by law (persons with health impairment who receive regular social aid, persons with health impairment of more than 70 % based on the full assessment of the rehabilitation authority who receive invalidity benefit; persons who are entitled to family allowance of a higher amount) have a personal right to public health care provision.

Those persons are entitled to normative public health care provision whose monthly regular health costs exceed 10 % of the minimum old age pension and the monthly income per person in the family is less than 100 % of the minimum old age pension.

It is an in kind benefit that can be used with a public health care certificate. The amount consists of an individual medicine budget depending on the monthly need for medicine (HUF 1,000–12,000) and an ad hoc budget. The latter one provides support in the case of

acute illnesses (a one-time amount of HUF 6,000 once a year). Public health care provision also covers using medical devices and medical services free of charge.

Municipal aid

As of 1 March 2015, the support provided by local governments based on the Social Act is uniformly called municipal aid. In the framework of this support, local governments can provide aid in the case of life situations which they consider to be subject to support and which they regulate.

For what purposes, on what conditions, and how much support can be provided by this aid is at full discretion of local governments. The only obligation imposed by the Social Act is that the board of representatives grants exceptional municipal aid to those in extreme life situations endangering their means of subsistence or who periodically or permanently have problems with their means of subsistence. Determining life situations endangering means of subsistence and the conditions of problems with means of subsistence is at the discretion of local governments, similarly to determining the amount of aid provided in these situations.

The Social Act only gives examples of benefits provided as municipal aid:

Support can be provided as municipal aid especially for the following purposes and people:

- a) covering regular housing-related costs,
- b) persons nursing and looking after a permanently sick relative who is older than 18 years of age,
- c) covering medicine-related costs,
- d) persons with debts related to housing costs.

- **The ECSR requests information whether job seekers who exhausted the disbursement period of job seeker's allowance and did not find a suitable job will be entitled to job seeker's aid.**

As of 1 September 2011, the job seeker's benefits system underwent substantial changes. In the case of the National Employment Fund (former Labour Market Fund), the Széll Kálmán reform programme set a requirement for cost-cutting as well as improving efficiency, which could be met by reducing costs: by a significant decrease in (passive) job seeker's benefits, termination of certain benefits and a change in the entitlement criteria for job seeker's benefits.

The disbursement period of the job seeker's allowance has become shorter. Instead of a maximum of 270 days, the job seeker's allowance may be granted for a maximum of 90 days. The two stages of disbursing job seeker's allowance were terminated. Job seeker's aid was terminated except for pre-retirement job seeker's aid. The entitlement period for job seeker's allowance decreased from four years to three years, and an entitlement period of ten days instead of the previous five became necessary for disbursing allowance for one day.

With these measures, the Government, in addition to making savings indispensable for public finances, wanted to stimulate a more effective and intensive job seeking activity and reduce the period of unemployment so that there would be no barriers on behalf of the labour market supply to increasing employment.

The modification of the benefits system was also related to the reform of social aids and public employment. The minimum daily amount of the job seeker's allowance remained 60 %

of the labour market contribution base, and its upper limit is now 100 % of the minimum wage. The lower and upper limits of the job seeker's allowance also increase according to the increase of the mandatory minimum wage and the guaranteed minimum wage set by law and determined during annual wage bargaining with social partners. OECD considered these amounts of minimum wage relatively high in its annual report assessing the economic situation of its member states (the latest report in 2016: "Economic Survey of Hungary 2016" http://www.keepeek.com/Digital-Asset-Management/oecd/economics/oecd-economic-surveys-hungary-2016_eco_surveys-hun-2016-en#page14) in the past period.

After changing the passive benefits system, only HUF 64 billion had to be spent on job seeker's allowances and aids compared to HUF 137 billion in 2010. This decrease of costs is primarily due to changes in the entitlement criteria for job seeker's benefits while the lower and upper limits of the job seeker's allowance increase according to the increase in the minimum wage.

At the same time, the public employment costs of the National Employment Fund show a considerable increase: in 2012, public employment costs doubled compared to the previous year, and also led to a significant increase in the number of persons who could receive a wage instead of aids.

The measures in the Széll Kálmán reform programme (including changes related to job seeker's benefits) facilitated a sustainable and decreasing level of public deficits and public debt, the consolidation of the Hungarian public finances on the medium term due to comprehensive and structural reforms, and in parallel, the extension of employment.

Changing the aid system and the benefits system of job seekers is part of a set of measures which create the conditions for economic growth, the long-term balance of the budget, the extension of employment and the improvement of competitiveness. It is an employment policy priority set by the Government of Hungary that more persons live on their wage and salary than benefits coming from state redistribution, and this objective can be met by supporting the supply side of the labour market, stimulating the economic activity of the labour force and strengthening the willingness to work.

The measures for extending employment include increasing the support for job creation, making the labour market more flexible, having a proportionate tax system which stimulates work performance, and terminating the possibility of early retirement. Due to these comprehensive structural measures, employment has been extended and unemployment has decreased permanently in Hungary in recent years.

- **The ECSR concluded that the minimum amount of old age pension and old age allowance is obviously not appropriate.**

According to the act on the central budget of Hungary for 2017, old age allowance granted to old age persons who do not have an income providing subsistence will increase with an average of 5 % as of 1 January 2017. Furthermore, as of 2018, the amount of the allowance will increase with the same extent as the prevailing pensions. The increase in the amount of the allowance is shown by entitlement categories in the following table.

Monthly amount of old age allowance		
Persons entitled	Up 31 December 2016	to From 1 January 2017
persons who reached the applicable retirement age whose monthly income per person calculated based on their income and the income of their spouse or cohabitant living in the same household does not exceed 80 % of the prevailing minimum amount of old age pension	HUF 22,800	HUF 24,224
single persons who reached the applicable retirement age but are younger than 75 years of age with a monthly income not exceeding 95 % of the prevailing minimum amount of old age pension	HUF 27,075	HUF 28,500
single persons who turned 75 years old with a monthly income not exceeding 130 % of the prevailing minimum amount of old age pension	HUF 37,050	HUF 38,475

ARTICLE 13 – THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

A. Benefits that may be granted pursuant to Act III of 1993 on Social Administration and Social Services (hereinafter: Social Act)

1. Classification of benefits and the scope of the Social Act

Benefits that may be granted pursuant to the Social Act may be grouped as follows:

- a) income replacement allowances,
- b) compensation of expenses,
- c) benefits related to a crisis situation.

a) Income replacement allowances

Income replacement allowance is the last link in the social security system and provides subsistence support for people with no alternative income. The following benefits are included in this group of services:

- support for persons of active age (employment substitute support and regular social allowance/health damage and child home care support²⁷)
- old-age allowance,
- nursing fee.

b) Compensation of expenses

Compensation of expenses provides support for people in need in order to bear their regular expenses that are recognised by the society as necessary. The following benefits are included in this group:

- home maintenance support (it was removed from the benefits system as of 1 March 2015),
- debt management service (it was removed from the benefits system as of 1 March 2015),
- public healthcare provision.

²⁷ The regular social allowance was removed from the benefits system as of 28 February 2015. Its role has been taken over by the health damage and child home care support (see the details in the description of the allowance for persons of active age).

c) Benefits related to a crisis situation

Benefits related to a crisis situation are ad hoc allowances for the purpose of dealing with problems arising in crisis situations:

- temporary allowance (until 31 December 2013),
- funeral allowance (until 31 December 2013),
- municipal government aid (from 1 January 2014 until 28 February 2015, through the merging of the temporary allowance, the funeral allowance granted pursuant the Social Act and that of the irregular child protection support granted pursuant to the Child Protection Act),
- settlement aid (as of 1 March 2015).

The personal scope of the Social Act with regard to monetary and in-kind allowances (1 January 2012)

The Social Act applies to persons living in Hungary who are

- a) Hungarian citizens,
- b) migrants and settled persons,
- c) stateless persons or
- d) persons recognised by the Hungarian authorities as refugees.

With regard to the temporary allowance the scope of the Social Act covers even those citizens of the countries ratifying the European Social Charter, who are legally residing in the territory of the Republic of Hungary.

The Act applies to persons entitled to free movement and residence provided that the right of free movement and residence exceeding three months is exercised in the territory of the Republic of Hungary at the time of applying for benefits, and the given person has a registered residence under the Act on the Registration of Personal Data and Address of Citizens.

With regard to old-age allowance, the Social Act applies to persons defined as beneficiaries pursuant to the European Union regulations on the coordination and implementation of social security schemes, provided that the right of free movement and residence is exercised in the territory of the Republic of Hungary at the time of applying for the allowance, and the given person has a registered residence under the Act on the Registration of Personal data and Address of Citizens.

With regard to old-age allowance, the Social Act applies to third-country nationals holding the permission for highly-qualified employment and residence (EU Blue Card), provided that the given person has a registered residence under the Act on the Registration of Personal data and Address of Citizens. (As of 1 August 2011)

Amendment

From 1 January 2014 on: With regard to old-age allowance, the Act applies to third-country nationals who hold a single permit and are legally residing in the territory of Hungary.

With regard to the allowances replacing the temporary support (namely the municipal government aid and the funeral allowance) the scope of the Social Act covers, similar to that of the temporary support, those citizens of countries ratifying the European Social Charter who are legally residing in the territory of the Republic of Hungary.

2. Detailed description of allowances

2.1. Income replacement allowances

2.1.1. Allowance for persons of active age

Regulations in force on 1 January 2012

The allowance for persons of active age is an allowance for persons of active age in a disadvantaged position in the labour market and for their families. Persons over 18 years of age who have not reached the legal age of retirement or are under the age of 62 shall be deemed as persons of active age.

The establishment of the provision, on 1 January 2012, fell within the competences of the notary.

Allowance for persons of active age can be granted to persons of active age

- a) who have lost at least 67% of their working capacity or suffered an impairment of at least 50% or whose rating per health conditions does not exceed 50% according to the complex assessment of the rehabilitation authority, or
- b) who receive personal allowance for the blind or
- c) who receive disability support (persons under points (a)-(c), hereinafter together referred to as people of impaired health), or
- d) for whom the period of disbursement of unemployment benefit, job seeker's allowance, job seeker's support or entrepreneurial allowance (hereinafter together referred to as job-seeking support) has expired or
- e) for whom, due to the pursuance of income-earning activities, the disbursement of the job-seeking support has been terminated before the expiry of the disbursement period, and after the income-earning activities the person does not become eligible for job-seeking support under the Act IV of 1991 on the promotion of employment and provisions to the unemployed, or
- f) who, within the last two years prior to the submission of an application for allowance for persons of active age, has acted in cooperation with a governmental employment body, or
- g) in the case of whom the disbursement of nursing fee, child home care allowance, child raising support, regular social allowance, health impairment allowance for miners, temporary allowance, rehabilitation allowance, disability pension, accident disability pension, the allowance for persons with a reduced capacity for work and of the temporary widow's pension, or the disbursement of the widow's pension has been terminated pursuant to Section 52 (3) of the Pension Act, and immediately before the submission of the application the person has acted in cooperation with the governmental employment body,

provided that him- or herself and their family does not have any other source of income for a living, they do not pursue any income-earning activities (including public employment, domestic labour or any work performed in the context of an employment relationship established pursuant to the Simplified Employment Act).

With respect to the establishment of eligibility for allowances for persons of active working age, subsistence is not provided for if the family's monthly income for one unit of consumption does not exceed 90% of the minimum amount of the old-age pension in effect at

any given time and they have no property or assets of a value exceeding the threshold in the Social Act. (The minimum amount of the old-age pension has been HUF 28,500 since 2008.)

Persons entitled to an allowance for persons of active age may be granted two kinds of monetary allowance, namely the employment substitution support and regular social allowance.

Employment substitution support

The employment substitution support is deemed to be an allowance for people of active working age who are available for employment. The beneficiary of the allowance is obliged to cooperate with the governmental employment body. Eligibility for the allowance shall be terminated if the given person is not employed for at least 30 days in a year.

The employment substitution support is of a fixed amount of HUF 22,800 per month.

Regular social allowance

Regular social allowance may be established for any person of active age, unavailable for employment, who

- suffers from health-impairment or
- reaches the applicable retirement age within 5 years or
- is raising a child under the age of 14, where the child cannot receive daytime care in any other way, or
- pursuant to a local government decree, meets further conditions laid down in the context of family conditions, health and mental conditions.

The regular social allowance complements the family income until the threshold for family income. Yet, it may not exceed 90% of the net public employment wage (which was HUF 42,326 in year 2012). The upper threshold of family income equals with the sum of ratios belonging to family consumption units multiplied by the amount corresponding to 90% of the minimum amount of old-age pension in effect at any given time.

Any person entitled to regular social allowance shall cooperate with the body designated, for this purpose, by the local municipality. In the framework of this, he/she shall meet the requirements of the programme intended to provide assistance in his/her inclusion.

Within a period of time, only one person in the family is entitled to allowance for persons of active age, with the exception that a family member is entitled to employment substitution support and another one is eligible for regular social allowance. The total sum of the two allowances shall not exceed 90% of the net public employment wage.

Amendments

- As of 1 January 2012 local governments are authorized to provide the employment substitution support partly in an in-kind format (similar to the regulation for regular social allowances), provided that there is a child under protection in the family.
- As of 1 August 2012 municipal governments may stipulate in their decree that in the case of regular social allowances disbursed in an amount of at least HUF 10,000 (allowance for persons of active age who are unavailable for employment), HUF 5,000

of the given sum shall be provided in the form of in-kind benefit 'Erzsébet-utalvány' (Erzsébet vouchers) valid for ready-made food.

- The upper threshold for regular social allowance (which equals 90% of net public employment wages) has been moved, as of 1 January 2014, from HUF 44,508 to HUF 45,569. For families with a member entitled to employment substitution support, the amount of regular social allowance has been increased from HUF 21,708 to HUF 22,769 as of 1 January 2014.
- The upper threshold for regular social allowance (which equals 90% of net public employment wages) has been moved, as of 1 January 2015, from HUF 45,569 to HUF 46,662. For families with a member entitled to employment substitution support, the amount of regular social allowance has been increased from HUF 22,769 to HUF 23,862 as of 1 January 2015.
- The establishment of allowances for persons of active age, which used to fall within the competence of notary, constitutes an authorised activity of the district office as of 1 March 2015. Types of allowances that may be granted to persons of active age in the framework of allowance provision have also changed, along with the scope of eligibility:
 - The allowance under the name 'regular social allowance' ceased to exist as of 1 March 2015. Those previously entitled to this support have been granted eligibility for other allowances.
 - Those who have been granted any regular social allowance on the grounds of qualifying as persons suffering from a health damage or with reference to the only possible way to provide child care for their child/children under 14, automatically have become eligible for the new allowance for health damage and child home care support.
 - If they have agreed with the obligation to engage in cooperation as a condition for receiving the employment substitution support (registration as a job-seeker, cooperation with the employment agency), those who were to reach the retirement age-limit within 5 years and those who were entitled to receive regular social allowance based on the conditions in the local government decree, could be granted employment substitution support.
 - For those who were to reach the retirement age-limit within 5 years and for those who were entitled to receive regular social allowance based on the conditions in the local government regulation, yet refused the obligation to engage in cooperation, the eligibility for allowance for persons of active age had to be withdrawn.

As of 1 March 2015, with regard to the healthcare and child home care support, the upper threshold of family income equals with the sum of ratios belonging to family consumption units multiplied by the amount corresponding to 92 % of the minimum amount of old-age pension in effect at any given time.

2.1.2. Old-age allowance

Regulations in force on 1 January 2012

Old-age allowance is a kind of support granted to old-age persons with no livelihood supporting income.

The eligibility for old-age allowance may be established for those who have reached the relevant retirement age-limit, on the condition that the following conditions are met:

- a) for those applicants who are not single or are under the age of 75, eligibility for the allowance may be established if the net monthly income per capita, based on their own income or with the inclusion of their spouse or partner's income, does not exceed 80% of the minimum amount of old-age pension in effect at any given time (i.e. HUF 22,800),
- b) for those applicants who are single or under the age of 75, eligibility for the allowance may be established if their monthly income does not exceed 95% of the minimum amount of old-age pension in effect at any given time (i.e. HUF 27,075).
- c) for those applicants who are single or above the age of 75, eligibility for the allowance may be established if their monthly income does not exceed 130 % of the minimum amount of old-age pension in effect at any given time (i.e. HUF 37,075).

The sum of old-age allowance for those without any income equals

- a) 80% of the minimum amount of the old-age pension in effect at any given time (i.e. HUF 22,800) if the applicant is not single,
- b) 95 % of the minimum amount of the old-age pension in effect at any given time (i.e. HUF 27,075) if the applicant is single and is under the age of 75,
- c) 130 % of the minimum amount of the old-age pension in effect at any given time (i.e. HUF 37,075) if the applicant is single and is above the age of 75.

For those with an income, the amount of the allowance shall be defined by the difference between the above sum and the entitled person's monthly income.

If the sum of the allowance, disbursed to an entitled person with an income, is lower than HUF 1,000, an allowance of at least HUF 1,000 should be established for the entity.

The disbursement of old-age allowance is not restricted to any time limit.

With regard to old-age allowance, the Social Act applies to third-country nationals holding the permission for highly-qualified employment and residence (EU Blue Card), provided that the given person has a registered residence under the Act on the Registration of Personal data and Address of Citizens. (As of 1 August 2011)

Amendment

The establishment of eligibility for old-age allowance, which used to fall within the competence of the notary, constitutes an authorised activity of the district office as of 1 January 2013.

With regard to old-age allowance, as of 1 January 2014, the Act applies to third-country nationals holding a single permit and legally residing in the territory of Hungary.

2.1.3. Nursing fee

Regulations in force on 1 January 2012

The nursing fee is a financial contribution to an adult relative undertaking to provide care for a person in need of permanent care.

The Social Act made regulations for the following three forms of nursing fee on 1 January 2012:

- Persons can receive the normative-based basic amount of the nursing fee if they provide care for their relatives, with severe disabilities, in need of constant care or who are chronically ill and under 18 years of age. The amount of the nursing fee is, in this case, the basic amount determined in the budget law (i.e. HUF 29,500).
- Relatives providing care for persons, with severe disabilities, in need of intensive care may receive nursing fee at a higher amount. In this case, the nursing fee equals 130% of the basic amount determined in the budget law (i.e. HUF 38,350).
- The representative body of the municipal government can establish a nursing fee on the grounds of equity for the relative who provides care for a chronically ill person over the age of 18 years, provided that the conditions laid down in the local government decree are met. In this case the exact amount of the nursing fee is determined by the local government decree in such a way that it cannot be less than 80% of the basic amount determined in the budget law (i.e. HUF 23,600). The monthly family income limit per capita, with regard to establishing eligibility, is regulated in such a way that an income eligibility criterion for less than the amount of the minimum old-age pension in effect at any given time, or in case of a single person, for less than 150% of the amount of the minimum old-age pension in effect at any given time, cannot be laid down by the local government decree.

In the case of an entitled person receiving other regular monetary benefits, the monthly amount of the nursing fee is the difference between the amount of the nursing fee and the monthly amount of the other regular monetary benefits received by the entitled person. If the difference does not reach HUF 1,000, a nursing fee of HUF 1,000 shall be established for the entitled person.

The disbursement of the nursing fee is not restricted to any time limit. The disbursement period of the nursing fee grants the beneficiary a certain length of service. The person receiving the nursing fee is obliged to pay pension contributions for the provision.

Amendments

As of 1 January 2014, the amount of a higher nursing fee, that family members who provide care for their relatives with severe disabilities in need of intensive care are granted, has increased from 130% of the basic amount, determined in the budget law, to 150% thereof (i.e. HUF 44,250).

Introduced from 1 January 2014, the increased nursing fee may be awarded to those nursing close relatives in the most serious condition. A close relative is entitled to the increased nursing fee if he or she is nursing or caring for a person who:

- is over the age of 18 and in respect of whom the rehabilitation authority determined, through complex assessment, that the person of reduced working capacity has significant health impairment and is unable to care for him- or herself or requires help to do so,
- is not over the age of 18 (or is studying at a public education institution, in which case, family support is payable until the end of the academic year in which they turn 20, or 23 in the case of a student with special educational needs yet not being entitled to disability allowance) and receives an increased amount of family support and the medical expert verifying the condition making him or her eligible for a higher amount

of family support certifies that he or she needs permanent nursing and care due to his or her illness or disability.

From 1 January 2014, the monthly amount of the increased nursing fee is 180 % of the basic amount of the nursing fee, that is 53,100 HUF.

As of 1 March 2015 regulations on equity nursing fee have been removed from the Social Act. No such allowance under the same name may be provided subsequently. Municipal governments did not use to be obliged to provide such allowance earlier. Local governments may grant settlement aid to those family members who provide care for any patient, over 18, suffering from a chronic illness.

2.2.Allowance for the compensation of expenses

2.2.1. Home maintenance support

Regulations in force on 1 January 2012

The home maintenance support provides support to socially deprived persons and families to cover their regular expenses regarding the maintenance of their homes or premises that are not used for living purposes.

The establishment of home maintenance support falls within the competence of the notary. Home maintenance support can only be granted to one entitled person in the same home, irrespective of the number of persons and households living in the real estate.

The Social Act made regulations for two types of the support.

- a) home maintenance support provided to those eligible under the conditions stipulated in this act (hereinafter: home maintenance support on a normative basis) or
- b) home maintenance support granted to those receiving debt management service. The aim of the housing maintenance support related to the debt management service (and granted for its duration) is to enable the debtor to cover his or her housing maintenance expenses while paying off the outstanding amount. Those receiving home maintenance support under this title are not entitled to home maintenance support on a normative basis simultaneously.

Both types of support may be provided in the form of monetary allowance or in an in-kind format (by crediting the entitled person's account or in any other form, such as fuel).

Such households were entitled to home maintenance support on a normative basis where the net monthly income per capita did not exceed a minimum of 250% of the old-age pension.

The amount of the home maintenance support for a month (for both forms of allowance):

- a) 30% of the acknowledged monthly costs of home maintenance if the monthly income per capita in the household of the entitled person does not exceed 50% of the minimum of the old-age pension in effect at any given time,
- b) the acknowledged monthly costs of home maintenance multiplied by the rate of the support (hereinafter: RS) if the monthly income per capita in the household of the entitled person exceeds the amount determined in point (a),

the amount should not be less than HUF 2,500 claiming that the amount of the support shall be rounded up to the nearest HUF 100.

The following formula is used when calculating the rate of support (RS) determined in point (b):

$$RS = 0.3 - \frac{J - 0.5}{NYM} \times 0.15,$$

where J indicates the monthly income per capita in the household of the entitled person, and NYM indicates the minimum amount of the old-age pension in effect at any given time. RS must be rounded up to the nearest hundredth.

The amount of home maintenance support on a normative basis is determined for a period of one year. The allowance can be repeatedly established if the eligibility conditions are met.

As per the regulation of the municipal government, other conditions in the regulation may stipulate, with regard to eligibility to home maintenance support on a normative basis, that the person entitled to the allowance will be obliged to meet further conditions, laid down in its regulation, concerning the maintenance of the housing environment.

Amendments

Rules for home maintenance support were removed from the Social Act as of 1 March 2015. Local governments may provide support for the bearing of regular expenses related to housing, in the framework of the settlement aid.

Based on claims filed prior to 2015, the allowance could be established for a period of one year. For claims submitted between 1 January 2015 and 28 February such allowance could be established until 28 February 2015, meaning that any allowance under the title 'home maintenance support on a normative basis' may be disbursed until 30 December 2015. As of 31 December 2015, it is only the home maintenance support related to debt management services that may be granted.

2.2.2. Debt management services

Regulations in force on 1 January 2012

The debt management service provided ex-post support for households that have outstanding debts with regard to their home maintenance expenses (public utility fees, rentals, co-proprietor charges, and housing loans). Three-pillar assistance is provided in the framework of the service, which characteristically operates in family assistance centres. The in-kind benefits and the service have got interconnected:

- **Support for debt discharging:** monetary benefit provided for the creditor – in addition to the compulsory self-financed contribution – in order to pay back the debt (its amount shall not exceed 75% of the debt involved in debt management or HUF 200,000; in special cases (namely in some cases of outstanding arrears on housing loans defined by law) it may be a maximum of HUF 400,000). The support may be granted in a lump sum or in monthly instalments, except for large housing loans, subject to the undertaking of the debtor.
- **Home maintenance support:** for the purpose of enabling clients to cover their current expenses related to home maintenance in addition to repaying their arrears.

- **Debt management consultancy:** the debtor is obliged to cooperate with the debt management consultant for developing good management practices, for using the support in a proper way and in the interest of prevention.

The operation of the service was obligatory only in settlements of over 40,000 inhabitants and in the districts of the capital city, otherwise it depended on the will of local governments whether they wanted to start operating the service.

The local government may provide debt management service for a family or a person

- a) whose
 - (aa) debt is over HUF 50,000 and whose debt is at least six months overdue, or
 - (ab) service has been cut off due to outstanding public utility fees, furthermore
- b) where the monthly income per capita in the household does not exceed the threshold specified in the local government decree (the threshold shall be regulated in such a way that an income eligibility criterion for less than 150% of the amount of the minimum old-age pension in effect at any given time or, in case of a person living alone, for less than 200% of the amount of the minimum old-age pension in effect at any given time, cannot be laid down by the local government decree) and
- c) who lives in a home not exceeding the minimum size and quality acknowledged by the settlement, provided that the family or the person undertakes to pay the difference between the debt and the support for debt-discharging determined by the local government and to participate in the debt management consultancy.

The time period of the debt management service is maximum 18 months, which can be prolonged once in justified cases. In some cases of arrears on housing loans, the time period of debt management service may be at least 24 but not more than 60 months.

The maximum amount of support for debt-discharging may not exceed 75% of the debt included in debt management. It should amount up to HUF 300,000; in some exceptional cases it may be a maximum of HUF 600,000.

Amendments

As of 1 March 2015 the rules on debt management services were removed from the Social Act. For those clients, in the case whom debt management service was established before 1 March 2015, service shall be provided under the former regulations. (This means that the debt management service under the former regulations shall cease to exist within sixty months, along with the related home maintenance support.) Local governments may provide support for those accumulating arrears related to housing expenses, through the settlement aid.

2.2.3. Public healthcare provision

Regulations in force on 1 January 2012

Public health care is a contribution provided for socially disadvantaged persons to reduce their expenses in relation to the preservation and restoration of their health.

The person holding the public health care card is entitled to receive certain services – as specified in separate legislation – covered by the social security scheme, free of charge, such as

- a) certain medicines, including dietary foods for special dietary needs, that can be prescribed in the out-patient services up to the medicine allowance of the person,
- b) certain therapeutic equipment, including prosthetic and orthodontic instruments and their repair and hire, specified in separate legislation, and
- c) medical treatment for rehabilitation.

Three types of eligibility for public healthcare were included in the Social Act on 1 January 2012:

- i. Persons entitled to public healthcare under subjective right:
 - persons in institutional care, minors in institutional and state care;
 - persons receiving regular social support due to health impairment;
 - veterans and wards of the nation receiving financial provision;
 - persons receiving central social allowance;
 - persons receiving invalidity annuity;
 - persons receiving invalidity allowance;
 - persons who, or whose parents or guardians, receive family support at an increased amount.
- ii. Persons are also entitled to public healthcare on a normative basis if the fee of their monthly regular remedial treatment acknowledged by the health insurance fund exceeds 10% of the minimum of the old-age pension in effect at any given time, provided that the per capita income in their family does not reach the minimum of the old-age pension, or 150% of the minimum in case of single persons.
- iii. Persons are entitled to public healthcare on grounds of equity if they meet the conditions laid down in the local government decree. The Social Act constitutes the framework for adopting local government decrees, with regard to the income threshold specified as an eligibility criterion for public healthcare, and the rate of the monthly regular remedial treatment.

The notary made a decision on the entitlement to public healthcare on 1 January 2012. Eligibility has been established for two years in case of persons entitled to benefits under point (i), and for one year in case of persons entitled to benefits under points (ii)-(iii). The allowance could be repeatedly established if the eligibility conditions were met.

The medicine allowance

- a) consists of the individual medicine allowance for supporting regular medical needs and
- b) the ad hoc allowance for supporting medical needs arising from acute diseases.

The individual medicine allowance is the amount of the monthly regular pharmaceutical expenses of the entitled person but it shall not exceed HUF 12,000 per month²⁸.

The annual amount of the ad hoc allowance is HUF 6,000. If an individual medicine allowance is not established for the entitled person, then the amount of the medicine allowance shall be the same as the ad hoc allowance.

²⁸ The monthly upper threshold for individual medicine allowance and the amount of ad hoc allowance shall be determined by the Act on Annual Central Budget.

Amendments

Persons entitled to public healthcare under subjective right, as of 14 April 2012, are

- persons in institutional care, minors in institutional and state care;
- persons receiving regular social support due to health impairment;
- veterans and wards of the nation receiving financial provision;
- persons receiving central social allowance;
- persons receiving invalidity annuity;
- those who
 1. receive invalidity allowance and the rating per health conditions of whom does not exceed 30% according to the complex assessment made by the rehabilitation authority,
 2. pursuant to Act CXCI of 2011 on the benefits of persons with changed capacity to work and on the amendment of specific acts (hereinafter: Mmtv.), in the context of Section 30 (4) (b) (ba) or Section 32 (1) (a) of the said Act, persons who shall be granted invalidity allowance and who are entitled to disability, accident-related disability pension of class I or II on 31 December 2011,
 3. persons who shall be granted invalidity allowance, yet are not subject to subpoints (1) and (2) and whose eligibility for public health care services was established until 15 April 2012,
 4. pursuant to the Mmtv., in the context of Section 31 thereof, persons who shall be granted old-age pension and who were entitled to disability, accident-related disability pension of class I or II on 31 December 2011, or
 5. shall be granted old-age pension, and prior to the day of the establishment of their eligibility for pension, were subject to subpoint (1) or (2),
- persons who, or whose parents or guardians, receive family support at an increased amount.

The establishment of eligibility for public healthcare under subjective right and on a normative basis, which used to fall within the competence of the notary, constitutes an authorised activity of the district office as of 1 January 2013.

As of 1 January 2014 public healthcare provision on the grounds of equity falls within the competence of the representative body.

As of 1 January 2015 eligibility for public healthcare under subjective rights shall be terminated for persons who receive invalidity allowance but are not subject to subpoints (1) and (2) and whose eligibility for public healthcare was established until 15 April 2012. As of 1 March 2015 the rules on public healthcare on the grounds of equity have been removed from the Social Act. Local governments may provide support for the bearing of medical expenses through settlement aid. The allowance was terminated as in its last phase of operation, therefore based on the applications submitted before 1 March 2015, the allowance, which is to be established for one year, will still have to be provided.

2.2.4. Eligibility for health care services

Regulations in force on 1 January 2012

Eligibility for health care services can be established by the notary on the grounds of social deprivation, for a person in whose family the monthly income per capita does not exceed

120% of the minimum old-age pension (150% of the minimum old-age pension in case of a person living alone) and the family has no property or assets. An official certificate shall be issued by the notary for the verification of social deprivation. The certificate shall be valid for one year. The certificate can be issued again if the eligibility conditions are met.

As the owner of the certificate, the socially deprived person is eligible for health care services pursuant to Section 16 (1)(o) of Act LXXX of 1997 on the Persons Entitled to Obtain the Services of Social Insurance and Private Pension, and the Coverage of such Services (hereinafter: Social Insurance Act).

Amendments

The establishment of eligibility for health care services, which used to fall within the competence of the notary, constitutes an authorised activity of the district office as of 1 January 2013.

2.3.Benefits related to a crisis situation

2.3.1. Temporary allowance

Regulations in force on 1 January 2012

Temporary allowance determined by a local government decree is provided by the representative body of the local government for persons who are in an extraordinary situation endangering their subsistence, or who suffer from problems of subsistence temporarily or permanently. The temporary allowance can also be granted in the form of an interest free loan, not considered as an allowance by financial institutions.

Temporary allowance can be granted occasionally or regularly on a monthly basis.

The disbursement of temporary allowance is justified primarily for persons who cannot provide subsistence for themselves and their families in any other way, or are in need of financial assistance due to occasional extra expenses, particularly because of disease and damage due to natural disasters.

The detailed eligibility criteria for the temporary allowance are specified by the local government decrees drawn up by the representative bodies thereof. The Social Act only stipulates the basic framework of the eligibility criteria, i.e. aim of the allowance, lower threshold of family income. In accordance with the Social Act, the monthly family income per capita determined by the local government decree cannot be less than the minimum amount of the old-age pension in effect at any given time, or in case of a person living alone it cannot be less than 150% of that amount (i.e. HUF 42,750).

Amendments

- As of 1 January 2014 the temporary allowance, the funeral allowance and the irregular child protection support ceased to exist as an independent form of benefit, and were merged into municipal government aid.

The representative body of the municipal government grants municipal aid, in accordance with its decree, to those in extreme life situations endangering their means of subsistence or who periodically or permanently have problems with their means of subsistence. Municipal

government aid may be provided on an ad hoc basis or for a limited period of time on a monthly basis, as well as in the form of an interest free loan.

Municipal government aid is primarily intended for persons who are unable to provide a subsistence for themselves or their family by other means, or who require financial assistance due to unexpected, sudden extra expenses (in particular, expenses related to illness, death in the family, damage through natural causes, keeping a child in the case of a pregnant mother in a crisis situation, schooling, preparing for the adoption of a child, maintaining contact with the family of a child in foster care or helping a child to return to his or her family) or the disadvantaged status of their child.

The detailed eligibility criteria for municipal government aid are specified by the local government decrees drawn up by the representative bodies thereof. The Social Act only stipulates the basic framework of the eligibility criteria, i.e. aim of the allowance, and the lower threshold of family income. In accordance with the Social Act, the monthly family income per capita determined by the local government decree cannot be less than 130% of the minimum amount of the old-age pension in effect at any given time.

The amount of municipal government aid established as a contribution to the burial of the diseased shall not be less than 10% of the usual cheapest burial in the locality but may extend to the whole costs of the burial, if the burial costs endanger the subsistence of the applicant or that of his or her family.

- As of 1 March 2015 the municipal government aid ceased to exist. From the said date on, the allowance provided by local governments pursuant to the Social Act bear the single name 'settlement aid'.

It is at the will of local governments to provide support to situations that they find eligible as per their decrees, through this aid. Aid for purposes that were previously supported by allowances removed from the benefits system as of 1 March 2015 (namely the home-maintenance support, nursing fee on grounds of equity, public healthcare on grounds of equity, debt management service) may be provided through this allowance.

On what conditions, for what purposes, and how much support can be provided by this aid is at full discretion of the local government. The Social Act sets out only one single requirement, according to which the representative body shall provide irregular settlement aid to persons who are in an extraordinary situation endangering their subsistence, or who suffer from problems of subsistence temporarily or permanently.

Irregular settlement aid is primarily intended for persons who are unable to provide a subsistence for themselves or their family by other means, or who require financial assistance due to unexpected, sudden extra expenses (in particular, expenses related to illness, death in the family, damage through natural causes, keeping a child in the case of a pregnant mother in a crisis situation, schooling, preparing for the adoption of a child, maintaining contact with the family of a child in foster care or helping a child to return to his or her family) or the disadvantaged status of their child.

The local government decree shall regulate the monthly amount of the settlement aid (with the exclusion of the allowance for debt management) in a way that it does not exceed the minimum amount of the old-age pension in effect at any given time.

2.3.2. Funeral allowance

Regulations in force on 1 January 2012

A funeral allowance can be established by the local government according to the conditions specified in its decree for a person who arranged for the burial of the deceased, though he or she was not obliged to do so, or was obliged to do so as a relative, but bearing the burial costs endangers his or her and his or her family's subsistence.

The detailed eligibility criteria for the funeral allowance are specified by the local government decrees drawn up by the representative body thereof. The Social Act only stipulates the basic framework of the eligibility criteria. In accordance with the Social Act, the monthly family income per capita determined by the local government decree cannot be less than the minimum amount of the old-age pension in effect at any given time, or in case of a person living alone it cannot be less than 150% of that amount (HUF 42,750), and it shall not be less than 10% of the usual cheapest burial in the locality but may extend to the whole costs of the burial, if the burial costs endanger the subsistence of the applicant or that of his or her family.

Amendments

As of 1 January 2014 the temporary allowance, the funeral allowance and the irregular child protection support ceased to exist as an independent form of benefit, and were merged into municipal government aid.

As of 1 March 2015 the municipal government aid ceased to exist. From the said date on, the allowance provided by local governments pursuant to the Social Act bear the single name 'settlement aid'. Functions of the municipal aid have been taken over by the irregular settlement aid, which is to be provided on an obligatory basis.

Information concerning municipal government aid and settlement aid has been detailed in connection with temporary allowance.

2.3.3. Other benefits granted by local governments

The representative body of the local government can supplement the monetary benefits within its competence and can also establish – in the manner and according to the conditions specified in its decree – other monetary benefits for socially deprived persons.

B. Benefits issued on the basis of Act XXXI of 1997 on the Protection of Children and on Guardianship Administration (hereinafter: Child Protection Act)

The aim of Child Protection Act is to establish the basic rules according to which the state, local governments, natural and legal persons protecting children, and other non-legal-entity organisations can provide support by means of certain allowances and measures for the purpose of enforcing the rights and interests of children laid down in the Act, for fulfilling parental duties and ensuring prevention and termination of the vulnerability of children, for substituting lacking parental care and promoting social inclusion of the young adults leaving child protection care.

The personal scope of Child Protection Act (1st January 2012)

The scope of Child Protection Act covers

- a) persons living in the territory of the Republic of Hungary who are Hungarian nationals and – unless otherwise specified by an international agreement – settled persons, migrants, persons with a settled status and children, young adults and their parents recognised by the Hungarian authorities as refugees, protected or stateless persons;
- b) persons entitled to free movement and residence in case the right of free movement and residence exceeding three months is exercised in the territory of the Republic of Hungary at the time of applying for benefits, and the given person has a registered residence under the Act on the Registration of Personal Data and Address of Citizens;
- c) foreign children under 18 applying for asylum, who under law or custom entered the territory of Hungary without being accompanied by an adult responsible to be their guardian, or who were left without such a person after entering the country. They shall fall within the scope of the Act until they are accompanied by an adult responsible to be their guardian, provided that the refugee authority determined that the child is a minor.

With regard to extraordinary child protection support, Child Protection Act also applies to nationals of the countries ratifying the European Social Charter who are legally staying in the territory of the Republic of Hungary.

Amendments

As of 1 January 2014 the irregular child protection support ceased to exist as an independent form of benefit, and together with the temporary allowance and the funeral allowance it was merged into the form of municipal government aid.

Municipal government aid was detailed in the Section of amendments related to temporary allowance.

According to the Act on Child Protection, the following monetary and in-kind allowances may be provided.

1. Regular child protection allowance

Regulations in force on 1 January 2012

The aim of establishing eligibility for regular child protection allowance is to verify that, depending on the social situation, the child is entitled to receive

- normative allowance for child catering,
- financial support disbursed twice a year (in August and in November) at an amount of HUF 5,800,
- other benefits (school book subsidies, tuition subsidies etc.) specified in separate legislation.

The aim of the regular child protection allowance is to enable socially deprived families to provide care for the child at home, in accordance with children's rights.

Children are entitled to receive the allowance if, in their foster family, the per capita monthly income does not exceed 130% of the minimum amount of the old-age pension in effect at any given time.

In some cases – with regard to the special situation of the family – the income threshold for eligibility for the allowance is higher, i.e. 140 % of the minimum amount of the old-age pension in effect at any given time. Cases deserving such special consideration are

- a) if the child is cared for by a single parent or other legitimate representative, or
- b) if the child is chronically ill or severely disabled, or
- c) if the child has reached his or her maturity,
 - pursues full-time studies and is below the age of 23, or
 - pursues full-time studies at a higher education institution and is below the age of 25, or
 - in case of marriage, the monthly income per capita or property in the new family of the entitled person does not reach the determined income threshold or rate after the marriage.

Another eligibility criterion for the allowance is that, during the verification of the property, the property per capita (usable real estate, vehicles and other rights representing assets) in the family rearing the child cannot exceed

- a) twenty times the minimum amount of the old-age pension when calculated separately, or
- b) seventy times the minimum amount of the old-age pension when calculated together.

The real estate in which the parent, or other legitimate representative legally required to provide maintenance, habitually lives, the property rights on the real estate they live in and the vehicle maintained because of disability do not qualify as properties, and thus shall not be taken into consideration during property verification.

Amendments

As of 1 October 2012, the total sum of the financial support related to regular child protection allowance (HUF 5,800 per child on two occasions a year) shall be provided in the form of the in-kind benefit, 'Erzsébet-utalvány' (Erzsébet voucher). Erzsébet vouchers granted for this purpose may be used for foodstuff, clothing or school equipment.

As of 1 April 2013 the supplementary child protection support shall not be granted as an independent form of benefit, but may be received, under unchanged eligibility conditions, as a financial support related to the regular child protection allowance.

In the case of children having reached maturity, as of 1 April 2013, in accordance with the additional condition for eligibility – besides income and property-related conditions and the student status –, the child having reached maturity must have been entitled to receive regular child protection allowance for at least one day in the period between the first day of the second month prior to his/her reaching maturity and the day prior to his/her reaching maturity.

2. Establishment of disadvantaged or highly disadvantaged status

Regulations in force on 1 January 2013

In the context of the definition laid down in the Child Protection Act for a disadvantaged or highly disadvantaged status

- a disadvantaged child is a child or a child having reached maturity, who is entitled to regular child protection allowances and to whom one of the following circumstances applies:
 - o the parent or the adoptive guardian has a low level of education, if it can be determined that both parents raising the child together, a single parent or an adoptive guardian have at most primary education,
 - o the parent or the adoptive guardian has a low level of employment, if it can be determined that any of the parents raising the child or the adoptive guardian is eligible for the allowance for persons of active working age or have been registered as job-seeker for at least 12 months,
 - o the child has an inadequate living environment or housing circumstances, if it can be determined that the child is living in an environment that has been declared segregated in the integrated community development strategy for the settlement, or in accommodation with limited or no amenities or emergency accommodation, or in living circumstances where the necessary conditions for healthy development are limited.
- highly disadvantaged child
 - o is a child, or a child having reached maturity, who is entitled to regular child protection allowance and to whom at least two of the above circumstances apply,
 - o a child in foster care,
 - o a young adult who receives after-care and has a student status.

Parallel to the assessment of eligibility for regular child protection allowance, the guardianship authority will confirm the disadvantaged or highly disadvantaged status of a child, or of a child reaching maturity, upon request. A disadvantaged or highly disadvantaged status is complemented with various allowances (accommodation in a dormitory, scholarship programmes) in the public education system.

3. Supplementary child protection support

Regulations in force on 1 January 2012

The guardian appointed for a child receiving regular child protection allowance is eligible for supplementary child protection support if

- a) the guardian is obliged to rear the child, and
- b) receives pension, early retirement provision, service contribution, annuity for ballet dancers, temporary miner's benefit, old-age allowance or any other benefit that falls within the scope of the law on raising regular pension-like provisions.

The monthly amount of the supplementary child protection support is 22 % of the minimum amount of the old-age pension in effect at any given time (HUF 6,720), per child.

Additionally, entitled persons are eligible for a supplement twice a year (every August and November). The amount of the supplement was HUF 8,400 in year 2012.

Amendments

As of 1 April 2013 the supplementary child protection support shall not be granted as an independent form of benefit, but may be received as a financial support related to the regular

child protection allowance. The eligibility criteria for the support and its sum have remained unchanged.

4. Irregular child protection support

Regulations in force on 1 January 2012

The child is provided with irregular child protection support by the representative body of the local government if the family rearing the child has temporary subsistence problems or is faced with an extraordinary life situation jeopardising its subsistence.

Irregular child support is provided on an occasional basis primarily to children and families whose subsistence cannot be provided in any other way, or who are in need of financial assistance because of occasional extra expenses (particularly when a pregnant mother in a social crisis situation decides to keep her child, expenses related to preparing for the adoption of a child, the child taken into foster care is supported in order to being able to communicate with his or her family and to re-integrate into his or her family, or expenses related to diseases or schooling arise).

The detailed eligibility criteria for irregular child protection support are specified by the local government decrees drawn up by the representative bodies thereof.

Amendments

As of 1 January 2014 the temporary allowance, the funeral allowance and the irregular child protection support ceased to exist as an independent form of benefit, and were merged into municipal government aid.

As of 1 March 2015 the municipal government aid ceased to exist. From the said date on, the allowance provided by local governments pursuant to the Social Act bear the single name 'settlement aid'.

Information concerning municipal government aid and settlement aid has been detailed in connection with temporary allowance.

5. Advancing child support

Regulations in force on 1 January 2012

The child support can be advanced by the state if alimony has been finally ruled upon by the court, but the person required to pay alimony fails to meet his or her obligation, and recovery by order of the court is temporarily impossible.

A further condition of advance payment is that the person rearing the child is unable to provide the child with the necessary rearing, i.e. the amount of average per capita monthly income in the family rearing the child does not reach double the amount of the minimum old-age pension.

The guardianship authority prepays the amount set forth in the court's decision to be paid as child support or, if the amount of the child support is set forth as a percentage, it prepays the basic amount provided, that, the amount of prepaid child support may not exceed 50 % of the

lowest amount of old-age pension per child (amendment in effect as of 1 January 2012). The guardianship office may determine a smaller amount than the previous one if the rearing of the child can partly be ensured by the parent rearing the child. Even in this case, the amount paid in advance cannot be less than 10 % of the minimum amount of the old-age pension.

Disbursement of child support in advance can last from the submission date of the application until the day when the grounds on which the application is based cease to apply, but not more than a maximum of three years. In justified cases, disbursement of the advance payment can be re-ordered by the court – on a single occasion – up to a maximum of an additional three years.

If the conditions are met, the advance payment of child support can also be determined after the child has reached his or her maturity, or the already determined child support can be further disbursed until the child finishes his or her full-time secondary school studies, but not longer than his or her twentieth birthday.

During the advance payment period, the state – in the interest of protecting the children's rights – temporarily acts on behalf of the person required to pay alimony as a 'responsible person in the background'. The person required to pay alimony is obliged to pay back the advance payment to the state.

Amendments

No substantial changes were made in the reporting period with regard to eligibility conditions and the amount of the support.

6. Home-start assistance

Regulations in force on 1 January 2012

The aim of home-start assistance is to support young adults leaving short-term or long-term foster care (foster parents, children's homes) in solving their problem of access to housing or permanent housing. The application for assistance can be submitted after the young adult has reached his or her maturity.

Young adults are entitled to receive home-start assistance if their

- a) foster care, uninterrupted for at least three years, at the foster place, ended upon their maturity, and
- b) holdings of cash, deposits fixed for insurance or for any other reason, or real estate property do not exceed sixty times the minimum amount of the old-age pension at the time of their reaching maturity.

The assistance can be partially or fully used for the following purposes: to buy, build, make habitable, renovate or extend in order to acquire holding in or possession of a building plot, a home suitable for habitual residence, a family house or a homestead coming into the ownership of the young adult; to pay a rent for an apartment; to renovate an apartment rented by the local government; to buy tenant rights; to participate in a state-subsidised housing programme; and to repay housing support loans from credit institutions in one amount. In justified cases the home-start support can be used to pay the one-off contribution to the residential social institutions, covered by the Social Act, providing care for chronically ill or disabled young adults.

The amount of home-start assistance shall be established on the basis of the total value of the years spent in continuous rearing, as well as the cash and real estate property of the entitled person in a manner that it should reach the following amount in the case of entitled persons having no property, as well as together with the property, if the entitled persons have property:

- a) forty times the minimum amount of the old-age pension upon rearing for less than four years,
- b) fifty times the minimum amount of the old-age pension upon rearing for more than four years,
- c) sixty times the minimum amount of the old-age pension upon rearing for more than five years.

The application for home-start assistance can be submitted by the applicant after he or she has reached his or her maturity but by the 30th birthday of the applicant at the latest. This is the forfeit deadline.

Amendments

No substantial changes were made in the reporting period with regard to eligibility conditions and the amount of the support.

7. Kindergarten support

Regulations in force on 1 January 2012

The aim of introducing the kindergarten support was to motivate the parents of highly disadvantaged children to sign up their children to kindergarten at the earliest age possible.

The kindergarten support can be established for the parent of the child, receiving regular child protection allowance, who signed up his or her three- or four-year-old child to kindergarten, who ensures regular kindergarten attendance by the child, and has successfully completed at most the first 8 grades of primary school education by the time his or her child reached the age of 3.

After establishing eligibility for support, the entitled parent receives the support specified by legislation twice a year (every June and December). The support shall be disbursed from the date his or her child was signed up to kindergarten until the end of the child's kindergarten education, in the amount of HUF 20,000 for the first time and HUF 10,000 for every subsequent occasion.

It can be specified in a local government decree that the child may be provided with in-kind benefit instead of cash benefit for the first time.

Amendments

As of 1 September 2015 the regulations concerning kindergarten attendance support, parallel to the introduction of kindergarten attendance from the age of 3, have been repealed from the Child Protection Act. The date of the last disbursement was June 2015. The benefit has been replaced by a new support.

8. Other benefits granted by local governments

The representative body of the local government may supplement the allowances within its competence and establish other monetary benefits regarding the needs of children and young adults in the manner and according to the conditions specified in its decree.

9. Catering services for children

Regulations in force on 1 January 2012

A 100 % (free of charge) or 50 % normative allowance of the institutional fee may be claimed for catering services, for children, provided in nursery schools, kindergartens, primary and secondary schools and in the students' homes connected to it, in dormitories, in external care, as well as in institutes for the education of disabled children and students, in daytime-care institutes for children and in daytime-care institutes for disabled persons under the scope of Szt.

A 100% normative allowance of the institutional fee shall be granted to children who receive regular child protection allowance and are placed in institutions, under the scope of Szt., that provide daytime-care to disabled children attending nursery school, kindergarten, or receiving full-time education in a school for 8 years.

A 50 % normative allowance of the institutional fee shall be granted to children or students who do not belong to the above group yet receive regular child protection allowance and to those children or students who live in a family of three or more children or who suffer from a chronic illness or disability.

A separate amount is provisionally allocated, in the Act on Central Budget, to help municipal governments provide for the summer catering services of children in need. Support from the appropriations may be claimed for by local governments that undertake to provide catering service in the summer for children eligible for regular child protection allowance. Detailed rules on claiming for the support, on its decision-making system, disbursement, usage, accountability and control shall be stipulated in the regulation issued in the reference year by the minister for children and youth protection, based upon the opinion of the minister for public finances and the minister for local governments.

Amendments

The regulation of summer catering services for children in need was modified by Act of 2015 on the Central Budget. The appropriations serve the purpose of helping municipal governments, by means of tendering, with the provision of summer catering services for children in need. Tender applications may be submitted by municipal governments that undertake to provide summer catering services for children receiving regular child protection allowance. Decision about the support shall be made by the minister for children and youth protection. The non-repayable support is granted in the form of prefinancing as a one-off amount. The residual amount from the appropriations may be used as a one-off amount for those municipal governments that have organized the summer catering services for children by relying on their own resources.

From 1 July 2015 on, a 100 % allowance of the institutional fee shall be granted to those children, in foster care, who are attending nursery school, kindergarten or who have a student status and receive full-time school education, and to those young adults who receive after-care and full-time school education. Those children who have been temporarily placed in

institutions and have no student status and those young adults who receive after-care and are involved in non-full-time school education, may not be granted any normative allowance, similarly to previous experience.

As of 1 September 2015, a 100 % allowance of the institutional fee shall be granted to those children who receive nursery school or kindergarten services, if they receive regular child protection allowance, suffer from a chronic illness or disability, or live in a family where children suffering from a chronic illness or disability are raised, or live in a family of three or more children, or live in a family where the per capita income, based on a parental statement, does not exceed 130 % of the lowest compulsory wage, reduced with the income tax, the employee's share of labour market contributions, the health insurance and pension contribution. (The said amount in year 2015 equalled HUF 89,408.)

10. Dental services for patients with a disability, requiring special treatment

For patients who suffer from a disability and need special treatment, the necessary dental interventions require the meeting of special conditions. In most cases, even the simplest treatment may have to be carried out under anaesthesia. Given the fact that this group of patients need special care and circumstances, such treatment may only be carried out in institutions (centres) that have in-patient care facilities, offering an appropriate room for such purposes, together with a well-equipped surgery room. The availability of skilled professionals is indispensable, and it should be ensured that both personal and technical resources are present at the very same time for surgical and traditional dental interventions.

With a view of finding a solution to the problem of dental treatment for disabled persons requiring special care, Government Decree 43/1999 (III. 3.) on the detailed rules of financing healthcare services from the Health Insurance Fund was modified at the end of 2012.

Single-day treatment is available in six centres:

- Semmelweis University of Budapest
- University of Pécs, Clinical Centre
- University of Szeged, Szent-Györgyi Albert Clinical Centre
- University of Debrecen, Centre for Medical and Health Sciences
- Heim Pál Children's Hospital, Budapest
- Bethesda Children's Hospital of the Hungarian Reformed Church, Budapest

2) KEY DATA AND STATISTICS

1. Number of persons receiving cash and in-kind social and child protection allowances, 2012-2015

Name of the allowance	Number of persons receiving the allowance			
	2012	2013	2014	2015
Regular social allowance (<i>health damage and home child care support as of 1 March 2015</i>)	38,031	36,824	37,598	14,018
Employment substitute support	236,609	212,699	160,858	157,423
Old-age allowance	6,081	6,175	6,598	6,784
Home maintenance support (related to normative basis and debt management)	495,508	454,438	412,416	333,149
Support for debt discharging	13,450	10,463	8,924	4,536
Nursing fee (under subjective right)	47,457	48,845	54 674	55,357
Nursing fee on grounds of equity	10,514	9,335	8,298	7,783
Public healthcare	354,046	281,874	289,186	297,103
Eligibility for health care services*	107,117	109,435	106,276	96,325
Funeral allowance (number of cases)	35,082	31,723		
Temporary allowance	341,555	349,497		
Municipal government aid			411,605	37,068
Regular child protection allowance	572,184	547,633	494,311	442,238
Established disadvantaged status	-	28,032	78,744	78,624
Established highly disadvantaged status	-	50,876	143,215	128,764
Supplementary child protection support	1,166	1,133	872	672
Irregular child protection support	139,529	126,663		
Home-start assistance	1,433	1,438	1,287	1,286
Advancing child support	17,444	18,751	17,179	15,352
Kindergarten support	34,773	35,685	33,033	22,815

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

*Source: Reporting of the Hungarian Central Statistical Office

2. Average amount of cash and in-kind social and child protection allowances

2.1. Average monthly amount of allowances provided on a monthly basis

Name of the allowance	Average <u>monthly</u> amount (HUF)			
	2012	2013	2014	2015.*
Regular social allowance	25,305	25,327	25,281	28,517
Old-age allowance	26,679	27,468	26,912	27,362
Nursing fee (under subjective right)	31,176	32,131	35,692	37,459
Nursing fee on grounds of equity	23,200	23,752	24,450	24,198
Public healthcare**	5,461	5,375	5,454	5,560
Supplementary child protection support	6,471	6,498	6,531	6,531
Advancing child support	9,388	9,439	9,071	9,735

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

* Preliminary data

** Average of monthly medicine budget, Source: National Health Insurance Fund (OEP)

2.2. Average annual allowances provided according to annual eligibility

Name of the allowance	Average <u>annual</u> amount of allowances (HUF)			
	2012	2013	2014	2015.*
Home maintenance support (related to normative basis and debt management)	44,801	46,400	47,226	26,164
Support for debt discharging	105,574	107,192	113,386	103,712
Kindergarten support	17,301	16,841	16,833	11,035

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

*Preliminary data

2.3 Amounts of ad hoc allowances

2.3. a) Average amount per occasion

Name of the allowance	Average amount per occasion (HUF)			
	2012	2013	2014	2015.*
Funeral allowance (amount per occasion)	23,329	23,826		
Temporary allowance (amount per occasion)	6,659	7,232		
Irregular child protection support	6,006	5,870		
Municipal government aid			8,018	8,204

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

*Preliminary data

2.3. b) Amount per capita

Name of the allowance	Average annual amount per capita (HUF)			
	2012	2013	2014	2015*
Temporary allowance	11,482	12,261		
Irregular child protection support	9,928	10,404		
Municipal government aid			14,529	9,513
Home-start assistance	1,058,801	840,186	677,665	672,398

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

*Preliminary data

3. Poverty threshold, minimum wage, minimum old-age pension, 2012-2015

		2012	2013	2014	2015
Value of poverty threshold/year²⁹	Single-person household	787,200	772,200	803,748	843,941

²⁹ A threshold value determined at 60% of the equivalent median income.

	Household of two adults and two children	1,653,120	1,621,620	1,687,870	1,772,275
Minimum wage	gross	HUF 93,000/month	HUF 98,000./month	HUF 101,500/month	HUF 105,000 /month
	net (with no children)	HUF 60,915/month	HUF 64,190/month	HUF 66,483/month	HUF 68 775 / month
Minimum old-age pension		HUF 28,500			

4. Normative allowance of catering services for children, use of summer catering services for children in need

		2012	2013	2014	2015
Normative allowance of catering services for children	100%	347,360	342,947	318,693	479,836
	50%	202,006	203,575	208,810	161,877
Summer catering services for children in need		105,270	110,642	119,391	134,326

Source: EMMI Statistical data collection concerning public education and EMMI data concerning claims for summer catering services for children

3) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **ECSR is requesting information about the obligations of those eligible for social allowance, the applicability of any restriction and whether any person failing to meet their cooperation requirements may be deprived of eligibility for social allowance.**

1. Collaborative obligation of persons eligible for employment substitution support

Cooperation with governmental employment bodies

According to Section 35 (2) of the Social Act, any person eligible for employment substitution support shall request his or her registration as job-seeker at a governmental employment body, and shall cooperate with the governmental employment body.

According to Section 36 (2) of the Social Act, eligibility for allowance for persons of active age shall be terminated for persons eligible for employment substitution allowance if

- a) they refuse the job offered through their cooperation with the governmental employment body or illegally terminate their public employment, or their public employment was terminated with immediate effect by the employer;
- b) they have been deleted from the registry of job-seekers, by the governmental employment body, for reasons attributable to them;
- c) they do not apply for registration as job-seeker at the governmental employment body, before the deadline set out in the decision concerning the establishment of allowance for persons of active age;

Obligation for the pursuance of activities for 30 days

According to Section 36 (2)(e) of the Social Act, eligibility for the allowance for persons of active age shall be terminated for persons entitled to receive employment substitution support if, according to the annual review of their eligibility for employment substitution support, for a period of at least 30 days in the year preceding the review during their eligibility period for employment substitution support,

- ea)* they were not involved in public employment,
- eb)* they did not pursue any income-earning activity, including activities through employment created pursuant to the Act on Simplified Employment or in the form of a household job,
- ec)* they did not take part in any labour market programme,
- ed)* they did not take part in the training, in accordance with the Act on Job Assistance and Unemployment Benefits, offered for at least 6 months, and are currently neither involved in such training, or
- ee)* they did not directly get engaged in the joint production of the social association through their membership.

According to Section 36 (2a), for persons who are eligible for the employment substitution support but do not fulfil the obligation pursuant to paragraph (2) point (e) and whose unavailability for employment for at least 30 days in the reviewed period was justified, a new deadline of 60 days shall be set, by the district office, for meeting the requirements.

According to Section 36 (3), the calculation of the period of 30 days defined in paragraph (2) point (e) shall consider the total duration of activities, in accordance with subpoints (eb)–(ee), pursued in the year preceding the date of the review. Should the entitled person still fail to meet the condition pursuant to point (e), the calculation of the 30-day-period shall consider even the period of his or her voluntary activity of public interest pursued at an organisation registered under the Act on Voluntary Activities in the Public Interest.

2. Requirements for persons receiving other social allowances

Persons receiving allowances shall cooperate with the authority during the review of eligibility for the allowance, and they shall report any change in the substantial facts and circumstances affecting the eligibility conditions within the deadline set out in the regulation.

- **ECSR is repeatedly requesting information about the eligibility for other allowance or assistance, of an appropriate value, of persons who are not entitled to receive social allowance (for persons of active age).**

The extraordinary child protection support, as an independent form of benefit, ceased to exist as of 1 January 2014. Between 1 January 2014 and 28 February 2015 municipal government aid, replacing the former temporary allowance, funeral allowance and irregular child protection support, could be provided as a new form of benefit.

The benefit provided by local governments pursuant to the Social Act bear the single name 'settlement aid' as of 1 March 2015. It is at the will of local governments to provide support to situations that they find eligible as per their decrees, through this aid.

On what conditions, for what purposes, and how much support can be provided by this aid is at full discretion of the local government. The local government may make decisions on the intervals and frequency that define the use of the various forms of support.

The Social Act sets out only one single requirement, according to which the representative body shall provide irregular settlement aid to persons who are in an extraordinary situation endangering their subsistence, or who suffer from problems of subsistence temporarily or permanently. Extraordinary situation endangering subsistence and conditions of subsistence problems may be defined by the local government, also holding the right to determine the amount of benefit to be provided in such situations.

The list of benefits to be provided through the settlement aid, in the definition of the Social Act, includes, among others, the following.

Benefit through settlement aid is primarily provided

- a) for the purpose of the bearing of the regular expenses related to housing,
- b) for persons who provide care for a chronically ill relative over the age of 18 years,
- c) for the bearing of medical expenses,
- d) for persons accumulating arrears related to housing expenses.

The creation of the settlement aid enabled settlements to establish an allowance system that better reacts to local needs, since they can determine the types of benefits under their

competence and the criteria system thereof. In this way, they can regulate and adjust other forms of benefits in close consideration of local residents' needs.

Besides the settlement aid, persons who are not eligible for allowance for persons of active age may be granted other allowances based on deprivation (such as public healthcare provision, or the eligibility for health care services).

In addition, apart from social allowances, there are several other social benefits in Hungary that contribute to the ambition that everybody shall have accessibility to the income and assets needed for a living, albeit that this may not be exclusively targeted at those having less favourable income conditions. Besides insurance-based allowances (such as pension, benefits for job-seekers and for persons with reduced capacity to work, family support for insured parents) and social allowances, the Hungarian assistance system also makes sure that universal benefits are available to everyone, irrespective of income status and insurance interval. From among the latter benefits, family support should be highlighted, which is independent from the insurance interval.

- **ECSR is requesting confirmation whether its statement with regard to the amount of employment substitution support, of regular social support for persons living alone and old-age allowance is correct.**
 1. The amount of employment substitution support equals 80% of the minimum amount of the old-age pension in effect at any given time, which is HUF 22,800. This suggests that the ECSR statement is correct.
 2. Regular social allowance was removed from the benefits system as of 1 March 2015. The function of the allowance was taken over by the health care and child home care support. (The details thereof are described in point (1) demonstrating the changes in the benefits system.) The amount of health damage and home child care support payable to any person living alone equals 92% of the minimum amount of the old-age pension, that is HUF 26,220. In this context, the ECSR statement is considered to be incorrect.
 3. The amount of allowance payable to persons who are eligible for old-age allowance, live alone and are under the age of 75, equals HUF 27,075. This means that the ECSR statement is correct.
 4. The amount of allowance payable to persons who are eligible for old-age allowance, live alone and are over the age of 75, equals HUF 37,050. This means that the ECSR statement is incorrect.

- **ECSR has made a statement according to which the allowance granted to persons who have no income and live alone is insufficient.**

Changes introduced in the benefits system in the past few years have been driven by the ambition that all persons available for employment should earn their living through work instead of benefits, since employment is the most important tool for breaking out of poverty.

The government aims to make the opportunity of employment available to everyone. The past few years have seen a rise in the number of those who could gain their income for a living from wages instead of an allowance of HUF 22,800. This may be attributed to the fact that resources for public employment have risen significantly.

In 2016 a person who has no children and is employed 8 hours a day receives a net public employment wage of HUF 52,638. Whereas for persons raising children this amount is further increased with family allowance. In the case of parents raising two or more children the net public employment wage, for a job of 8 hours per day, amounts to HUF 77,968. Public employment does not only enable people to return to the labour market, but through the wages it makes subsistence easier for the group of people affected.

From among the social allowances available to persons who have no income and live alone, public health care is worth highlighting. It is a wage subsidising allowance provided with the aim to reduce the costs related to the preservation and restoration of health conditions. The said allowance is granted by district offices.

Eligibility for public healthcare for the group of people, defined by law, is under subjective right. They are persons with health impairment, receiving regular social allowance; persons who are granted invalidity allowance and whose rating per health condition, as per the complex assessment of the rehabilitation authority, does not exceed the level of 30%; or persons entitled to receive family support at a higher amount etc.

A person is eligible for public health care on a normative basis, if the amount of their monthly regular medical allowance is higher than 10% of the minimum amount of the old-age pension in effect at any given time. Another condition is that the monthly income per capita in the family cannot reach 100% of the minimum amount of the old-age pension.

In-kind benefit, which may be made use of with a public health care card. The amount of the benefit comprises, on the one hand, the individual medicine allowance whose amount depends on the monthly medical needs (HUF 1,000–12,000) and, on the other hand, the ad hoc amount of allowance. The latter is dedicated to provide support in case of chronic illnesses (a single annual amount of HUF 6,000). Besides this, public health care also contributes to the use of therapeutic appliances and medical services, free of charge.

As a result of the actions and measures taken so far, the latest data for 2015 (even with regard to previous years), compiled by the Hungarian Central Statistical Office (hereinafter referred to as KSH) according to a European Union methodology, shows a steady and remarkable improvement in poverty-related data for Hungary. In 2015 28.2% of the total population of Hungary, i.e. 2,738,000 people were exposed to the risks of relative income poverty or social exclusion. This was 3.6 percentage points lower than in 2014, affecting 359,000 people less. The growth in the proportion of people living in income poverty has come to a standstill. The value of 14.9% shown in 2015 is the same as the results two years earlier. In 2015, 19.4% of the population (that is 1,880,000 people) were hit by severe financial deprivation, which showed a decline of 4.6 percentage points as compared to the previous year. In year 2015, 690,000 people (7.1% of the population) were living in households with ultra low work intensity, which was 2.6 percentage points lower than in 2014.

Efforts and work commenced in view of a strengthened system of social allowances will be continued as of 1 January 2017. According to the central budget act of Hungary for 2017, the old-age allowance granted to old-age persons with no livelihood supporting income will increase, on average, by 5% from 1 January 2017. In addition, from 2018 on, the amount of the allowance will be increased in a proportion equivalent to the rise in the amount of the old-age pension in effect at any given time.

As of 1 January 2017, the monthly amount with regard to the nursing fee, at principal sum, shall increase from HUF 29,500 to HUF 31,000. Whereas in the case of the allowance at a higher sum, the monthly amount shall rise from HUF 44,250 to HUF 46,500. The amount of extra nursing fee will increase from HUF 53,100 to HUF 55,800.

The sum with regard to the in-come benefits, provided twice a year through regular child protection support, shall also grow. Instead of the present allowance of HUF 5,800 per occasion, the support to be granted shall amount to HUF 6,000 in normal cases. For disadvantaged or highly disadvantaged children the sum of the support shall be HUF 6,500.

- **ECSR is requesting information about the appeals lodged against decisions concerning social allowances, and its possible judgement by an independent body.**

The establishment of eligibility for allowances granted pursuant to the Social Act fall within the competence of the district office or the representative body of the municipal government.

1. Legal remedy against decisions made by the district office within its competence

An appeal may be lodged against the social administrative decisions made by the district office.

It is the government office in the capital or in the county that shall act, as an authority with competence to decide on an appeal, in administrative matters attributed, at first instance, to the district office, in accordance with the Social Act. [Government Decree 63/2006 (III. 27.) laying down detailed rules on the claiming, establishment and payment of social benefits in cash and in kind, Section 6/A, paragraph (2)]

Pursuant to Act CXL of 2004 on the general rules of administrative proceedings and services (hereinafter referred to as Ket.) the authority making a decision at second instance may approve of, modify or annul the decision.

Subsequent to the exhaustion of the right to appeal, judicial control may be proposed. [Ket, Section 109]

2. Decisions made within the competence of a representative body

In the context of Section 100 (1)(f) of Ket., no appeal may be lodged against a decision made, by the representative body, in a local government-related administrative issue. Judicial control may be proposed against the decision made by the representative body. [Ket., Section 100, paragraph (2)]

Pursuant to Section 41 (4) of Act CLXXXIX of 2011 on local governments in Hungary, the representative body may confer its jurisdiction and competence, with the exception of the ones specified in the Act, to the mayor, the relevant board, the panel of the municipal government responsible for a specified part of the settlement, the notary or to its association.

Decision-making on appeals lodged in connection with local government-related issues falls within the competence of the representative body, if the decision at first instance was not made by the representative body. [Ket., Section 107, paragraph (1)]

Eligibility conditions for allowances provided under the competence of the local government are laid down in the local government decree. Review of legality is exercised over the operation of local governments by the county-based government office. In the framework of this, the said government office is authorised to assess whether the local government regulations comply with the legislative requirements. It is exclusively the lawful nature of the local government decision that may be examined by way of judicial proceedings.

- **ECSR is requesting information about the way it was assessed, in practice, whether a person with the right to free movement and residence has the appropriate resources and does not become a burden to the social benefits system.**

In addition to the conditions outlined above, Section 21 of Government Decree 113/2007 (V. 24.) on the Implementation of Act I of 2007 on the Entry and Stay of Persons with the Right of Free Movement and Residence stipulates the following in Section 21:

“Section 21 (1) Sufficient resources shall mean if the per capita monthly income in the applicant's household reaches at least the prevailing minimum old-age social security pension. A person shall be considered to lack sufficient resources if he or she draws, under Act III of 1993 on Social Administration and Welfare Benefits (hereinafter referred to as Social Act, SSA),

- (a) Section 32/B(1), social welfare for the elderly,*
- (b) under Section 33 benefits provided to persons of active age,*
- (c) under Section 43/B attendance allowance,*

for any period of more than three months.’

(2) If the per capita monthly income in the applicant's household is below the prevailing minimum old-age social security pension, the competent authority shall check the applicant's income and financial position to determine as to whether the applicant has sufficient resources for him/herself and his/her family members not to become a burden on the social assistance system of Hungary during their period of residence.

(3) If the purpose of residence is to pursue studies, the competent authority shall determine the availability of sufficient resources without the examination referred to in Subsection (2), if the applicant provides a statement declaring to have sufficient resources for him/herself and his/her family members not to become a burden on the social assistance system of Hungary during their period of residence.

(4) The examination referred to in Subsection (2) shall cover, in particular, the following criteria:

- (a) number of family members of the household with any income or assets;*
- (b) number of dependant persons living in the household;*
- (c) as to whether the applicant is the owner, beneficial owner or user of the real estate property in which they reside.*

(5) The applicant may verify of having sufficient means of subsistence with his/her financial assets or any regular income he/she receives in the form of

- (a) payments from the social security or social assistance system of any EEA Member State;*
- (b) income from funds or benefit plans financed by payment of membership dues or other regular contributions;*
- (c) income from a deposit account or contract registered in any EEA Member State or any other bank or investment asset, a bank guarantee provided by a credit institution established*

in any EEA Member State or that is guaranteed by a legal person established in any EEA Member State;

(d) income from maintenance or alimony supported by documentary evidence.

(6) The assets referred to in Subsection (5) may not comprise:

(a) Sections of everyday use and household equipment and accessories;

(b) any property serving as the residence of the EEA national and his dependant family members;

(c) the vehicle of handicapped persons; and

(d) any assets which are required for the EEA national's gainful activity.

(7) The amount of monthly income shall be calculated as the monthly average of the sums:

(a) received during the three-month period prior to the registration of residence for regular income;

(b) received during the twelve-month period prior to the registration of residence for non-regular income.

(8) For the purposes of this Decree 'income' shall mean the income and assets defined, respectively, in points (a) and (b) of paragraph (1) of Section 4 of the SAA."

According to Section 19 (2) of the Social Act, should the person with the right to free movement and residence receive old-age allowance for more than 3 months and if their eligibility for allowance for persons of active age persists for more than 3 months, the district office shall notify the competent regional immigration authority thereof, based on the residence of the person with the right to free movement and residence.

- **According to an ECSR statement, children in need do not have access to an appropriate rate of social allowances. In addition, allowances granted to persons who are living alone and have no income, including the elderly, cannot be considered sufficient.**

Changes introduced in the benefits system in the past few years have been driven by the ambition that all persons available for employment should earn their living through work instead of benefits, since employment is the most important tool for breaking out of poverty.

The government aims to make the opportunity of employment available to everyone. The past few years have seen a rise in the number of those who could gain their income for a living from wages instead of an allowance of HUF 22,800. This may be attributed to the fact that resources for public employment have risen significantly.

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Efforts and work commenced in view of a strengthened system of social benefits will be continued as of 1 January 2017. According to the central budget act of Hungary for 2017, the old-age allowance granted to old-age persons with no livelihood supporting income will increase, on average, by 5% from 1 January 2017. In addition, from 2018 on, the amount of the allowance will be increased in a proportion equivalent to the rise in the amount of the old-age pension in effect at any given time.

As of 1 January 2017, the monthly amount with regard to the nursing fee, at principal sum, shall increase from HUF 29,500 to HUF 31,000. Whereas in the case of the allowance at a higher sum, the monthly amount shall rise from HUF 44,250 to HUF 46,500. The amount of extra nursing fee will increase from HUF 53,100 to HUF 55,800.

The sum with regard to the in-come benefits, provided twice a year through regular child protection support, shall also grow. Instead of the present allowance of HUF 5,800 per occasion, the support to be granted shall amount to HUF 6,000 in normal cases. For disadvantaged or highly disadvantaged children the sum of the support shall be HUF 6,500.

[With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:]

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

The prohibition of negative discrimination with regard to the provision of social and child protection allowances (monetary and in-kind) are laid down in the following regulations:

Fundamental Law of Hungary

Article XV

“Everyone shall be equal before the law. Every human being shall have legal capacity.

(2) Hungary shall guarantee the fundamental rights to everyone without discrimination and in

particular without discrimination on grounds of race, colour, sex, disability, language, religion, political or other opinion, national or social origin, property, birth or any other status.

(3) Women and men shall have equal rights.

(4) By means of separate measures, Hungary shall promote the achievement of equality of opportunity and social inclusion.

(5) By means of separate measures, Hungary shall protect families, children, women, the elderly and persons living with disabilities.”

Section 3 (2) of Child Protection Act stipulates that during the protection of children the requirement of equal treatment shall always be observed.

Pursuant to Act CXXV of 2003 on equal treatment and the promotion of equal opportunity (hereinafter Ebktv.) the requirement of equal treatment shall be observed by the Hungarian State, the local and minority governments, the bodies thereof and any organizations exercising authority rights in their establishment of legal relationships, procedures and actions. [Art. 4]

Section 24 of Ebktv. lays down that the requirement of equal treatment shall be enforced in relation to social security, particularly when services

- a) financed through social security schemes, and
- b) providing social, child protection (either monetary or in-kind) or personal care are claimed for and provided.

[With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:]

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

No substantial changes have been made to the social service system during the reporting period. Access to the necessary information and personal assistance to persons in need are both guaranteed. In addition, the provision also contains specifications on the extension of the scope of Directive (EU) 2004/38 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States³⁰. The relevant reference is made in Article 24 of the Directive, concerning equal treatment. According to the above, the personal scope of the Social Act covers all persons having the right to free movement and residence, provided that they exercise their right of residence for more than three months in the territory of Hungary. Besides this, persons in a protected status are also subject to the Social Act.

The Social Act in force on 1 January 2012

“Section 3 (1) The scope of this Act, including the differences in paragraphs (2)-(3), covers those, living in Hungary, who are

a) Hungarian citizens,

b) migrants and settled persons,

c) stateless persons,

d) persons recognised by the Hungarian authorities as refugees.

(2) The scope of the Act, with regard to services defined in Section 7 (1), besides the ones determined in paragraph (1), covers all the nationals of the countries ratifying the European Social Chart, who are legally residing in the territory of Hungary.

(3) The scope of the Act shall cover

a) persons entitled to free movement and residence under the Act on the Entry and Residence of Persons Entitled to Free Movement and Residence (hereinafter referred to as Residence Act), provided that at the time of claiming the service, under the Residence Act, they exercise the right of free movement and residence exceeding three months in the territory of Hungary and they have a registered permanent residence in Hungary under the Act on the Registration of Personal Data and Address of Citizens; and

b) with regard to the old-age allowance as per Section 32/A (1), the Social Act applies to persons defined as beneficiaries pursuant to the European Union regulations on the coordination and implementation of social security schemes, provided that the right of free movement and residence is exercised in the territory of the Republic of Hungary at the time of

³⁰ Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC.

applying for the allowance, and the given person has a registered residence under the Act on the Registration of Personal data and Address of Citizens.”

As of 1 January 2014, Section 3 (1) (d) of the Social Act was extended with the following:
'(d) persons recognised by the Hungarian authorities as refugees or protected persons.'

[With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:]

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

1. Personal scope of the Social Act with regard to monetary and in-kind allowances, 1 January 2012

The Social Act applies to persons living in Hungary who are

- a) Hungarian citizens,
- b) migrants and settled persons,
- c) stateless persons or
- d) persons recognised by the Hungarian authorities as refugees.

With regard to the temporary allowance the scope of the Social Act covers even those citizens of the countries ratifying the European Social Charter, who are legally residing in the territory of the Republic of Hungary.

The Act applies to persons entitled to free movement and residence provided that the right of free movement and residence exceeding three months is exercised in the territory of the Republic of Hungary at the time of applying for benefits, and the given person has a registered residence under the Act on the Registration of Personal Data and Address of Citizens.

With regard to old-age allowance, the Social Act applies to persons defined as beneficiaries pursuant to the European Union regulations on the coordination and implementation of social security schemes, provided that the right of free movement and residence is exercised in the territory of the Republic of Hungary at the time of applying for the allowance, and the given person has a registered residence under the Act on the Registration of Personal data and Address of Citizens.

With regard to old-age allowance, the Social Act applies to third-country nationals holding the permission for highly-qualified employment and residence (EU Blue Card), provided that the given person has a registered residence under the Act on the Registration of Personal data and Address of Citizens. (As of 1 August 2011)

Amendment

With regard to old-age allowance, as of 1 January 2014, the Act applies to third-country nationals who hold a single permit and are legally residing in the territory of Hungary.

With regard to the allowances replacing the temporary support (namely the municipal government aid and the funeral allowance), the scope of the Social Act covers, similar to that

of the temporary support, the citizens of countries ratifying the European Social Charter who are legally residing in the territory of the Republic of Hungary.

2. The personal scope of Child Protection Act (1 January 2012)

The scope of Child Protection Act covers

- a) persons living in the territory of the Republic of Hungary who are Hungarian nationals and – unless otherwise specified by an international agreement – settled persons, migrants, persons with a settled status and children, young adults and their parents recognised by the Hungarian authorities as refugees, protected or stateless persons;
- b) persons entitled to free movement and residence in case the right of free movement and residence exceeding three months is exercised in the territory of the Republic of Hungary at the time of applying for benefits, and the given person has a registered residence under the Act on the Registration of Personal Data and Address of Citizens;
- c) foreign children under 18 applying for asylum, who under law or custom entered the territory of Hungary without being accompanied by an adult responsible to be their guardian, or who were left without such a person after entering the country. They shall fall within the scope of the Act until they are accompanied by an adult responsible to be their guardian, provided that the refugee authority determined that the child is a minor.

With regard to irregular child protection support, Child Protection Act also applies to the children of the nationals of countries ratifying the European Social Charter, who are legally staying in the territory of the Republic of Hungary.

Changes

As of 1 January 2014 the irregular child protection support ceased to exist as an independent form of benefit, and together with the temporary allowance and the funeral allowance it was merged into the form of municipal government aid.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

The medical examination of those applying for refugee status shall be conducted according to Act LXXX on Asylum and Government Decree 301/2007 (XI. 9.) on the implementation of Act LXXX of 2007 on Asylum.

Healthcare for persons requesting recognition shall be provided partly in institutions maintained by the Office of Immigration and Nationality (hereinafter referred to as BÁH). Such institutions include accommodation centres and refugee camps, where primary care by General Practitioners is provided. Public health and epidemic-related duties are not carried out by the civil healthcare authority (ÁNTSZ, Government Office) in such institutions but by the Law-enforcement Service for Pandemic and other Public Health Emergencies, which is in close cooperation with the various bodies responsible for public health. Persons applying for refugee status and staying in private quarters shall be entitled to healthcare provisions from the general practitioner – acting with territorial responsibility to provide medical services – who is competent according to the place of accommodation.

If persons requesting recognition need both primary and secondary care, such services shall not be provided under the healthcare system of the above institution and the police. The applicable procedure is the same, in such cases, as with Hungarian citizens.

Medical screening of requesting recognition shall be conducted, in accordance with Government Decree No. 301/2007 (XI. 9.) on the Implementation of Act LXXX of 2007 on Asylum, on the premises of the regionally competent medical service provider or the accommodation centre. The latter site shall be determined by a decision made by the chief medical officer of the district office (of the region or of the district in the capital city), acting in the public health competences of the government office of the capital city and of the county. Subsequent to the declaration of an emergency situation due to mass immigration, screenings shall be completed in the transit zone on the southern border section, in Rösztke and Tompa. This will be the place for initial medical treatment, the detection of the presence of contagious diseases, the examination of medical complaints and, if necessary, their treatment.

The screenings, in general, cover the diseases listed below.

- tuberculosis (TBC)
- HIV infection
- syphilis
- typhoid and paratyphoid, in the status of being infected by the bacteria
- hepatitis B
- hepatitis C
- leprosy screening with dermatological test
- stoolparasitology test: worm egg protozoon
- scabies pediculosis: in the direction of skin symptoms of another skin diseases.

For diseases whose presence has been detected, the necessary emergency measures are the same as the ones applicable in the case of Hungarian patients.

Healthcare for persons requesting recognition children cover screenings, primary care (paediatrician, dental and nursing services), their immunisation, as well as emergency, inpatient and outpatient care. On top of this, if with respect to the individual circumstances of the persons concerned and according to the medical expert opinion it is necessary, the person requesting recognition is entitled – in addition the services provided for in Section 26 and 27 of the Government Decree – to healthcare services justified by his/her health status, as well as to rehabilitation, psychological and clinical specialist psychological care and psychotherapeutic treatment for free.

The provision of emergency care (against epidemics) is of utmost importance with regard to the healthcare of children requesting recognition in Hungary, especially for those who are residing in Hungary for a longer period of time. Therefore, their immunisation, the detection of potentially contagious diseases and the treatment thereof has been given priority. Vaccination falls within the responsibility of the nursing and paediatrician system, in close cooperation with the public health bodies of the district or region.

Having recognized the special healthcare needs among minors without an accompanying adult, in October 2015 the Government decided to make amendments to several regulations based on the implementation experience gained in healthcare provided to minors without an

accompanying adult. Such amendments have been enforced with a view to more efficient administration concerning minors who have no adults accompanying them and who are getting involved in specialist child protection services. Provisions on special competence-based obligations have made processes rather concentrated. Professional specifications have been made on the capacity of temporary accommodation facilities and of the children's home catering for minors who have no accompanying adult and who are solely not recognized as a refugee. As a result of this amendment, the effective regulation contains provisions even for the compulsory healthcare elements when an emergency due to mass immigration would arise. In this way, it shall also guarantee the enforcement of children's rights with regard to minors who have no adult accompanying them and who have been temporarily placed at institutions. It should be emphasized that, in the context of the effective regulation, those minors who are permanently residing in Hungary without an adult accompanying them and who are provided temporary foster care through accommodation support pursuant to Child Protection Act, and those young adults who receive after-care and international protection under Child Protection Act, shall be granted the very same services as children who receive foster care or young adults who receive after-care under Hungarian citizenship. This, however, shall be implemented by bearing in mind their special care needs.

BÁH shall provide for the accommodation of any asylum-seeking family, arriving in Hungary with children, at the accommodation centres. It should be noted, nevertheless, that minors who arrive in Hungary with their parents, shall not automatically get included in the special care system for child protection. Should the issue of vulnerability arise with the children of foreign families arriving in Hungary and seeking or not seeking asylum or of families finding Hungary as a transit country, the guardianship authority shall take into consideration all the conditions and circumstances of the situation, and shall act by bearing in mind the most important interests of the child. The idea that a family is forced to flee, leaving their home behind, evolves into an emergency situation for the child in any case. Yet, it is not in the interest of the child to be separated from his/her parents and family for this specific reason and to be placed in a child protection institution.

Should any child remain without parental control at the time of arriving in Hungary or after that, he/she shall be placed in a child protection institution in any case, provided that the child does not have a relative or an acquaintance, legally residing in Hungary, who would undertake to take care of him or her.

3) KEY DATA AND STATISTICS

The number of screenings, for public health and epidemics, conducted among those applying for refugee status is shown in the following table and chart for year 2015.

name of disease	number of completed screenings	positive results	
syphilis	1,454	35	2 %
HIV	1,455	11	0.8 %
hepatitis B	1,454	76	5 %
hepatitis C	1,292	18	1 %
tuberculosis	538	0	0 %
typhoid/paratyphoid	657	0	0 %
parasitology	317	3	1 %
leprosy	104	0	0 %

Hungary provides persons requesting recognition with all the necessary justified healthcare services. Coverage thereof is ensured by the Government.

Healthcare provision for persons requesting recognition is financed by BÁH and the National Health Insurance Fund. BÁH has to face the major part of healthcare duties related to immigrants, in this way the costs of screenings ordered by regional chief medical offers as well.

Apart from the above, the National Ambulance Service allocated, in the said period, almost HUF 50 million for extra duties related to the healthcare of immigrants.

ÁNTSZ has incurred a total amount of HUF 2,092,430 extra cost for the healthcare of persons requesting recognition, in connection with the laboratory tests carried out by the National Centre of Epidemiology.

Cost data	BÁH (HUF, in total)	OEP (HUF, in total)
01/2015	7,623,825	3,650,090
02/2015	7,962,313	3,826,874
03/2015	8,353,810	5,544,888
04/2015	11,213,653	3,780,996
05/2015	20,048,540	6,069,682
06/2015	35,947,617	6,604,342
07/2015	10,757,366	5,109,480

	Number of screenings	
	2014	2015 I.
syphilis	1 359	561
HIV	1 368	561
hepatitis B	1 317	558
hepatitis C	902	434
tuberculosis	500	173
typhoid / paratyphoid	794	266
parasitology	170	58
leprosy	284	95

3) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The Commission is requesting information with respect to the social and emergency support available to foreigners illegally residing in Hungary or for those who are currently staying at an accommodation centre or are being kept in custody. The Commission also would like to be informed about the category of persons who are considered to be minors without an adult accompanying them and about that of vulnerable people.**

In the case of minors without an adult accompanying them, full-scope supply to minors, who have no adult accompanying them and who are temporarily placed by the immigration authority and the police, is offered in accordance with Child Protection Act in the Children's Home for Minors Without an Accompanying Guardian operating in the Károlyi István Children's Centre, Fót, which has been extended with temporary capacity. After being registered for foster care, minors who have no adult accompanying them and who are permanently residing in Hungary, shall also be placed here or in a children's home in the capital city. There they shall be provided with the care for a home-like environment, making it possible for these children to stay even after they have reached their maturity, receiving after-care ordered by the guardianship authority upon their request.

It should be highlighted that any minor who arrives in Hungary without an accompanying adult receives the same care as other Hungarian nationals or citizens of other European Union Member States.

For further details about care provided to minors without an accompanying adult refer to the previous pages.

Foreign citizens will receive healthcare services in any case of emergency.

Government Decree No. 301/2007 (XI. 9.) on the Implementation of Act LXXX of 2007 on Asylum provides for the medical care of persons requesting recognition, more precisely about screenings 'appropriate to the epidemic situation'.

Under the Social Act, persons illegally residing in Hungary may not receive monetary and in-kind social benefits, since the Act does not apply to them in terms of such allowances.

- **ECSR is requesting clarification or confirmation whether persons who are legally residing in Hungary and who have a registered residence or have no such residence, are eligible for social and health care in the case of an emergency.**

With regard to the allowances defined in Section 7 (1) of the Social Act, the scope of the Act covers even those citizens of the countries ratifying the European Social Charter, who are legally residing in the territory of the Republic of Hungary.

Social Act, Section 7 (1) Irrespective of its jurisdiction and competence, the municipal government must provide any person in need with municipal aid, food and accommodation, if the lack thereof would threaten the said person's life or physical health.

Thus the municipal government must provide irregular municipal aid, food and accommodation to those citizens of countries ratifying the European Social Charter, who are

legally residing in Hungary, if the lack thereof is threatening those persons' life and physical health who are citizens of the country ratifying the European Social Charter and who are legally residing in the territory of Hungary. Registered residence is not required for the purpose of the provision of such services.

ARTICLE 14 – THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:

(1) to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

1. Basic child welfare services, reporting system

The implemented modifications of Act XXXI of 1997 on the Protection of Children and Guardianship Administration (hereinafter: Child Protection Act) and its implementing regulation aim the more efficient functioning of the warning system and the protection of the institution or person making a report. While performing his/her duties, the children's rights representative may directly be informed of the child's vulnerability so his/her report enables the timely assistance, as well as the prevention and termination of the child's vulnerability. The reformatory may come to possess such information – in particular, when the underaged person is placed together with his/her child or exercises his/her right to maintain contact with his/her family members – that must be announced to the child protection reporting system in the interest of immediate intervention. Since they are members of the children protection reporting system, the obligation to co-operate and the legislation relating to conciliation meetings also apply to the children's rights representative and reformatory, and a failure to make a report gives rise to legal consequences in their cases too.

Section 17 of the Child Protection Act as of 1 January 2012:

“(1) The following shall perform duties related to the child protection system regulated by this Act, within the framework of the principal activity specified by law, in order to facilitate that children be raised in families and to prevent and terminate the vulnerability of the child:

- a) those providing health care, especially the district nurse service, the general practitioner and the family paediatrician;*
- b) the service provider delivering care in the form of personal care, especially the family support service and the family support centre;*
- c) public education institutions, in particular the educational institution, the educational adviser;*
- d) the police;*
- e) the public prosecutor's office;*
- f) the court;*
- g) the service of probation officers;*
- h) organisations performing victim support and the duties of mitigation of damages;*
- i) receiving centres for refugees and temporary accommodation for refugees;*
- j) civic organisations, churches, foundations;*
- k) the labour authority.”*

As from 1 January 2015, points l) and m) shall be added to Sub-section 17 of Section (1):

- l) *the reformatory;*
- m) *the children's rights representative.*

Sub-section (2)–(3) of Section 17 of the Child Protection Act as of 1 January 2012:

“(2) The institutions and persons specified in paragraph (1) shall be obliged to

- a) report to the child welfare service in cases of vulnerability of the child;*
- b) initiate an administrative procedure if the child is abused or seriously neglected, or if there is any other serious threatening reason, or in case of the serious threatening behaviour of the child caused by himself/herself.*

Any citizen or civic organisation representing children's interests may also make such report or initiation.

The persons, service providers, institutions and authorities specified in sub-section (1) and (2) shall be obliged to cooperate with each other and mutually inform each other, in order to facilitate that children be raised in families and to prevent and terminate their vulnerability.”

As from 1 July 2014, Sub-section 2a) shall be added to Section 17:

“(2a) The child welfare service and the guardianship authority manage the data of the institution or person making a report or initiation concerning abuse or neglect of the child in confidence, even in the absence of a request to that effect.”

2. Specialist Child Protection Services

a.) Legal relationship of employment of foster parents

As of 1 January 2014, an uniform legal relationship of employment of foster parents was introduced in the interest of reforming the system of professional child protection services, which was justified by the fact that, out of around 5,500 foster parents, only the approximately 300 professional foster parents had received a remuneration in the same order of magnitude than today under the previous regulation; the so-called “traditional” foster parents constituting the majority had only received a very low foster parent remuneration of HUF 15,000 per month per child cared for, which had not even included insurance eligibility; however, practically almost the same activities were carried out under the two types of legal relationships. Therefore, in addition to the financial and societal recognition of the profession of a foster parent, the introduction of the legal relationship of employment of foster parents had also strengthened the interest enforcement and legal certainty of children, which guarantees the foster parent remuneration as follows:

- basic fee: 30 % of the minimum wage, irrespective of the number of children cared for;
- supplementary fee: 20 % of the minimum wage, per child cared for;
- additional fee: 5 % of the minimum wage, for children cared for with extra or special needs.

In addition to the increased foster parent remuneration, the legal relationship of employment of foster parents guarantees the following:

- the revalorization of foster parent remuneration (on the basis of the principle that it is linked to the minimum wage);
- the claim of family tax and contribution benefits per foster children;
- full eligibility for the provisions of health and pension insurance (sick pay, pension, receipt of pregnancy-confinement benefit, child home care allowance and child care fee for children);
- employment in addition to the legal relationship of employment of foster parents.

The allowances exclusively disbursed for meeting the needs of a child cared for (nursing fee – 120-150 % of the minimum amount of old-age pension; supplies – 25 % of the nursing fee) have not changed but the in-kind benefits, such as the freely available institutional catering and the free textbook provision available for full-time studies, that were introduced as of 1 July 2015 for children cared for and young adults receiving follow-up care have increased the amount of allowances for care.

The extraordinary and special foster parents constitute a priority category among the foster parents. The extraordinary foster parent is qualified to ensure a balanced upbringing for permanently ill and disabled children or children (with extra care needs) under the age of three; the special foster parent is qualified to ensure a balanced upbringing for children (with special care needs) placed by him/her who show severe psychological or severe antisocial syndromes, or use psychoactive substances.

The system of qualifications required for holding a legal relationship of employment of foster parents has also been reformed. It was stipulated that, as of 1 January 2014, the successful completion of the first module closing exam of the foster parent qualification which can be obtained in the 500-600-hour-long course accredited in the National Qualification Registry (hereinafter: OKJ) is required for establishing a legal relationship of employment of foster parents, while the OKJ-accredited foster parent qualification must be obtained within two years from the establishment of a legal relationship of employment of foster parents for the purposes of maintenance.

This regulation has been modified as of 1 July 2015. The foster parent must have a foster parent qualification listed in OKJ to be able to establish a legal relationship of employment, or he/she must successfully pass the final exam of required module “Basic tasks relating to the care for admitted children” of the foster parent qualification listed in OKJ, or he/she must successfully complete the 60-hour foster parent course stipulated in the ministerial decree on the professional and exam requirements related to the training of deputy parents, foster parents and people operating family daytime care services, as well as on the pre-adoption counselling and preparation course. The requirement for maintaining the legal relationship of employment of foster parents is that the foster parent obtains the OKJ-accredited foster parent qualification, or successfully completes the central educational programme (foster parent KOP) stipulated in the ministerial decree on the professional and exam requirements related to the training of deputy parents, foster parents and people operating family daytime care services within two years from the establishment of his/her legal relationship of employment.

b.) Priority of foster parent placement

In order to ensure the priority of foster parent placement, the Child Protection Act provides that a child under the age of twelve entering the system of professional child protection services after 31 December 2013 must be placed at foster parents, unless a child is permanently ill or severely disabled, or siblings cannot be placed together at adoptive parents or institutional placement is required for any other reasons. The foster parent placement of a child under the age of three receiving professional child protection services on 1 January 2014 must be provided for until 31 December 2014; the placement of a child between three and six years of age must be provided for until 31 December 2015, while the foster parent placement of a child between six and twelve years of age must be provided for until 31 December 2016 (while taking into account the above exception rules).

The aim of the provision is to ensure the right to be raised in a family included in the Convention on the Rights of the Child and transposed in the Child Protection Act for children being brought up within the system of professional child protection services, and to regulate this right in a way that makes it more unambiguous and reinforced, and accordingly schedule the placement of children already receiving professional child protection services.

c.) Legal institution of the child protection guardian

The legal institution of the child protection guardian has been introduced in parallel with the introduction of the legal relationship of employment of foster parents as of 1 January 2014. The aim of the legal institution is to make the legal representation of children receiving professional child protection services independent of the place of care and permanent so that the services can be continuously provided in case of a change in the potential place of care or the potential conflict of interest with the place of care for the purposes of protecting the child's rights. Therefore the legal representation is undertaken by a child protection guardian appointed by the guardianship authority and employed as a public servant by the Regional child protection specialist services who is independent both from the foster parents and the special children's home.

However, the modification of Child Protection Act enables the foster parent to undertake certain guardianship duties stipulated in the Child Protection Act on a proposal of the child protection guardian, provided that the foster parents has already been raising the child in his/her own household for at least 2 years, there is no ongoing procedure for terminating the foster care placement of the child, as well as the foster parent assumed these responsibilities and the guardianship authority appointed him/her to do so. (Pursuant to the Child Protection Act, such duties may include the following: obtaining the personal documents of a child, establishing the child's eligibility for public health services, prolonging the child's residence permit, declaration for the medical interventions to be carried out on the child, as well as the child's school enrolment and establishing the child's legal relationship of a student or private student).

It is important to highlight that the appointment of child protection guardian is not terminated due to the parent being appointed for undertaking certain duties; the child remains under child protection guardianship in this case too, and the foster parents and child protection guardian must co-operate with each other.

d.) Care for unaccompanied minors

From 1 May 2011 the system of professional child protection services must provide for the care of unaccompanied (migrant) minors. Two institutions provide for the care of unaccompanied minors: from August 2011 the state-maintained Children's Home for Unaccompanied Minors in the Károlyi István Children's Centre and the subsequently established temporary capacities and, from 2013, the children's home maintained by the Diocese of Szeged-Csanád and operated by the Saint Ágota Child Protection Provider in Hódmezővásárhely.

The regulation related to providing professional child protection services and managing the guardianship issues of unaccompanied minors were modified and supplemented in autumn 2015 as a recognition of the special care needs and specific situation of unaccompanied

minors. Therefore Government Decree No. 284/2015 (IX. 29.) on the modification of certain government decrees on child protection in the interest of solving the care for unaccompanied minors paved the way for establishing temporary admission capacities for the placement of unaccompanied minors. The definition of temporary admission capacity: a capacity registered pertinent to the children's home but outside of the building of the children's home exclusively providing care for unaccompanied minors who are not recognised as refugees, beneficiaries of subsidiary protection and beneficiaries of temporary protection. Temporary admission capacity may be provided for an unaccompanied minor on a provisional basis in case the admission of an unaccompanied minor in the building of the children's home exclusively providing care for unaccompanied minors not recognised as refugees cannot be granted due to lack of capacity. The temporary admission capacity is a solution for unaccompanied minors coming to Hungary in large numbers for a short period of time, which also takes into account the professional and economic aspects.

Through the amendment to Decree of the Minister of Welfare No. 15/1998 (IV. 30.) on the professional tasks and operating conditions of child welfare and child protection institutions and their staff providing personal care the content, personal and material conditions of universal care provided by the temporary admission capacity and children's home providing care for unaccompanied minors not recognised as refugees were regulated, taking into account the differences in the task provision caused by cultural and religious distinctions and – as experience has shown – shorter residence times.

3. Supported housing

The supported housing as a social services was introduced by the amendment of Act III of 1993 on Social Administration and Social Services (hereinafter: Social Act) which came into effect on 1 January 2013. The introduction of supported housing aimed at providing care for people with disabilities, psychiatric diseases or addictions by supporting and establishing their independent living. At the time of the entry into force of the Social Act, the care for adult people with disabilities was primarily based on large institutions in the area of providing residential social institutional care for people with disabilities. The demand for care based on small-group and individual needs has increased in the last 15 years, and this type of care has also been introduced in Hungary from the mid-1990s. By ratifying the United Nations Convention on the Rights of Persons with Disabilities and the related Optional Protocol Hungary has permanently committed itself to organising community-based and home care services. The Government adopted Government Resolution No. 1257/2011 (VII. 21.) on the Strategy of the replacement of the large social institutions providing nursing and caring for persons with disabilities with community-based settings and Government Duties in respect of its implementation in July 2011. For the purposes of implementing the strategy the Government has stipulated as a task that the professional content, personal and material conditions of supported housing must be elaborated until 30 June 2012. The Act contains the basic provisions of supported housing, the detailed rules of which will be regulated in an implementing regulation. This type of service creates appropriate conditions for people with disabilities, psychiatric diseases and addictions so as they can establish a more open, more natural, more homely lifestyle for themselves which enables a more personal treatment and greater autonomy. The supported housing provides housing and other social services to beneficiaries according to their age, health status and self-care ability by taking into account the individual decision, needs, skills and abilities of beneficiaries to the greatest possible extent. The introduction of supported housing enables the beneficiary to live under similar

living environment and living conditions as the local population and to participate in the life of the local society.

The most important novelty of the reform is that housing and daytime activities (e.g. education, care, freetime activities, social relationships) are separated thus ensuring a personalised and needs-based care form. The complex service provided until now by residential institutions is divided to housing services and services supporting independent living (such as development, attendance and care, assistance to the participation in social life).

Placement in supported housing may be provided for a definite or indefinite period, depending on the results of the complex survey of the needs of the beneficiary. Supported housing may be provided in two forms: in a flat or house designed for a maximum of 12 people or in a complex of flats or buildings designed to accommodate up to 50 persons.

The services supporting independent living are provided on the basis of the complex survey of the needs of the beneficiary.

Section 75 of the Social Act as of 31 December 2015:

“75 (1) The supported housing is an allowance provided to people with disabilities, psychiatric diseases or addictions in accordance with the age, health status and self-care ability, in order to maintain or support the independent living of the person receiving the support:

- a) housing service,*
- b) to support and maintain independent living, case management by applying techniques falling within the scope of mental health or social work and other supporting techniques,*
- c) support ensuring the monitoring of the living conditions of the beneficiary,*
- d) based on the complex assessment of the beneficiary's needs, if necessary:*
 - da) meals,*
 - db) attendance and care,*
 - dc) development,*
 - dd) services facilitating participation in social life.*

(2) The housing service may be provided

- a) in an apartment or house designed for a maximum of six people, or*
- b) in an apartment or house designed for a maximum of seven-twelve people, or*
- c) in a complex of apartments or buildings designed to accommodate up to fifty persons*

(3) The maintainer may provide the services falling under point d) of Sub-section (1) through the following:

- a) by means of an agreement concluded with the service provider or institution providing the social services,*
- b) jointly with the other maintainer providing other supported housing, based on an agreement on joint operation (network),*
- c) by means of an agreement concluded with another organisation registered in the register of service providers or holding an operating licence in this area of activity,*
- d) in accordance with the rules for providing institutional services by a non-institutional organisation*

(4) Furthermore, the rules on residential institutions shall be applied to supported housing, taking into account that

- a) *the allowance may be provided for a definite or indefinite period, depending on the results of the complex survey of the needs of the beneficiary,*
 - b) *Section 99 and Section 99/A shall not be applied.*
- (5) *Supported housing may be provided following the complex survey of the needs, on the basis of the result thereof.”*

4. Specialised services

Pursuant to Act CLIV of 2011 on the Consolidation of County Local Governments and on the Take-over of County Local Government Institutions and Certain Healthcare Institutions of the Municipal Government of Budapest, the social and child protection institutions under county municipal maintenance moved under state maintenance as of 1 January 2012. This process was continued by Act CXCII of 2012 on the Taking Over of Certain Specialised Social and Child Protection Service Providers and Amendment of Certain Laws, under which the organisation of care services providing temporary and permanent accommodation to persons with disabilities, psychiatric diseases and addictions, as well as the maintenance of institutions have become a state responsibility as of 1 January 2013; thus, the system of social services aimed at the above target groups have become more predictable and reliable. Based on Government Decree No. 316/2012 (XI. 13.) the state maintenance responsibilities and methodological support duties of the transferred institutions are carried out by the Directorate-General for Social Affairs and Child Protection (hereinafter: SZGYF) as of 1 January 2013.

The relevant provisions of Act CLIV of 2011 as of 1 January 2012:

“2. (1) the assets and rights representing assets of county municipalities, the institutions maintained by county municipalities, the assets and rights representing assets thereof, as well as the healthcare institutions maintained by the Municipal Government of Budapest, the assets and rights representing assets thereof, the county municipalities and the current accounts, deposits and securities of their maintained institutions (hereinafter referred to as “assets”) according to the inventory list, as well as the companies with or without legal personality in the ownership of county municipalities (to the extent of the ownership of the county government) will come under state ownership on 1 January 2012; the rights and obligations of establishment and maintenance relating to the asset and institutions and the right of establishment relating to foundations and public foundations established by county municipalities will be transferred to the bodies stipulated in this Act with the power of law. The budgetary institutions will be transferred to the state together with their arrears to suppliers, including the case under Sub-section (3). The succession shall be transferred by the courts and commercial courts immediately and in any event not later than 8 days from the submission of the relevant request. These provisions shall be without prejudice to the right of ownership of assets managed by county municipalities for the purposes of fulfilling the tasks taken over by county municipalities but owned by municipal governments. The asset management succession within the asset management contract is governed by the rules stipulated in Section 3.”

The relevant provisions of Act CXCII of 2012 as of 1 January 2013:

“1. For the purposes of this Act,

1. “transferred task” shall mean, prior to 1 January 2013, the specialised social care and professional child protection service provided by the organisation and maintenance of the following institutions listed by the municipal governments and their associations (hereinafter jointly referred to as “municipal government”) in Annex 1:

- a) *home of people with disabilities, psychiatric diseases or addictions,*

- b) *rehabilitation institute of people with disabilities, psychiatric diseases or addictions,*
- c) *residential home of people with disabilities, psychiatric diseases or addictions,*
- d) *care home of people with disabilities, temporary home of people with psychiatric diseases and addictions,*
- e) *institution providing professional child protection service, including the multi-purpose child protection institution*

- 2. *transferred assets shall mean all the movable and immovable properties of the municipal government that are used for the purpose of performing the transferred task and are required for the performance of the task and are expressly related to the transferred tasks and transferred institutions, including the share of ownership of municipalities in companies, as well as all movable and immovable properties, rights representing assets and shares of ownership in companies of transferred institutions functioning as budgetary institutions;*
- 3. *tasks transferred from an integrated institution shall mean the specialised social care and professional child protection service provided by the municipal government before 1 January 2013, and provided by the state – by means of an agreement or supply contract concluded with the municipal government for the purposes of operating the integrated institution – as of 1 January 2013;*
- 4. *integrated institution shall mean an institution listed in Annex 3;*
- 5. *integrated institutional asset: all movable and immovable assets, rights representing assets, share of ownerships in companies of the municipal government and the integrated institution functioning as a budgetary institution that are used for the purpose of performing the task transferred from the integrated institution and are required for the performance of the task and are expressly related to the transferred tasks and transferred institutions.”*

Government Decree No. 316/2012 (XI. 13.) on the Directorate-General for Social Affairs and Child Protection as of 31 December 2015:

“2. Tasks and competences of the Directorate-General

4. Section (1) The Government designates the Directorate-General to perform the tasks

- a) *related to the social and child protection institutions transferred on the basis of Act CLIV of 2011 on the Consolidation of County Local Governments and on the Take-over of County Local Government Institutions and Certain Healthcare Institutions of the Municipal Government of Budapest, as well as to the foundations, public foundations and companies performing social and child protection activities, pursuant to Sub-section (1) of Section 9,*
- b) *that are pursuant to Sub-section (3) of Section 2, Sub-section (1) of Section 9 and Sub-section (2) of Section 9/A of*

Act CXCVII of 2012 on the Taking Over of Certain Specialised Social and Child Protection Service Providers and Amendment of Certain Laws [institutions pursuant to points a) and b) are hereinafter jointly referred to as “transferred institutions”].

(2) The maintainer duties pursuant to Act III of 1993 on Social Administration and Social Services (hereinafter referred to as “Social Act”) and Act XXXI of 1997 on the Protection of Children and Guardianship Administration (hereinafter referred to as “Child Protection Act”) are performed by the following institutions:

- a) *the central body of the Directorate-General in the case of institutions under Annex 1,*
- b) *the field office – with the exception of the central body of the Directorate-General and the tasks performed by the Director-General – in the case of transferred institutions.*

(3) The central body shall exercise the following maintaining competences related to the maintained institutions:

- a) *submitting for ministerial decision the documents referred to in Sub-sections (3)-(4) of Section 91 of the Social Act, as well as Sub-section (2) of Section 122 of the Child Protection Act,*
 - b) *uniformly determining and publishing on its website the information referred to in points b)-f) of Sub-section (2) of Section 92 with regard to the maintained social institutions,*
 - c) *making a proposal concerning the annual budget of maintained budgetary institutions, determining the detailed rules of their management,*
 - d) *arranging for the termination of infringement in the cases referred to in Section 90/A, Sub-section (3) of Section 92/B and Section 92/L of the Social Act, as well as Sections 100/A-100/B of the Child Protection Act, following a proposal from the field office,*
 - e) *performing the maintainer duties referred to in Sections 122/A-122/C of the Social Act, following a proposal from the field offices.*
- (4) The field office shall*
- a) *perform that maintainer duties stipulated in points b)-h) of Sub-section (1) of Section 92/B of the Social Act and points c)-l) of Sub-section (1) of Section 104 of the Child Protection Act,*
 - b) *determine the institutional usage fee,*
 - c) *act on the cases relating to operational licensing,*
 - d) *submit –together with its proposal – the documents referred to in point c) of Sub-section (3) to the Director-General and make a proposal concerning Sections 122/A-122/C of the Social Act,*
 - e) *organise, manage and control the financial conditions required for the implementation of the professional tasks of the maintained institutions,*
 - f) *collect and control the compulsory, regular and ad hoc data reporting concerning the management of the maintained institutions and, if needed, cumulatively forward the data to the central body of the Directorate-General and the ministry lead by the Minister.*
- (5) The consent of the Director-General is required for determining the amount of the institutional usage fee in the course of performing the tasks of the field office.*
- Section 4/A. Home assistance within the reporting system is ensured by the Directorate-General pursuant to Sub-section (2) of Section 91 of the Social Act.”*

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

- 1. Sector-neutral, uniform principles and methodology for the detection and correction of child abuse [Ministry of Human Capacities (hereinafter referred to as “EMMI”) and Department of Methodology, SZGYF; 2014]**
- 2. Further development of sector-neutral, uniform principles and methodology for the detection and correction of child abuse [Social Renewal Operational Programme (hereinafter referred to as “SROP”) -5.4.1-12 Modernisation of social services – Flagship Project; 2014.]**

The flagship project prepared the sector-neutral methodological regulator at the request of the sectoral management bodies, with the participation of and based on the consensus of the various professions engaged in the functioning of the reporting system, which was based on the risk assessment/risk analysis criteria set, criteria line, and collected principles recognised

in the document and elaborated by the Ministry of Human Capacities and SZGYF for the purposes of carrying out the activities for detecting and correcting child abuse.

3. Activities that will be planned within the National Crime Prevention Strategy

In order to improve the efficiency of the reporting system, the functioning of the reporting system belonging to the child welfare services has been examined with the participation of the professionals of the National Office for Rehabilitation and Social Affairs (hereinafter referred to as "NORSA") through the child welfare services and by interviewing the members of the reporting system in the framework of a questionnaire-based survey aimed at a targeted review.

Two planned reviews by region at the designated district family and child welfare centres and the municipal family and child welfare services to be designated in the future

- survey of 60 settlements providing child and family welfare services
- survey of 50 family and child welfare centres

Carrying out an interview with 40 additional members of the reporting system (district nurse, general practitioner, family paediatrician, public education institution, police, the public prosecutor's office, the court, the service of probation officers, the children's rights representative, etc.).

4. Deinstitutionalisation – SIOP-3.4.1.A-11/1 Replacement of residential institutions "A" Social institutions component

The Government adopted Government Resolution No. 1257/2011 (VII. 21.) on the Strategy of substituting social institutional capacities offering care and nursing to disabled persons and the tasks of the Government related to the implementation thereof in July 2011. There is HUF 7 bn available within the "Substitution of residential institutions – social institutions component" of the Social Infrastructure Operational Programme (hereinafter referred to as "SIOP") for the implementation of a 30-year strategy. The tender aimed at substituting the capacities at residential social institutions with more than 50 capacities offering care and nursing to persons with disabilities, psychiatric diseases and addictions around principles defined by the strategy.

Four applications were received in phase I, and two applications were received in phase II of the tender. All applications had been accepted for a total grant amount of HUF 5.8 bn, out of which 660 capacities were substituted.

5. Deinstitutionalisation – SIOP-3.4.1.B-11/1 Replacement of residential institutions "B" Child protection institutions component

HUF 3bn was available under the tender. 15 applications had been submitted to the call for proposals, out of which 11 projects won in the amount of HUF 2,698,071,101. Out of this amount 8 tenders were awarded a total amount of HUF 2,210,355,056 in professional child protection services, 3 tenders were awarded a total amount of HUF 487,716,045 in basic child welfare services: two temporary homes for children and a temporary home for families).

6. SIOP 3.4.2-11/1 – Modernisation of residential institutions maintained by the municipal governments, state, churches or non-profit entities

The tender named “SIOP 3.4.2-11/1 – Modernisation of residential institutions maintained by the municipal governments, state, churches or non-profit entities” supported the modernisation of the social and child protection institutional system, the improvement of the service users' living conditions and the provision of professional care conditions. There are two ways for modernisation under the tender on the one hand, the building of the institution, the living rooms and community spaces within the institution may be renovated. On the other hand, the space suitable for living may be extended by mitigating the congestion that may exist in the institution. In addition to the modernisation of residential institutions as a main activity, the tender also aims to extend the scope of the institutional services available to the general population and with regard to the functioning basic services. The developments have indirectly contributed to the improvement of social activity and living conditions of the vulnerable, disadvantaged social groups with special needs belonging to the target group of the relevant institutions.

More than 300 applications had been submitted for the available funding of HUF 7.1 bn, out of which 9 tenders were awarded HUF 803,980,942 in professional child protection services.

7. SIOP 3.5.1. – Establishment of innovative, integrated regional services

In order to promote social inclusion, it is required to develop and improve, as well as establish the infrastructural conditions of the services improving social integration and facilitating the access to various public services in settlements and regions with multiple disadvantages. The social activity of beneficiaries can be enhanced by the means of these services. The aim of the infrastructural developments is that the centres provide services that are of higher quality than in the present, and adapt to the local needs in a more flexible and long-term sustainable way.

In addition to other subsidies aimed at economic or human resources development, there is also a need for a well-functioning coordinated network of public services, which provides an appropriate level of services in order to increase the chances of the general population. The service centre was established through intersectoral integration in order to strengthen the “one stop shop” concept and professional innovation.

8. SROP 5.3.1 C – First step – programmes designed to empower people with low employment prospects and to help them lead independent lifestyles”

The aim was to improve the independent lifestyles, employability and social integration of persons with low employment prospects and employment limitations by means of social services and social work and by making available and understandable the information, services and subsidies, by strengthening the key competences needed for an independent lifestyle and employment, as well as in co-operation with the employment organisations and other areas of expertise. The total amount of funding to be awarded was at least HUF 20 million, but maximum HUF 80 million.

9. SROP 5.3.3. programme for the social inclusion of people living in the street

The aim of the programme was to decrease the number of people living in the street and to promote the social integration of the people living in the street or public spaces through employment and housing benefits and social work supporting the maintenance thereof. The source of the entire programme was HUF 2.75bn, and was announced on several occasions.

A total number of 9 call for proposals have been published between 2009 and 2013 in the framework of the programme. With the exception of the last year, there were two call for proposals: one for the competitiveness region of Central Hungary and one for the other six regions falling under the convergence category. The call for proposal was only announced in the convergence regions last year. A total number of 52 projects were realised in the framework of the tender; the successful applicants used a total funding amount of HUF 3.1bn. The 52 projects were implemented in 27 settlements; outside the capital (with 10 projects), 16 towns with county status and 10 smaller settlements participated in the programme. According to the project indicators, 1,828 persons were finally involved.

The successful implementation of the SROP-5.3.3. programmes were supported by a separate flagship project (SROP-5.3.2), through the methodological establishment of achieving employment on the labour market and independent living (in a flat outside of the system of accommodation for homeless people), implemented in a consortium of the Hajléktalanokért Közalapítvány (Public Foundation for the Homeless Persons), the Southern Great Plain region of the Hungarian Charity Service of the Order of Malta and the SAVARIA REHAB-TEAM Non-profit Ltd in Szombathely, i.e. in the co-operation of partners from Budapest, Eastern Hungary and Western Hungary. The project financed from Hungarian and EU funding (HUF 105.0 million) was prolonged until the end of October 2015 (with an additional funding of HUF 40.0 million) so it could accompany the ongoing SROP-5.3.3 programmes.

10. SROP 5.4.1 – Modernisation of social services, strengthening of the central strategic planning capacities, defining the background of social policy decisions

Such professional and methodological developments were undertaken under this programme that enable the more professional, predictable and efficient functioning of the social and child protection care system, and give adequate support to those working in the field.

The professional documents elaborated within the framework of the project are novel and innovative, their contents are transparent and built on each other and, due to standardisation, they create the cornerstones for a common social reflection within the system. Collectively they may be the milestones for the modernisation process so they may promote the forward-looking development process ensuring further lasting results. The total budget of the project amounted to HUF 1.6241 bn.

11. SROP 5.4.2 – Central social information developments

The project engaged in the modernisation of the functioning of the social sector, the transparent operation, control and planning of sectoral services, and the development of central electronic services required for decision support, as well as the further development, extension and new developments of the already used services. The funding amounted to HUF 2.08 bn.

12. SROP 5.4.4 – Development of social training programmes, and training, further training and skills development of professionals, as well as the strengthening of local development capacities

The overall objective of the tender is to develop the social, child welfare and child protection competences, skills and knowledge of the professionals, as well as to harmonise the needs of the professional support services and practical work. The aim of the training development was to ensure the professionals, volunteers and layman supporters to the needs of the modernising service system.

13. SROP 5.4.9 – Model test programmes for the functional interconnection of basic services

The development of a new complex provision and co-ordination system of (social and child welfare) basic services for municipal governments, as well as the increased efficiency of services. The financial envelope of the programme was HUF 3.008bn. De facto 40 tenders started, with a total funding of HUF 1.327 bn.

14. Back from the street programme

Funded from domestic sources, the programme is designed to implement application programmes designed to prevent and cease crisis situations threatening life and reduce the number of homeless people living in the street. Through programmes using innovative and customized solutions, which are adjusted to the local conditions, the forced living on the streets of individuals, couples, groups or families in or threatened by a crisis situation can be ceased and their housing problems can be solved on the long term. From the source of over HUF 200 million provided between 2008 and 2013, 302 persons received assistance to date to surrender their living on the street, of whom 90 % were able to stop living on public grounds and change their housing conditions on the long term. Through this funding another 100 people were supported.

15. New motor vehicles for street social services

In order to support the effective performance and operation of street services, EMMI provided HUF 30 million in 2012 and another HUF 40 million in 2013 for the purchase of new motor vehicles. The vehicles were purchased by the Hajléktalanokért Közalapítvány (Public Foundation for the Homeless Persons) in the framework of a public procurement procedure, and a total of 21 vehicles were purchased. To acquire the right to operate the motor vehicles, the Hajléktalanokért Közalapítvány announced an open tender, approved by the competent ministry, to the organisations engaged in social work and providing care for the homeless.

16. Village caregiving and farm caregiving services

The institutional normative support after the services has been changed as of 2014: one service gets an annual support of HUF 2.5 million compared to the former amount of HUF 1,996,500 per service, which is a 25% increase. The work of the village and farm caregivers is supported by the associations they have established with a view to providing professional support and interest representation, to which the state has provided additional support by invitation to tender since 2012.

3) KEY DATA AND STATISTICS

1. Qualifications with regard to all social services, by employee in professional field – 2015.³¹

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Children's centres	Total number of persons employed in professional jobs	4,968	4,885	2,207	2,678	20	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Networks of foster parents	Total number of persons employed in professional jobs	5,996	5,996	833	1,703	3,460	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Regional specialist child protection services	Total number of persons employed in professional jobs	967	967	895	70	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Temporary Family Homes	Total number of persons employed in professional jobs	740.0	722.0	374.0	329.0	19.0	27.2	68.0	67.0	51.0	15.0	1.0	767.2
Family assistance	Total number of persons employed in professional jobs	2,293.0	2,219.0	1,988.0	224.0	7.0	112.8	255.0	231.0	202.0	28.0	1.0	2,405.8

³¹ Source: KSH Central Statistical Office

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Other (services that cannot be classified in the above categories)	Total number of persons employed in professional jobs	967.0	957.0	920.0	37.0		0.5	1.0	1.0	1.0			967.5
Catering in soup kitchens	Total number of persons employed in professional jobs	75.0	74.0	18.0	46.0	10.0	7.2	21.0	21.0	11.0	8.0	2.0	82.2
Catering in social kitchen or other eatery	Total number of persons employed in professional jobs	1,364.0	1,256.0	171.0	828.0	257.0	215.3	466.0	376.0	25.0	235.0	116.0	1,579.3
Village caregiving service	Total number of persons employed in professional jobs	921.0	889.0	7.0	490.0	392.0	2.7	4.0	3.0	0.0	2.0	1.0	923.7
nursing and caring residential home of persons with disabilities	Total number of persons employed in professional jobs	411.0	400.0	109.0	272.0	19.0	15.6	31.0	30.0	17.0	11.0	2.0	426.6
Care home of persons with disabilities	Total number of persons employed in professional jobs	97.0	97.0	27.0	63.0	7.0	16.2	28.0	14.0	10.0	3.0	1.0	113.2

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Home of persons with disabilities	Total number of persons employed in professional jobs	5,582.0	5,426.0	1,542.0	3,245.0	639.0	75.2	144.0	133.0	73.0	55.0	5.0	5,657.2
Rehabilitation institution of persons with disabilities	Total number of persons employed in professional jobs	314.0	310.0	153.0	141.0	16.0	3.5	6.0	6.0	4.0	2.0		317.5
Rehabilitation residential home of persons with disabilities	Total number of persons employed in professional jobs	62.0	62.0	26.0	32.0	4.0	6.0	11.0	10.0	5.0	5.0		68.0
Child welfare centre	Total number of persons employed in professional jobs	941.0	931.0	844.0	85.0	2.0	23.0	163.0	48.0	47.0	1.0		964.0
Child Welfare Service	Total number of persons employed in professional jobs	1,699.0	1,673.0	1,582.0	89.0	2.0	116.0	265.0	244.0	222.0	22.0		1,815.0
Temporary accommodation for homeless people	Total number of persons employed in professional jobs	645.0	631.0	437.0	180.0	14.0	35.2	64.0	56.0	31.0	21.0	4.0	680.2

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Night shelter for homeless people	Total number of persons employed in professional jobs	418.0	402.0	251.0	144.0	7.0	27.9	52.0	47.0	30.0	17.0		445.9
Periodic temporary accommodation for homeless people	Total number of persons employed in professional jobs	6.0	5.0	4.0	1.0								6.0
Periodic night shelter for homeless people	Total number of persons employed in professional jobs	108.0	102.0	48.0	49.0	5.0	6.5	11.0	11.0	6.0	4.0	1.0	114.5
Home for homeless people	Total number of persons employed in professional jobs	89.0	88.0	23.0	64.0	1.0	2.9	7.0	4.0	3.0		1.0	91.9
Rehabilitation institution for homeless people	Total number of persons employed in professional jobs	43.0	40.0	29.0	11.0		2.0	4.0	4.0	3.0	1.0		45.0
Home assistance	Total number of persons employed in professional jobs	12,737.0	11,920.0	657.0	9,179.0	2,084.0	662.1	1,131.0	895.0	31.0	586.0	278.0	13,399.1

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Care home of old-age persons (e.g. seniors' club providing accommodation)	Total number of persons employed in professional jobs	944.0	912.0	193.0	586.0	133.0	41.1	85.0	79.0	40.0	29.0	10.0	985.1
Old-age home	Total number of persons employed in professional jobs	15,105.0	14,696.0	3,169.0	9,472.0	2,055.0	411.9	883.0	838.0	422.0	326.0	90.0	15,516.9
Home assistance within the reporting system	Total number of persons employed in professional jobs	418.0	410.0	60.0	298.0	52.0	83.2	165.0	161.0	9.0	139.0	13.0	501.2
Community care for people with psychiatric diseases	Total number of persons employed in professional jobs	199.0	193.0	121.0	68.0	4.0	34.2	80.0	80.0	51.0	28.0	1.0	233.2
Community care for people with addictions	Total number of persons employed in professional jobs	183.0	182.0	110.0	70.0	2.0	30.5	69.0	64.0	53.0	10.0	1.0	213.5
Daytime care for people with disabilities	Total number of persons employed in professional jobs	1,261.0	1,222.0	466.0	684.0	72.0	100.2	176.0	143.0	58.0	68.0	17.0	1,361.2

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Daytime care for homeless people	Total number of persons employed in professional jobs	360.0	355.0	209.0	135.0	11.0	18.5	38.0	36.0	21.0	14.0	1.0	378.5
Daytime care for old-age persons	Total number of persons employed in professional jobs	2,494.0	2,430.0	866.0	1,399.0	165.0	108.9	195.0	171.0	64.0	87.0	20.0	2,602.9
Daytime care for people with psychiatric diseases	Total number of persons employed in professional jobs	215.0	214.0	127.0	79.0	8.0	23.9	49.0	47.0	29.0	12.0	6.0	238.9
Daytime care people with addictions	Total number of persons employed in professional jobs	212.0	202.0	135.0	58.0	9.0	14.5	26.0	23.0	16.0	4.0	3.0	226.5
Temporary home of people with psychiatric diseases	Total number of persons employed in professional jobs	30.0	30.0	4.0	25.0	1.0	0.5	1.0	1.0		1.0		30.5
Home for people with psychiatric diseases	Total number of persons employed in professional jobs	2,328.0	2,283.0	568.0	1,400.0	315.0	17.1	33.0	30.0	19.0	11.0		2,345.1

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Rehabilitation institution of people with psychiatric diseases	Total number of persons employed in professional jobs	17.0	17.0	8.0	8.0	1.0	0.8	1.0	1.0		1.0		17.8
Rehabilitation residential home of people with psychiatric diseases	Total number of persons employed in professional jobs	15.0	15.0	8.0	6.0	1.0	2.0	4.0	4.0	4.0			17.0
Low-threshold care for people with addictions	Total number of persons employed in professional jobs	126.0	125.0	82.0	43.0		37.5	80.0	75.0	60.0	15.0		163.5
Temporary home of people with addictions	Total number of persons employed in professional jobs	32.0	29.0	14.0	15.0		2.8	6.0	5.0	4.0	1.0		34.8
Home for people with addictions	Total number of persons employed in professional jobs	379.0	371.0	87.0	238.0	46.0	1.5	3.0	3.0	2.0	1.0		380.5
Rehabilitation institution for people with addictions	Total number of persons employed in professional jobs	158.0	158.0	79.0	71.0	8.0	15.3	37.0	34.0	23.0	11.0		173.3

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Rehabilitation residential home for people with addictions	Total number of persons employed in professional jobs	7.0	7.0	4.0	3.0		1.8	4.0	4.0	4.0			8.8
Support service	Total number of persons employed in professional jobs	992.0	979.0	302.0	572.0	105.0	54.8	95.0	82.0	18.0	52.0	12.0	1,046.8
Supported housing for people with disabilities	Total number of persons employed in professional jobs	65.0	65.0	19.0	46.0		2.0	5.0	3.0	2.0	1.0		67.0
Supported housing for people with psychiatric diseases	Total number of persons employed in professional jobs	16.0	16.0	5.0	11.0		5.8	9.0	8.0	2.0	6.0		21.8
Supported housing for people with addictions	Total number of persons employed in professional jobs	20.0	19.0	9.0	9.0	1.0	1.0	2.0	1.0		1.0		21.0
Farm caregiving service	Total number of persons employed in professional jobs	459.0	437.0	10.0	261.0	166.0	2.4	4.0	4.0		2.0	2.0	461.4

TYPE OF CARE	Name of professional job	Number of occupied full-time jobs	Total number of full-time persons with a professional qualification required for the job	Number of full-time persons with a higher education professional qualification required for the job	Number of full-time persons with a secondary education professional qualification required for the job	Number of full-time persons with a primary education professional qualification required for the job	Number of occupied part-time jobs	Total number of part-time persons	Total number of part-time persons with a professional qualification required for the job	Number of part-time persons with a higher education professional qualification required for the job	Number of part-time persons with a secondary education professional qualification required for the job	Number of part-time persons with a primary education professional qualification required for the job	Total number of occupied jobs
Street social worker	Total number of persons employed in professional jobs	171.0	170.0	117.0	53.0		10.5	21.0	21.0	13.0	8.0		181.5

2. Number of services

Number of services and change from the previous year

year	number of service providers	of change from the previous year
2012	14,668	100
2013	14,473	98.7
2014	14,509	100.2
2015	14,638	100.9

Source: NORSA

3. The annual number and distribution of services by service form

Distribution of services by service form

Service form	2012	2012 %	2013	2013 %	2014	2014 %	2015	2015 %
basic child welfare services	3,254	22.2%	3,143	21.7%	3,119	21.5 %	3,198	21.8%
specialist child protection services	1,099	7.5%	1,397	9.7%	1,443	9.9%	1,430	9.8%
specialised services	1,838	12.5%	1,805	12.5%	1,823	12.6 %	1,860	12.7%
social basic care	8,477	57.8%	8,128	56.2%	8,106	55.9 %	8,150	55.7%
<i>no indication</i>					18	0.1%		
Total	14,668	100.0 %	14,473	100.0 %	14,509	100.0 %	14,638	100.0 %

Source: NORSA

4. The annual number and distribution of services by service type³²

a) Distribution of service types, 2012–2013 (20 service types in 2012 and 22 in 2013)

Service type	2012	2012 %	2013	2013 %
Institution providing attendance and care	1,136	7.7%	1,122	7.8%
Institution providing temporary accommodation	453	3.1%	438	3.0%
Family assistance	683	4.7%	627	4.3%
Other special social institution	-	-	1	0.0%
Catering	2,243	15.3%	2,218	15.3%
Village caregiving and farm caregiving services	1,299	8.9%	1,292	8.9%
Temporary care of children	308	2.1%	281	1.9%
Daytime care of children	2,186	14.9%	2187	15.1%
Child welfare services	760	5.2%	675	4.7%
Home assistance	1,444	9.8%	1,388	9.6%
Home assistance within the reporting system	258	1.8%	225	1.6%
Community care	286	1.9%	251	1.7%
Residential home	187	1.3%	184	1.3%
Daytime care	1,817	12.4%	1,731	12.0%
Home provision	559	3.8%	557	3.8%
Follow-up care after the home-start benefit	-	-	2	0.0%
Rehabilitation institution	62	0.4%	60	0.4%
Support service	329	2.2%	301	2.1%
Regional child protection specialist service	23	0.2%	21	0.1%
Street social worker	118	0.8%	95	0.7%
Follow-up care	8	0.1%	288	2.0%
Follow-up care services	509	3.5%	529	3.7%
Total	14,668	100.0%	14,473	100.0%

Source: NORSA

³² The name (and number) of the service types have changed in the meantime and a previous name may include more present service types. The distributions by type and sub-type is presented in a two-year breakdown, putting those years in pairs by the comparison of which no problems have arisen.

b) Distribution of service types, 2014-2015 (29 service types in 2014 and 30 at the end of 2015)

Service type	2014	2014 %	2015	2015 %
Alternative daytime care	121	0.8%	128	0.9%
Institutional care services providing attendance and care	1,119	7.7%	1,119	7.6%
Institutional care services providing temporary accommodation	437	3.0%	442	3.0%
Nursery	739	5.1%	758	5.2%
Family child care	3	0.0%	2	0.0%
Family daytime care	1,330	9.2%	1,390	9.5%
Temporary family homes	159	1.1%	161	1.1%
Family assistance	624	4.3%	622	4.2%
Family assistance and child welfare services	-	-	2	0.0%
Village caregiving service	935	6.4%	942	6.4%
Temporary children's homes	33	0.2%	33	0.2%
Child welfare services	649	4.5%	636	4.3%
Children's home	1,184	8.2%	1,185	8.1%
Child-minding	22	0.2%	20	0.1%
Home assistance	1,355	9.3%	1,345	9.2%
Deputy parent care services	76	0.5%	69	0.5%
Home assistance within the reporting system	209	1.4%	207	1.4%
Community care	242	1.7%	234	1.6%
Follow-up care provided at an external place	44	0.3%	39	0.3%
Residential home care	178	1.2%	172	1.2%
Daytime care	1,734	12.0%	1,724	11.8%
Network of foster parents	136	0.9%	132	0.9%
Rehabilitation institutional care	58	0.4%	60	0.4%
Social catering	2,218	15.3%	2,251	15.4%
Support service	286	2.0%	286	2.0%
Supported housing	31	0.2%	67	0.5%
Farm caregiving service	418	2.9%	447	3.1%
Regional child protection specialist service	29	0.2%	28	0.2%
Street social worker	90	0.6%	91	0.6%
Follow-up care home	50	0.3%	46	0.3%
Total	14,509	100.0%	14,638	100.0%

Source: NORSA

5. Number and distribution of service sub-types

a) Distribution of service sub-types, 2012–2013. (73 sub-types in 2012, 74 sub-types in 2013)

Service sub-type	2012	2012 %	2013	2013 %
Alternative daytime care	175	1.19%	144	0.99%
Nursery	741	5.05%	728	5.03%
Family child care	2	0.01%	3	0.02%
Family daytime care	1,201	8.19%	1,244	8.60%
Family daytime care service network	40	0.27%	42	0.29%
Temporary family homes	177	1.21%	161	1.11%
Family assistance	683	4.66%	627	4.33%
Daytime care of demented persons	38	0.26%	13	0.09%
Other special social institution	-	-	1	0.01%
Night shelter	99	0.67%	99	0.68%
Catering	2,204	15.03%	2173	15.01%
Village caregiving and farm caregiving services	1,223	8.34%	1109	7.66%
Village caregiving service	47	0.32%	96	0.66%
Home of persons with (visual, mobility, mental) disabilities	171	1.17%	169	1.17%
Nursing and caring residential home of persons with disabilities	111	0.76%	111	0.77%
Care home of persons with disabilities	23	0.16%	23	0.16%
Daytime care of persons with disabilities	289	1.97%	288	1.99%
Rehabilitation residential home of persons with disabilities	45	0.31%	43	0.30%
Rehabilitation institution of persons with disabilities	23	0.16%	22	0.15%
Temporary children's homes	36	0.25%	34	0.23%
Child welfare centre	45	0.31%	45	0.31%
Child welfare service	575	3.92%	467	3.23%
Children's home	241	1.64%	285	1.97%
External places operated by the children's home	14	0.10%	14	0.10%
Temporary accommodation for homeless people	110	0.75%	109	0.75%
Home for homeless people	15	0.10%	15	0.10%
Rehabilitation institution for homeless people	10	0.07%	10	0.07%
Child-minding	25	0.17%	25	0.17%
Home assistance	1,444	9.84%	1,388	9.59%
Network of deputy and foster parents	6	0.04%	12	0.08%
External places operated by the network of deputy and foster parents	2	0.01%	5	0.03%
Network of deputy parents	33	0.22%	34	0.23%
Weekly nursery	2	0.01%	1	0.01%
Old-age home	847	5.77%	837	5.78%
Care home of old-age persons	206	1.40%	193	1.33%
Home assistance within the reporting system	258	1.76%	225	1.55%
Community care	6	0.04%	3	0.02%
Extraordinary children's home	59	0.40%	78	0.54%
External places operated by the extraordinary children's home	3	0.02%	2	0.01%

Extraordinary family group home	122	0.83%	152	1.05%
External places operated by the extraordinary family group home	1	0.01%	1	0.01%
External place	6	0.04%	2	0.01%
Family group home	437	2.98%	582	4.02%
External places operated by the family group home	5	0.03%	3	0.02%
Daytime care for homeless people	122	0.83%	120	0.83%
Daytime care for old-age persons	1,218	8.30%	1,157	7.99%
Soup kitchen	39	0.27%	45	0.31%
Network of foster parents	88	0.60%	121	0.84%
External places operated by the network of foster parents	5	0.03%	5	0.03%
Independent child welfare service provider	140	0.95%	163	1.13%
Independent deputy parent	62	0.42%	52	0.36%
Temporary home of people with psychiatric diseases	7	0.05%	7	0.05%
Residential home of people with psychiatric diseases	18	0.12%	17	0.12%
Daytime care for people with psychiatric diseases	74	0.50%	78	0.54%
Home for people with psychiatric diseases	78	0.53%	76	0.53%
Rehabilitation institution of people with psychiatric diseases	7	0.05%	7	0.05%
Basic community care for people with psychiatric diseases	103	0.70%	92	0.64%
Special children's home	21	0.14%	25	0.17%
Special family group home	16	0.11%	17	0.12%
Low-threshold care for people with addictions	69	0.47%	61	0.42%
Temporary home of people with addictions	8	0.05%	7	0.05%
Residential home for people with addictions	13	0.09%	13	0.09%
Daytime care for people with addictions	76	0.52%	75	0.52%
Home for people with addictions	25	0.17%	25	0.17%
Rehabilitation institution for people with addictions	22	0.15%	21	0.15%
Basic community care for people with addictions	108	0.74%	95	0.66%
Support service	329	2.24%	301	2.08%
Farm caregiving service	29	0.20%	87	0.60%
Regional child protection specialist service	23	0.16%	29	0.20%
External places operated by the regional child protection specialist service	14	0.10%	13	0.09%
Street social worker	118	0.80%	95	0.66%
Follow-up care family group home	7	0.05%	16	0.11%
Follow-up care home	28	0.19%	33	0.23%
External places operated by the follow-up care home	1	0.01%	2	0.01%
Total	14,668	100.00%	14,473	100.00%

Source: NORSA

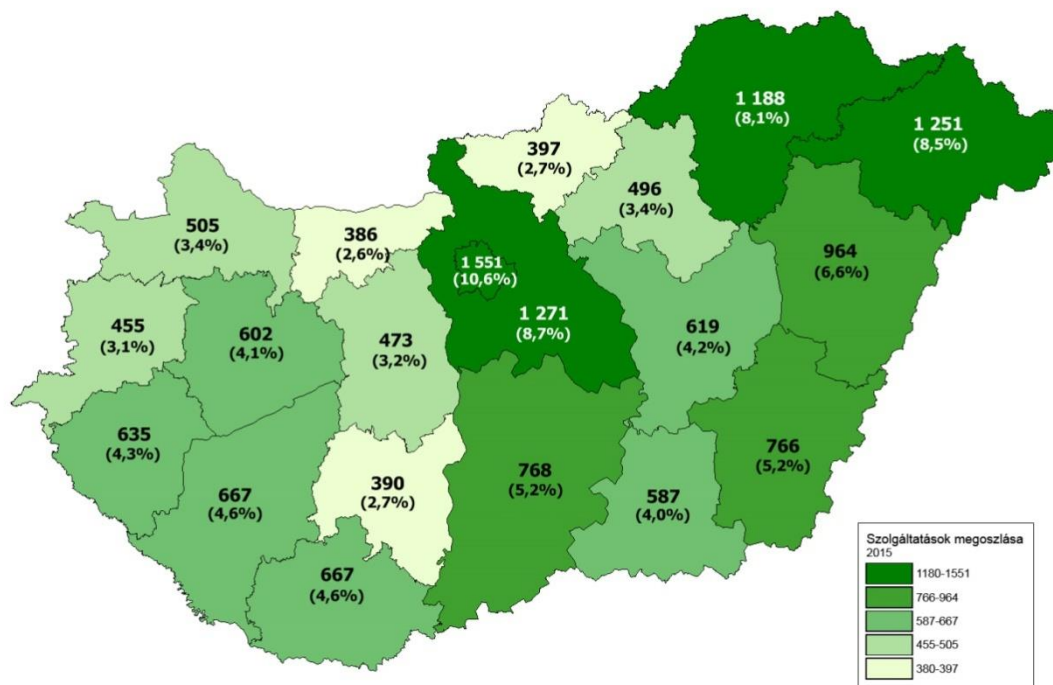
b) Distribution of service sub-types, 2014-2015. (78 sub-types in 2014, 77 sub-types in 2015)

Service sub-types	2014	2014%	2015	2015%
Family and child welfare centre	-	-	1	0.01%
Family and child welfare service	-	-	1	0.01%
Other eatery	800	8.41%	849	8.85%
Night shelter	101	1.06%	104	1.08%
Nursing and caring residential home of persons with disabilities	111	1.17%	111	1.16%
Care home of persons with disabilities	20	0.21%	21	0.22%
Daytime care of persons with disabilities	293	3.08%	297	3.10%
Home of persons with disabilities	165	1.73%	165	1.72%
Rehabilitation residential home of persons with disabilities	40	0.42%	40	0.42%
Rehabilitation institution of persons with disabilities	19	0.20%	20	0.21%
Child welfare centre	55	0.58%	56	0.58%
Child welfare service	594	6.24%	580	6.04%
Temporary accommodation for homeless people	112	1.18%	111	1.16%
Daytime care of homeless people	123	1.29%	122	1.27%
Rehabilitation institution of homeless people	11	0.12%	12	0.13%
Home for homeless people	15	0.16%	14	0.15%
Family daytime care operated within a network	180	1.89%	243	2.53%
Network of deputy parents	28	0.29%	25	0.26%
Old-age home	839	8.82%	839	8.74%
Care home of old-age persons	190	2.00%	193	2.01%
Daytime care for old-age people	1,160	12.19%	1,136	11.84%
Deputy parent care services not provided within a network	48	0.50%	44	0.46%
Soup kitchen	52	0.55%	64	0.67%
Home provision – Children's home	140	1.47%	126	1.31%
Home provision – Network of deputy and foster parents	2	0.02%	-	-
Home provision – Children's home providing care for unaccompanied minors	1	0.01%	1	0.01%
Home provision – Central special children's home	1	0.01%	2	0.02%
Home provision – Special children's home not classified as central special children's home	15	0.16%	14	0.15%
Home provision – Extraordinary children's home	37	0.39%	31	0.32%
Home provision – Extraordinary family group home	63	0.66%	66	0.69%
Home provision – Family group home	230	2.42%	238	2.48%
Home provision – Network of foster parents	49	0.51%	50	0.52%
Home provision – Special family group home	10	0.11%	11	0.11%
Independent family daytime care service	1,150	12.09%	1147	11.95%
Temporary home of people with psychiatric diseases	7	0.07%	7	0.07%
Daytime care for people with psychiatric diseases	81	0.85%	88	0.92%
Home for people with psychiatric diseases	75	0.79%	76	0.79%
Rehabilitation residential home of people with psychiatric diseases	15	0.16%	13	0.14%
Rehabilitation institution of people with psychiatric diseases	7	0.07%	7	0.07%

Basic community care for people with psychiatric diseases	92	0.97%	91	0.95%
Temporary home of people with addictions	7	0.07%	6	0.06%
Daytime care for people with addictions	77	0.81%	81	0.84%
Home for people with addictions	25	0.26%	25	0.26%
Rehabilitation residential home for people with addictions	12	0.13%	8	0.08%
Rehabilitation institution for people with addictions	21	0.22%	21	0.22%
Low-threshold care for people with addictions	58	0.61%	59	0.61%
Basic community care for people with addictions	92	0.97%	84	0.88%
Social kitchen	1,366	14.36%	1338	13.94%
Supported housing for people with disabilities	16	0.17%	38	0.40%
Supported housing for people with psychiatric diseases	6	0.06%	13	0.14%
Supported housing for people with addictions	9	0.09%	16	0.17%
Regional child protection specialist service	20	0.21%	20	0.21%
Follow-up care	46	0.48%	15	0.16%
Follow-up care – Children's home	73	0.77%	63	0.66%
Follow-up care – Special children's home not classified as central special children's home	2	0.02%	2	0.02%
Follow-up care – Extraordinary children's home	15	0.16%	13	0.14%
Follow-up care – Extraordinary family group home	38	0.40%	41	0.43%
Follow-up care – Family group home	151	1.59%	165	1.72%
Follow-up care – Network of foster parents	6	0.06%	28	0.29%
Follow-up care – Special family group home	2	0.02%	2	0.02%
Follow-up care – Follow-up care family group home	6	0.06%	6	0.06%
Follow-up care – Follow-up care home not classified as follow-up care family group home	6	0.06%	5	0.05%
Follow-up care service – Children's home	123	1.29%	112	1.17%
Follow-up care service – External places operated by the children's home	13	0.14%	12	0.13%
Follow-up care service – Network of deputy and foster parents	1	0.01%	-	-
Follow-up care service – External places operated by the network of deputy and foster parents	5	0.05%	-	-
Follow-up care service – Central special children's home	-	-	1	0.01%
Follow-up care service – Special children's home not classified as central special children's home	7	0.07%	6	0.06%
Follow-up care service – Extraordinary children's home	21	0.22%	21	0.22%
Follow-up care service – External places operated by the extraordinary children's home	2	0.02%	1	0.01%
Follow-up care service – Extraordinary family group home	61	0.64%	64	0.67%
Follow-up care service – External places operated by the extraordinary family group home	1	0.01%	-	-
Follow-up care service – Family group home	193	2.03%	205	2.14%
Follow-up care service – External places operated by the family group home	4	0.04%	5	0.05%
Follow-up care service – Network of foster parents	41	0.43%	47	0.49%
Follow-up care service – External places operated by the network of foster parents	5	0.05%	10	0.10%
Follow-up care service – Special family group home	1	0.01%	1	0.01%
Follow-up care service – External places operated by the regional specialist child protection services	12	0.13%	9	0.09%

Follow-up care service – Follow-up care family group home	10	0.11%	9	0.09%
Follow-up care service – Follow-up care home not classified as follow-up care family group home	28	0.29%	26	0.27%
Follow-up care service – External places operated by the follow-up care home	2	0.02%	2	0.02%
Total	9515³³	100.00%	³⁴	100.00%

Source: NORSÁ



³³ 4,994 services without a sub-type are not included in the table (which is 34.4% of all services).

³⁴ 5,042 services without a sub-type are not included in the table (which is 34.4% of all services).

6. Aggregated distribution of services by county on 31 December 2015

	qty	%
Bács-Kiskun County	768	5.2%
Baranya County	667	4.6%
Békés County	766	5.2%
Borsod-Abaúj-Zemplén County	1,188	8.1%
Budapest	1,551	10.6%
Csongrád County	587	4.0%
Fejér County	473	3.2%
Győr-Moson-Sopron County	505	3.4%
Hajdú-Bihar County	964	6.6%
Heves County	496	3.4%
Jász-Nagykun-Szolnok County	619	4.2%
Komárom-Esztergom County	386	2.6%
Nógrád County	397	2.7%
Pest County	1,271	8.7%
Somogy County	667	4.6%
Szabolcs-Szatmár-Bereg County	1,251	8.5%
Tolna County	390	2.7%
Vas County	455	3.1%
Veszprém County	602	4.1%
Zala County	635	4.3%
Total	14,638	100.0%

Source: NORSA

7. Number of service users by service type

a) Distribution of service users in KENYSZI* by service type, 2012–2013

service type	2012	2012%	2013	2013%
Institution providing attendance and care	73,617	10.8%	73,875	10.7%
Institution providing temporary accommodation	11,518	1.7%	11,810	1.7%
Family assistance	81,522	12.0%	87,496	12.7%
Other special social institution	-	-	-	-
Catering	144,366	21.2%	145,001	21.0%
Village caregiving and farm caregiving services	-	-	-	-
Temporary Care of Children	4,136	0.6%	4,171	0.6%
Daytime care of children	32,576	4.8%	31,409	4.5%
Child welfare services	89,019	13.1%	89,123	12.9%
Home assistance	119,610	17.6%	124,950	18.1%
Home assistance within the reporting system	24,294	3.6%	22,865	3.3%
Community care	8,410	1.2%	7,943	1.2%
Residential home	2,031	0.3%	2,012	0.3%
Daytime care	59,967	8.8%	60,897	8.8%
Home provision	18,143	2.7%	18,257	2.6%
Follow-up care after the home-start benefit		0.0%		-
Rehabilitation institution	1,701	0.3%	1,627	0.2%
Support service	6,497	1.0%	6,037	0.9%
Regional child protection specialist service	-	-	-	-
Street social worker	-	-	-	-
Follow-up care	-	-	41	0.0%
Follow-up care service	2,690	0.4%	2,871	0.4%
Total	680,097	100.0%	690,385	100.0%

Source: NORSA

* Central Electronic Registry on Service Users

b) Distribution of service users in KENYSZI by service type, 2014-2015

Service type	2014	2014%	2015	2015%
Institutional care services providing attendance and care	74,506	10.66%	75,983	10.69%
Institutional care services providing temporary accommodation	11,954	1.71%	13,955	1.96%
Nursery	28,753	4.11%	32,616	4.59%
Family daytime care	5,040	0.72%	5,414	0.76%
Temporary family homes	3,883	0.56%	4,373	0.62%
Family assistance	85,259	12.19%	66,072	9.30%
Temporary care of children	23	0.00%	-	-
Temporary children's homes	282	0.04%	358	0.05%
Daytime care of children	76	0.01%	-	-
Child welfare services	90,115	12.89%	95,592	13.45%
Children's home	7,215	1.03%	8,742	1.23%
Home assistance	127,539	18.24%	117,172	16.49%
Deputy parent care services	18	0.00%	16	0.00%
Home assistance within the reporting system	22,621	3.24%	22,340	3.14%
Community care	7,894	1.13%	7,738	1.09%
Follow-up care provided at an external place	358	0.05%	321	0.05%
Residential home	9	0.00%	-	-
Residential home care	1,934	0.28%	1,878	0.26%
Daytime care	61,812	8.84%	73,162	10.30%
Network of foster parents	12,872	1.84%	14,660	2.06%
Home provision	8	0.00%	-	-
Rehabilitation institutional care	1,587	0.23%	1,627	0.23%
Social catering	148,881	21.29%	158,047	22.24%
Support service	6,035	0.86%	9,740	1.37%
Supported housing	221	0.03%	389	0.05%
Regional child protection specialist service	13	0.00%	22	0.00%
Follow-up care home	248	0.04%	286	0.04%
Follow-up care service	13	0.00%	-	-
Total	699,169	100.0%	710,503	100.00%

Source: NORSA

8. Aggregated data of qualified workers

County distribution of the number of qualified workers at the end of 2015 and the ratio of beneficiaries to qualified workers

county	number of qualified workers	number of beneficiaries	beneficiary per qualified worker
Bács-Kiskun	4,112	37,940	9.2
Baranya	3,494	29,846	8.5
Békés	4,777	55,134	11.5
Borsod-Abaúj-Zemplén	5,632	65,617	11.7
Budapest	10,255	97,072	9.5
Csongrád	3,166	24,552	7.8
Fejér	2,471	19,822	8.0
Győr-Moson-Sopron	2,506	22,206	8.9
Hajdú-Bihar	6,080	52,645	8.7
Heves	2,033	19,152	9.4
Jász-Nagykun-Szolnok	3,108	27,305	8.8
Komárom-Esztergom	2,135	16,704	7.8
Nógrád	1,507	14,717	9.8
Pest	6,019	47,466	7.9
Somogy	2,479	24,421	9.9
Szabolcs-Szatmár-Bereg	7,116	79,402	11.2
Tolna	1,746	15,711	9.0
Vas	1,994	16,144	8.1
Veszprém	2,457	25,172	10.2
Zala	2,427	19,475	8.0
Total	75,514	710,503	average 9.2

Source: NORSA

4) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR repeatedly requests information as to the requirement concerning the residence of the States Parties' citizens, on the basis of which they may be eligible to social services different from residential placement, catering and temporary assistance. The ECSR has also concluded that the situation in Hungary does not comply with the conditions set forth by Article 14(1), on the ground that the citizens of other States Parties are not granted equal and effective access to the social welfare services of the country.**

The personal scope of the Social Act covers every person with the right of free movement and residence if they exercise the right of residence exceeding three months in the territory of Hungary.

“3. (1) The scope of this Act shall cover – with the exceptions set forth in Sub-sections (2)-(3) – the following persons living in Hungary:

- a) Hungarian citizens,*
- b) holders of immigration or settlement permits,*
- c) stateless persons,*
- d) persons recognized as refugees or beneficiaries of subsidiary protection by the Hungarian authority.*

(2) Further to Sub-section (1), the scope of this Act shall also cover the citizens of countries ratifying the European Social Charter legally residing in the territory of Hungary with regard to the allowances set forth in Sub-section (1) of Section 7.

(3) The scope of this Act shall cover

- a) persons entitled to free movement and residence under the Act on the Entry and Residence of Persons Entitled to Free Movement and Residence (hereinafter referred to as “Residence Act”), provided that at the time of claiming the service, under the Residence Act, they exercise the right of free movement and residence exceeding three months in the territory of Hungary and they have a registered permanent residence in Hungary under the Act on Maintaining Records on the Personal Data and Address of Citizens; as well as*
- b) with regard to the old-age allowance specified in Sub-section (1) of Section 32/B, persons falling under the eligibility criteria set forth in the Union regulations on the coordination of social security systems and its implementing regulations (hereinafter referred to as “Union regulations”) in case they exercise the right of free movement and residence specified in the Residence Act in the territory of Hungary at the time of claiming the services, and they have a registered permanent residence in the territory of Hungary under the Act on Maintaining Records on the Personal Data and Address of Citizens.”*

- **The ECSR requests information on the conditions for the application of the social administrative fine.**

The body authorising the operation may levy a social administrative fine on the institutions providing social services without authorisation. Whereas in the case of service providers with an operating licence an administrative contract will be concluded.

The annual aggregated data of social administrative fines (source: NORSA)

in 2012: social administrative fine was not levied.

in 2013: overall HUF 3.6m (prior to appeal). The amount of the fine was decreased to HUF 1.075m with the decision at first instance of EMMI, taking into account the willingness of the maintainer and the head of institution to cooperate, as well as the measures taken to eliminate infringements.

in 2014: Decision on the merits (order) on the elimination of shortcomings and the restoring of the orderly functioning was not taken; the Office did not make a decision to order the levy of a social administrative fine; administrative contract was not concluded.

in 2015: The Office made 22 decisions to order the levy of a social and child protection administrative fine; administrative contract was not concluded. The amount of the levied social administrative fine is HUF 760,000, while the amount of the child protection administrative fee is HUF 220,000.

- **The ECSR requests information on the number of staff providing social services, and its ratio to the number of persons using the services.**

See point 3) above with regard to the data concerning all social services related to the staff conditions set forth in Decree of the Minister of Social and Family Affairs No. 1/2000 (I. 7.) on the Professional Tasks and Operating Conditions of Social Institutions Providing Personal Care.

- **The ECSR requests information on the regulations regarding the protection of personal data in the context of the use of social services.**

See the information given in point 1) above.

[With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:]

2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF THE REFORMS

As of 31 December 2015, pursuant to Sub-section (1) of Section 92/K., provided that the conditions prescribed by law are satisfied, any maintainer may provide social services if (the headquarters or site of) the social service provider or social institution maintained by this maintainer is in the register of service providers.

As of 31 December 2015, the following institutions can be maintainers of the institutions providing social services: Pursuant to point m) of Sub-section (1) of Section 4 of the Social Act:

“ma) the organisation appointed by the government in a decree to perform maintainer duties, the local government, the association of local governments (hereinafter jointly referred to as “state maintainer”);

mb) the ecclesiastical legal entities (hereinafter jointly referred to as “church maintainer”);

mc) the sole trader;

md) a legal entity and sole proprietorship not mentioned in sub-points ma)-mb) with a registered seat in Hungary,

me) branch office incorporated in Hungary of an enterprise established in a state that is party to the EEA agreement (hereinafter referred to as “EEA state”), and if, in accordance with an international treaty with the European Community or its Member States, the service providers of a state have the same legal status as the service providers of EEA states with regard to freedom of establishment, then the branch office incorporated in Hungary of an enterprise established in a non-EEA state [those mentioned in sub-points mc)-me) hereinafter jointly referred to as “non-state-maintainer”], if it establishes and operates a social services or social institutions under the conditions laid down by this Act or other legislation.”

2) RESPONSES TO THE QUESTIONS OF THE ECSR CONCERNING THIS PARAGRAPH

- **The ECSR requests information on the funding of non-state social service providers.**

The financing logic changed with regard to certain social services in the reporting period. As of 2013, the normative funding was replaced by a funding distribution based on average wages in the case of professional social and child protection services. The non-state maintainers receive a higher amount of funding through the modification of financing.

Nevertheless, every benefit related to a social services included in the statutory financing system and taking into account the geographical coverage of social services is regulated by the Act concerning the budget of the current year. In addition to basic benefits, the church maintainers are eligible to supplementary church benefits.

- **The ECSR requests information on how the social consultation procedure operates in the case of social services.**

The participation of social services in the social consultation procedure is fulfilled on the basis of Act CXXXI of 2010 on the Participation of Civil Society in the Preparation of Legislation; the Minister responsible for preparing the legislation establishes strategic partnership agreements with the organisations that are ready for mutual co-operation and represent a wide social interest in preparing the regulation of given legislative areas. On the maintainers' side, thus, for instance, non-profit organisations, recognised churches and interest representing organisations are also included in the process of direct negotiation. In the process of direct negotiation it is the obligation of the strategic partner to represent the opinion of organisations engaged in a specific legislative area that are without a strategic partnership. In addition to strategic partners, the Minister responsible for preparing the legislation may involve other partners in the direct negotiation of the relevant draft or, upon request, may provide an opportunity to participate in the review of a specific legislation.

- **The ECSR requests information on how the Government ensures that the services provided by non-state service providers are equally and efficiently available to everybody without discrimination on grounds of gender, ethnicity, religion, disability, age, sexual orientation and political opinion.**

The Social Act imposes obligations on municipal and state actors. Nevertheless, the commitment of church and non-profit maintainers is on a voluntary basis, but it is compulsory to determine the professional content in the case of every institution providing social services irrespective of the type of maintainer so the obligations and responsibilities are the same in the case of both maintainers. Pursuant to Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunity the access is guaranteed, irrespective of race, gender, age, ethnic and religious belonging, disability, political views and sexual orientation. The requirement of equal treatment should be observed by the persons and institutions providing social and child welfare care, as well as child welfare services in the course of establishing their legal relationship and in their legal relationships, procedures and measures.

ARTICLE 16 – THE RIGHT OF THE FAMILY TO SOCIAL, LEGAL AND ECONOMIC PROTECTION

In order to ensure the conditions for the full development of the family, being the fundamental unit of the society, the Parties agree to promote the economic, legal and social protection of families by instruments such as social and family benefits, taxation solutions, family housing allowance, support to the newly married and other appropriate means.

Conclusions by the ECSR (2015/XX-4):

- **The ECSR concluded that the Hungarian situation did not comply with Article 16 of the Charter because evicted families may become homeless.**

I. Regulation in the Fundamental Law

The Fundamental Law of Hungary deals with living without a dwelling in Article XXII:

“(1) Hungary shall strive to ensure decent housing conditions and access to public services for everyone.

(2) The State and local governments shall also contribute to creating decent housing conditions by striving to ensure accommodation for all persons without a dwelling.

(3) In order to protect public order, public security, public health and cultural values, an Act or a local government decree may, with respect to a specific part of public space, provide that staying in public space as a habitual dwelling shall be illegal.”

Article XXII of the Fundamental Law sets ensuring decent housing conditions as a state objective. This state objective is to be met, among others, by the State and local governments striving to ensure accommodation for all persons without a dwelling.

Besides ensuring decent housing conditions, Act II of 2012 on offences, the procedure in relation to offences and the offence record system (hereinafter: the Act on Offences) makes it clear that it does not support misusing public space, i.e. staying in public space as a habitual dwelling. A rule on guarantee regarding the classification as an illegal act pursuant to Article XXII(3) of the Fundamental Law is the fact that it can only be done for achieving the objectives described (in order to protect public order, public security, public health and cultural values) and only with respect to a specific part of public space.

1. The right to decent housing conditions

Ensuring decent housing conditions and access to public services is a new measure in the Fundamental Law. The justification of Article XXII(1) of the Fundamental Law says in connection with this that the State can rectify several problems related to housing conditions with establishing an appropriate legislative environment and in certain cases with establishing a set of institutions.

“However, the regulation has the characteristics of a programme, and its implementation depends on the economic capacity of the State in every case. The other objective is ensuring access to public services, whose guarantees can be ensured by other legislative acts like the

Local Government Act which contains separate safeguards in case a local government does not perform its duties and does not ensure public services.”

2. The role of local governments concerning decent housing conditions

The fourth amendment of the Fundamental Law (25 March 2013) imposed striving to ensure accommodations for persons without a dwelling as a constitutional obligation on local governments in Article XXII(2) of the Fundamental Law. According to the regulation, it is still not mandatory to provide for persons without a dwelling, but it is mandatory for all local governments to strive to terminate living without a dwelling and make decent housing conditions available.

3. Legislation by local governments

As a result of the fourth amendment of the Fundamental Law, the rule incorporated in Section 186 of the Act on Offences facilitated sanctions related to living without a dwelling. The Commissioner for Fundamental Rights challenged the regulation in the Constitutional Court, and it resulted in AB Decision 38/2012 (XI. 14.) also on other significant issues, which concluded in connection with persons living without a dwelling that the provision of breaching the prohibition of staying in public space as a habitual dwelling regulated in Section 186, effective as of 15 April 2012, of the Act II of 2012 on offences is against the Fundamental Law. The fourth amendment of the Fundamental Law modified the regulation taking the decision of the Constitutional Court into consideration. First, it specified the objectives to be protected which can justify the sanction (protecting public order, public security, public health and cultural values). Second, it is another restriction that staying in public space as a habitual dwelling can only be deemed illegal with respect to a specific part of public space. The sanctioning norm can be an act or a local government decree. However, this does not mean that local governments can establish a new offence because according to Section 1(1) of the Act on Offences, an offence is an activity or default which is dangerous to the society and is to be sanctioned by this act. Therefore, offences can only be established by the Act on Offences, and local governments only have the opportunity to designate areas where staying in public space is considered illegal based on the interests above (Section 179/A(2) and (3) of the Act on Offences).

Section 179/A(1) of the Act on Offences defines the offence of staying in public space as a habitual dwelling. According to paragraph (2) and (3) of this section, the local government or in respect of the capital city the capital local government can designate areas of public space where staying as a habitual dwelling is deemed illegal in order to protect public order, public security, public health and cultural values.

Section 179/A(4) defines which behaviours can be considered staying at a place as a habitual dwelling. It includes all behaviour that lead to the conclusion that staying in the designated space as a habitual dwelling is not coupled with the intention of returning to the place of domicile or residence or other accommodation and its purpose is staying in the designated space for a longer time, and the circumstances of staying in the designated space or the behaviour suggest that the offender does the activities, especially sleeping, cleaning, eating, clothing and having animals, regularly, returning at short intervals, in the designated space serving as his or her dwelling.

According to Section 179/A(1), the offence is not sanctioned immediately; the offender is first requested to leave the forbidden area. The Act on Offences regulates in Section 179/A(5) that

in the case of the circumstances laid down by law, if the offender refuses to leave the area despite the request, community service can be imposed. If the offender does not undertake community service, a fine can be imposed.

The act excludes imposing on-the-spot fines in the case of this offence.

II. The practice of the Constitutional Court related to issues of eviction and living without a dwelling

1. Decisions related to living without a dwelling

The Constitutional Court established constitutional criteria in connection with the constitutional supervision of regulations of different content and level related to living without a dwelling several times.

AB Decision 40/2012 (XII. 6.)	on establishing that certain provisions of Act CXCI of 2011 on benefits for persons with changed working capacity and the amendment of certain other acts are against the Fundamental Law and annulling them
AB Decision 38/2012 (XI. 14.)	on the annulment of the provision of offence sanctioning staying in public space as a habitual dwelling and other legislative provisions
AB Decision 12/2013 (V. 24.)	on rejecting the proposal to establish that certain provisions of the fourth amendment of the Fundamental Law of Hungary (25 March 2013) are against the Fundamental Law and to annul them ³⁵
AB Decision 3/2016 (II. 22.)	on establishing a constitutional criterion in relation to Section 7(3) of Local Government Decree No. 7/2013 (III. 4.) on the basic rules of community living issued by the local government of Kaposvár, City of County Rights

1.1. In its AB Decision 40/2012 (XII. 6.), the Constitutional Court confirms its previous practice when it refers to AB Decision 42/2000 (XI. 8.).

“Specifically determined partial rights such as the right to housing cannot be deducted as constitutional fundamental rights from the guarantee of a minimum level of subsistence. However, this decision also says that protecting human life and dignity is a fundamental requirement resulting from the Constitution when establishing and operating a social security and social institutional system. Accordingly, the State is obliged to ensure the basic conditions of human life including handling emergencies which directly threaten human life in the case of living without a dwelling.”

³⁵ This decision is not described in details because the promoter raised issues of content in his proposal to establish that the amendment was against the Fundamental Law due to invalidity according to public law and to annul it, but the Constitutional Court cannot supervise the Fundamental Law and its amendments as far as the content is concerned.

The Constitutional Court made this decision before the third amendment of the Fundamental Law (21 December 2012). At that time, Article XXII of the Fundamental Law contained only the following: *'Hungary shall strive to ensure decent housing conditions and access to public services for everyone.'*

1.2. The Constitutional Court in its AB Decision 38/2012 (XI. 14.) annulled the provision of offence sanctioning staying in public space as a habitual dwelling. The decision centres around the fact that living without a dwelling should not be sanctioned with punishment but it should be handled with the means of social administration and social care.

The Constitutional Court made this decision before the third amendment of the Fundamental Law (21 December 2012). At that time, Article XXII of the Fundamental Law contained only the following: *'Hungary shall strive to ensure decent housing conditions and access to public services for everyone.'*

Section 186 of the Act on Offences, which was considered unconstitutional by the Constitutional Court, contained the following provision:

"186. (1) Those who misuse public space for staying there as a habitual dwelling or store movable assets used for habitual dwelling in public space, commit an offence.

(2) The offence specified in paragraph (1) cannot be deemed committed if the conditions of caring for persons without a dwelling are not ensured by the local government entrusted with this responsibility.

(3) Also the public area supervisor can impose on-the-spot fines for the offence specified in paragraph (1)."

The Constitutional Court made its decision detailed below taking into consideration the provisions of the Fundamental Law applicable at that time and the Act on Offences.

According to the Constitutional Court, the legislator considered a life situation, living on the street, i.e. living without a dwelling itself, punishable.

"The reason and the interest to be protected which justify that the legislator declares a life situation which falls in the scope of social care according to the Social Act (Act III of 1993 on Social Administration and Social Services) a behaviour that is dangerous to the society and criminal based on the state responsibility regulated in Article XIX of the Fundamental Law cannot be identified based on either the Act on Offences or its justification."

The Constitutional Court, when making its decision, examined the most important criteria for declaring something punishable: this declaration cannot be arbitrary, thus there must be constitutional reasons for it, and the norm foreseeing the sanction has to comply with the principle of legislative clarity and the requirements of the rule of law.

According to the Constitutional Court, protecting public order can be an interest of a constitutional nature which can be a reason for the legislator to impose offence penalties. The very fact that a person lives in public space does not infringe other persons' rights, does not cause damage, and does not threaten the proper use of public space, or public order. In order to sanction behaviour which infringes other persons' rights and threatens public order while using public space, the Act on Offences establishes several independent provisions on whose basis persons living without a dwelling who use public space threatening public order can be punished. The fact that using public space as a habitual dwelling entails the possibility of

infringing other persons' rights and violating public order cannot be considered a legitimate reason for declaring it punishable.

Living without a dwelling is a social problem which the State should handle with the means of social administration and social care and not with punishment. The protection of human dignity provided for in Article II of the Fundamental Law is not compatible with declaring persons who lost their housing for some reasons and are forced to live in public space dangerous to the society and punishing them for this, while they do not infringe other persons' rights, do not cause damage and do not commit any other illegal acts. It is also against the freedom of act resulting from the individual's human dignity if the State uses punishment to force people to use social services. (The Constitutional Court notes that offence penalties are not suitable to solve the social problem of living without a dwelling because the persons concerned cannot pay for their housing in the absence of an income; therefore, they are also incapable of paying fines.)

The other part of the decision dealt with the right of local governments to sanctioning based on the mandate in Section 51 of the Local Government Act which authorized local governments to impose administrative penalties in local government decrees in the case of extremely anti-community behaviour. These administrative penalties would have been other substantive law penalties to be used pursuant to Act CXL of 2004 on the general rules of administrative proceedings and services (hereinafter: AP).

“The Constitutional Court extended its examination to the constitutionality of Sections 94/B(1) to (3) of the AP based on their strong connection with the contested rules, and concluded that the words ‘or local government decree’ in these provisions are against the Fundamental Law, and imposing confiscation in a local government decree, in the absence of regulating the legislative framework, infringes legal certainty and, in connection with protecting the right to property, it is against Article I(3) of the Fundamental Law. Therefore, the Constitutional Court also annulled those provisions of the AP which it considered being against the Fundamental Law.”

The legislator amended the Act on Offences due to this decision; currently, it's Section 179/A of the Act on Offences which contains provisions related to violating the rules of staying in public space as a habitual dwelling.

After this decision of the Constitutional Court, the Fundamental Law was amended for the fourth time, and Article XXII of the Fundamental Law was supplemented. First, the new provisions specify the objectives to be protected, which can justify sanctioning. These are the protection of public order, public security, public health and cultural values. Second, it is another restriction of the Fundamental Law that staying in public space as a habitual dwelling can only be deemed illegal with respect to a specific part of public space (designated area). In view of this, only those findings of AB Decision 38/2012 (XI. 14.) are relevant which are not affected by the amendments of the Fundamental Law.

Article XXII of the Fundamental Law currently in force due to the fourth amendment is as follows:

“(1) Hungary shall strive to ensure decent housing conditions and access to public services for everyone.

(2) The State and local governments shall also contribute to creating decent housing conditions by striving to ensure accommodation for all persons without a dwelling.

(3) In order to protect public order, public security, public health and cultural values, an Act or a local government decree may, with respect to a specific part of public space, provide that staying in public space as a habitual dwelling shall be illegal.”

1.3. The Constitutional Court made AB Decision 3/2016 (II. 22.) after the fourth amendment of the Fundamental Law. The Constitutional Court made its decision based on the new regulation enshrined in the Fundamental Law.

The Constitutional Court concluded that in respect of Section 7(3) of Local Government Decree 7/2013 (III. 4.) on the basic rules of community living issued by the local government of Kaposvár, City of County Rights (hereinafter: Local Government Decree), it is a constitutional requirement resulting from Article XXII(3) of the Fundamental Law that the decree cannot be applied in the case of persons living without a dwelling in areas within its scope. The Constitutional Court rejected the proposal to establish that Section 7(3) of the Local Government Decree is against the Fundamental Law and to annul it.

According to the justification, based on the mandate given in Article XXII(3) of the Fundamental Law, the legislator, if it wishes to sanction staying in public space as a habitual dwelling, has the possibility of doing so with declaring it an offence or with the threat of other administrative penalties. It is also possible that this is done by the Parliament or the local governments, with the restriction that the latter ones cannot declare a behaviour an offence. The legislator finally declared infringing the rules of staying in public space as a habitual dwelling an offence within the framework based on this mandate; this behaviour is currently sanctioned by Section 179/A of the Act on Offences. It is not against the Fundamental Law by itself if the legislator sanctions the same behaviour both with offence penalties and other administrative penalties as long as the relationship of these procedures is clear. According to Article XXII(3) of the Fundamental Law, an act or a local government decree can declare staying in public space as a habitual dwelling illegal. The alternative given here means that if the legislator used this mandate for legislation, it excluded the legislative autonomy of local governments in this respect; therefore, staying in public space as a habitual dwelling and the related behaviours can only be sanctioned as offences. Law enforcers decide exactly which behaviours constitute an offence and are part of the contested provision. Legal rules always need clarification; however, the texts of legislative acts are basically expected to contain recognizable norms. ‘Finding’ the actual content of law is the responsibility of bodies interpreting the law, and the legislator may facilitate this process with its own means, that is with explanatory notes. Section 179/A(4) of the Act on Offences defines the circumstances of staying at a place as a habitual dwelling. As a result, local governments cannot declare staying in public space as a habitual dwelling and behaviours related to it according to the provision of offence above illegal and cannot sanction them.

The Constitutional Court took into consideration the information given to the Commissioner for Fundamental Rights by the Government Delegate heading the Government Office in Somogy County, according to which the contested provision refers to persons and behaviour other than persons living without a dwelling and activities inevitably related to this kind of living indicated in the proposal. The Constitutional Court examined the contested provision in proceedings for an abstract review of statutory provisions; therefore, if the law enforcement bodies use it to sanction staying in public space as a habitual dwelling in spite of this decision, it is possible to conduct a constitutional complaint procedure as well in relation to this issue. According to the Constitutional Court, the contested provision cannot be applied in the case of activities related to living without a dwelling, and there is no connection between the issue

whether movable assets can be stored in public space and the fundamental right to human dignity; therefore, the Constitutional Court did not examine Section 7(3) of the Local Government Decree from this point of view. The Constitutional Court, in order to promote the constitutional interpretation of the contested provision, concluded that it is a constitutional requirement resulting from Article XXII(3) of the Fundamental Law that Section 7(3) of the Local Government Decree cannot be applied to persons living without a dwelling in areas within its scope.

2. Constitutional Court decisions on eviction

2.1. The Constitutional Court made no substantial decisions related to eviction issues in the examined period (1 January 2012 – 31 December 2015).

2.2. There is one decision of the Constitutional Court which mentions eviction: AB Decision 22/2013 (VII. 19.) mentions eviction moratorium [Section 182/A of Act LIII of 1994 on judicial execution (hereinafter: Judicial Execution Act)] which promotes the principle of proportionate and gradual enforcement.

3. Conclusions related to implementing the provisions of the Revised European Social Charter in Hungary

The ECSR concluded in its ‘conclusions’ in 2013 that the Hungarian regulation did not comply with Article 16 of the Charter because the accommodation of persons forced to leave in the case of evicting squatted dwellings is not ensured and consequently, families may become homeless. It also criticised that pursuant to the Judicial Execution Act, eviction is also possible in winter.

In this respect we maintain our opinion that had been described in details several times, namely the legal system should provide the entitled persons with the given property regardless of the operation of state institutions placing families and it is not right to think that eviction of squatted dwellings leads to homelessness.

In the reporting period, the rules of eviction in the Judicial Execution Act (Sections 172–177, Sections 181–184) changed as follows.

As of 1 January 2012, Section 183/B which facilitates evicting railway station rooms and facilities in an expedited procedure was added to the Judicial Execution Act; as of 20 June 2012, Section 183/C was added which contains a provision protecting state property in relation to dwellings which become state property as it simplifies eviction-related execution rules in the case of expired rental agreements because leasers can initiate non-contentious proceedings specified in Section 183 of the Judicial Execution Act.

According to the information provided by the National Judicial Enforcement Body, there were about 400 evictions based on the rules of eviction of squatted dwellings in 2015; more accurate statistics are not available.

- **The ECSR concluded that the Hungarian situation did not comply with Article 16 of the Charter because the support of suitable housing of disadvantaged families and the access of Roma families to suitable housing cannot be established.**

The main directions of the Government's activities are specified in the National Social Inclusion Strategy (hereinafter: NTFS) which was adopted in 2011 and updated in 2014. The measures taken in the framework of the NTFS centres around the areas where the greatest intervention is needed based on the present situation. Such issues are child poverty, access to quality public services, labour market integration, improving housing conditions, and discrimination against the Roma. The programmes are implemented in an interlinked manner based on a complex and multidisciplinary approach, focused on the target groups, taking into consideration individual responsibility and the participation of the community.

In recent years, the housing-related results are as follows:

1. The complex settlement reconstruction programmes using more than HUF 4 billion of EU funding provide better access to public services and ensure accessibility of community services as well. Within the projects implemented in the course of the complex settlement programmes (TÁMOP 5.3.6.) a total of 22 bidders received subsidies totalling HUF 3.1 billion in 2012 in the first round (the implementation currently going on) with a total of 62 tenders submitted for the second round, of which – after augmenting the budget of the funding – a total of 34 received subsidies. The financing contracts are being concluded, and the projects start continuously.
2. The TIOP 3.2.3/A tender announcement entitled 'Supporting housing investments' (after increasing the budget: HUF 2.6 billion) was prepared to support the housing element of the TÁMOP 5.3.6 settlement programme, and received 8 applications until the deadline with a claim of HUF 1.96 billion. Apart from building social apartment houses, the other investments corresponding to the residential environment (e.g. parks, playgrounds, etc.) will also be accessible for all residents of the settlement. It is expected that the programmes will involve 2,520 persons (currently 1,710 persons), 60 % of whose, that is 1,512 persons (currently 700 persons), also take part in training.
3. By overweighing the system of state housing subsidies, the scope of the beneficiaries is significantly expanded (by over 80 % compared to the same period in 2011, to a total of 377,398 persons in 2013) by raising the income threshold per consumption unit of the eligibility for the housing support to 250 % of the minimum amount of the old age pension.

In summer 2015, in relation to the complex settlement programme, the Government adopted the 'Policy strategy underpinning the management of living in slum-like environments' which sets the most important objectives for the period between 2014–2020 in order to improve underdeveloped parts of settlements and segregated housing conditions. The strategy

- provides the framework for managing the housing problems of underdeveloped parts of settlements; however, local features must be presented and validated by the local entities, local governments in the Community Intervention Plans to be obligatorily prepared during the use of support resources. In the case of underdeveloped parts of settlements, the management of the situation reaches beyond the borders of settlements. In these cases, the effects and possibilities for townships must also be taken into account, and the problems of slums shall be managed in consultation with other settlements of the region. The primary goal of creating opportunities for housing is to create interventions by which an individual is able to manage his or her own housing and living conditions while local community interests are mutually taken into account based on the cooperation norms.
- The general objective of the strategy is to eliminate slums, which are often hardly suitable for human living; and in some cases – by largely taking into account the

individual circumstances – to rehabilitate the slums, embedded into settlements; and to establish the basis for directions and contents of the targeted policy applicable until 2020.

After updating the strategy, in September 2015, the Government adopted the second action plan of the inclusion strategy for the period between 2015–2017 which in coordination with the *Policy strategy underpinning the management of living in slum-like environments* serves to implement the NTFS and the strategy of managing living in slum-like environments by means of the following measures.

1. Complex programmes should be launched to socially and economically integrate disadvantaged regions. For this to happen, the framework, mechanisms of coordination and integration into local processes of harmonised interventions and services improving the chances of people living in underdeveloped districts should be established.
2. Targeted programmes should be launched to stop and reverse the segregation tendencies of settlements.
3. A targeted programme should be launched to prevent the segregation processes of rural areas suffering from depopulation
4. Inclusion programmes combined with a continuous technical presence should be launched in highly disadvantaged settlements where local communities lacking private resources, know-how and information can only be mobilised with external efforts of development.
5. A complex programme should be launched to support human development projects aimed at the social and regional integration of groups living in slum-like environments, as well as the implementation of relevant investments into infrastructural development and housing. The support of programmes proposed and backed by groups living in slum-like environments should be ensured.
6. The unified professional and methodological support of complex housing programmes arising from various operative programmes should be supported to enable a continuous exchange of experience and mutual learning. Projects, training and community programmes related to this area should be supported.
7. Innovative programmes should be developed to support the integration of people living in extreme poverty, including Roma, and disadvantaged groups, as well as to improve the effectiveness of organisations dealing with them, with particular attention to regional disadvantages.

It shall be examined how regional segregation could be treated by improving transportation and the means of transport, considering the reduction of regional inequalities mentioned in Section 1(f) of the Decision as well as the improvement of opportunities in the labour market.

Please also refer to the comments on Article 14(1) above.

- **The ECSR concluded that the Hungarian situation did not comply with Article 16 of the Charter on the ground that the citizens of other States Parties are not granted equal treatment in respect of family support benefits due to the requirement of a too long residence period.**

Regarding the ECSR's point of view, we further maintain the reply given in the 2014 report.

The personal scope of the Family Support Act changed compared to the one in 2012. Since 1 January 2014, third-country nationals are also entitled to family support, even in the absence of a residence permit or an EU Blue Card, if they stay in Hungary in possession of a single permit, provided that employment was permitted for them for a period exceeding six months (Section 2(f) of the Family Support Act).

The persons holding a single permit are employees coming from a third country or staying legally in the territory of one of the member states within the meaning of Directive 2011/98/EU on single application procedure for a single permit for third-country nationals to reside and work in the territory of a Member State and on a common set of rights for third-country workers legally residing in a Member State.

In summary, those persons who are not citizens of a European Union Member State or another country that is a party to the Agreement on the European Economic Area, or citizens having equivalent legal status in terms of the freedom of movement and residence based on an international treaty (EEA citizens) may be entitled to the benefits under the Family Support Act without obtaining a residence permit in the following cases:

- The family members of Hungarian citizens and EEA citizens have the right to freedom of movement and residence as of 1 January 2008, therefore they do not have to confirm any prior residence.
- As regards maternity benefit under the Family Support Act, the personal scope of the Family Support Act was extended as of 1 January 2011 in order to protect the health of mothers and children. According to the amendment, women residing legally in Hungary are entitled to maternity benefit as long as they attended prenatal care in Hungary on at least 4 occasions during their pregnancy, or once in the case of a premature delivery. In this case, the confirmation of prior residence is not required, either.
- As of 1 January 2012, third-country nationals holding a work permit for highly qualified work and a residence permit (EU Blue Card) may also avail themselves of the benefits under the Family Support Act without confirming prior residence.
- As of 1 January 2014, third-country nationals holding a single permit may avail themselves of the benefits under the Family Support Act without confirming prior residence provided that the employment was authorised for a period longer than 6 months.

As a result of the extension of the personal scope of the Family Support Act to persons holding a single permit, third-country nationals taking a job in the territory of Hungary for a period longer than six months become eligible for the benefits under the Family Support Act.

In our opinion, the amendments above made the Hungarian regulation comply with the requirements in Article 16 of the Charter.

APPENDIX

Sources of international law incorporated into Hungarian Law

(In the appendix of the questionnaire from among the international conventions referred to with regard to Article 3, 11, 12, 13 and 20)

Name of Convention	Date of Signature of Convention	Ratification, date of accession	Number of Law
International Covenant on Economic, Social and Cultural Rights (1966)	25 March 1969	17 January 1974	Legislative Decree 9/1976 on the Promulgation of the International Covenant on Economic, Social and Cultural Rights accepted on 16 December 1966 by the 21st session of the General Assembly of the United Nations
European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)	06 November 1990	05 November 1992	Act XXXI of 1993 on the Promulgation on the Convention for the Protection of Human Rights and Fundamental Freedoms, and the Convention signed on 04 November 1950 and the eight related supplementary protocols
Convention on the Rights of the Child (1989)	14 March 1990	07 October 1991	Act LXIV of 1991 on the Promulgation on the Convention on the Rights of the Child (1989) signed on 20 November 1989 in New York
ILO Convention No. 155 on Occupational Safety, Health and Working Environment		04 January 1994	Act LXXV of 2000 on the Promulgation on the Convention No. 155 on Occupational Safety, Health and Working Environment adopted on the 67th session of the International Labour Conference
ILO Convention No. 161 on Occupational Health Services		24 February 1988	Decree Law No. 13 of 1988 on the Promulgation on the Convention on Occupation Health Services signed on 16 June 1985 in Geneva